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OF MEDICAID

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SPECIAL ISSUE 2004

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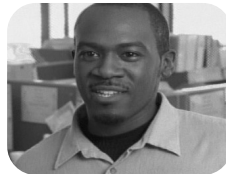
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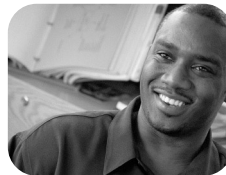
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1883 First use in North
America of antiseptic
during childbirth to protect
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from deadly infections
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1896 First use of X-ray
image for diagnosis in U.S.
— *Massachusetts General Hospital*

1929 First use of iron lung
to save polio victim
— *Brigham and Women's Hospital*



1947 First artificial kidney
machine in U.S. perfected
— *Brigham and Women's Hospital*

1954 First successful human
organ transplant
— *Brigham and Women's Hospital*

1962 First successful surgical
reattachment of severed limb
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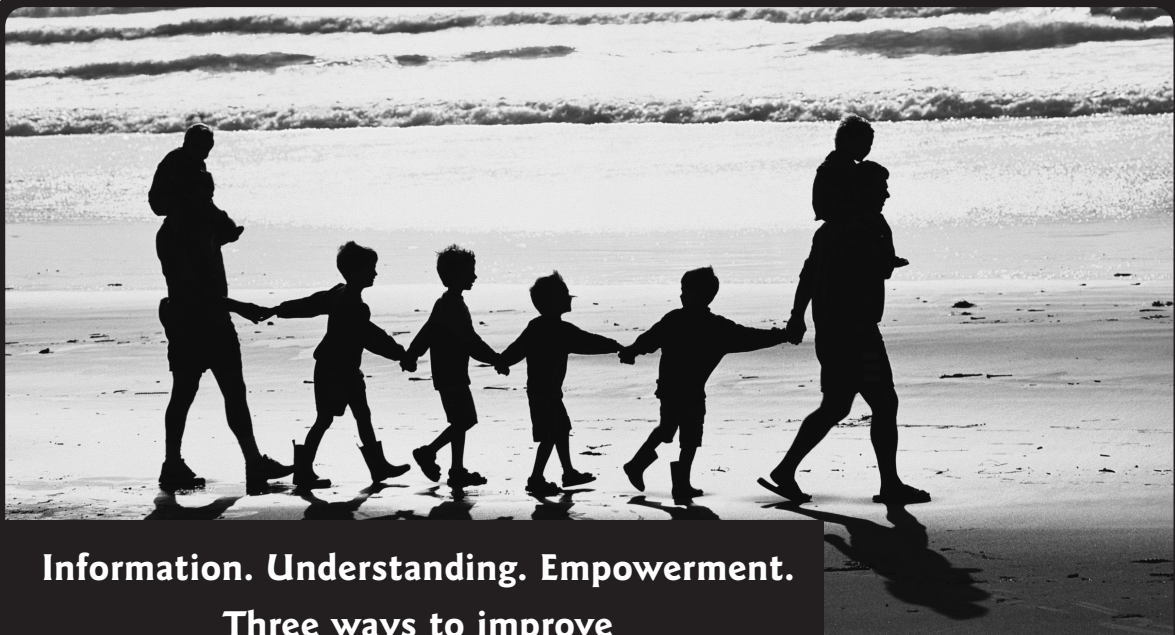
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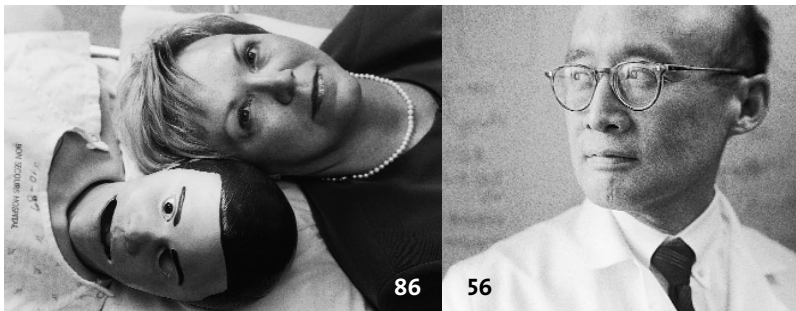
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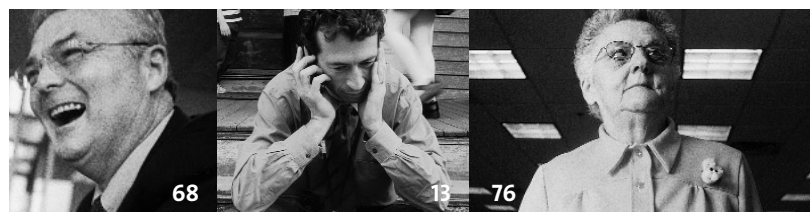
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To your health

Health care is the elephant in the room. For individuals, nothing is more intensely personal, more urgent, and more closely linked to self-esteem and dignity than the ability to get the health care they need when they need it. For state government, health care finance muscles its way to center stage in deliberations over budgetary priorities. And for Massachusetts as a whole, leadership and innovation in health care have long been fundamental to our economy and to our sense of identity. Health care is an issue we can't afford to get wrong.

For middle-class families, health care is a source of angst and anxiety. It's a reason to cling to a job that provides coverage, and to worry about losing it. It's a reason that salaries don't go up, or raises are offset by higher premiums or co-payments. For employers, health care is an expense that is out of control. It can be the deciding factor against raising wages or hiring new employees. For hospitals and other providers, health care spending is a referendum on their performance and, in some cases, a verdict on their very existence.

As Michael Jonas reports in this issue, the future may force consumers to take on the unfamiliar task of deciding how much to invest in their own health care. Not unlike the transition from company pensions to 401(k)s, we are seeing the individual thrust into the great societal debate over how to provide care and security in an uncertain, and increasingly costly, world. How prepared are any of us to

decide what our own health is worth, and how much society should spend securing it?

These are the questions and concerns that motivate this special issue of *CommonWealth*. It is only the second extra edition in the magazine's eight-year history, and the topic—health care—is one of few that, like education reform two years ago, legitimately commands the attention of a full issue unto itself. Cost, quality, and coverage are the three legs of the health care stool, and there is no responsible account of today's health care conundrum that does not address all three. The articles, analyses, and commentaries in this issue take all three fully into account, and if they chart no clear way forward, it is because they give full respect to each.

This special issue of *CommonWealth* is made possible by the most remarkable consortium ever to fund a publication on health care. The 28 sponsors of this issue represent the

full spectrum of interests involved—providers, insurers, employers, labor unions, consumers. That all of these groups, with their varied viewpoints, have made an investment in an independent journalistic investigation into issues in which they have so much at stake, with no promise of editorial control or influence, is a testament to their civic-mindedness. We thank them for their generosity and support, and for their faith in *CommonWealth*.

This issue is by no means *CommonWealth's* last word on the subject. Given the centrality of health care to the Commonwealth's budget, economy, and quality of life, the magazine will be treating this extra edition not as the end of its coverage but the beginning. The life sciences are the future—of the Commonwealth, and of its people—and *CommonWealth* will be there every step of the way, taking stock of progress and asking difficult questions.



Ian Bowles

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Rational rationing

There is a way to get the most health care bang for the buck

BY PETER J. NEUMANN AND MILTON C. WEINSTEIN

The federal government recently reported that health care spending has surpassed \$1.5 trillion. Roughly 15 percent of our gross domestic product goes to health care, a far higher percentage than in any other nation. Yet life expectancy is lower in the US than in Sweden, Japan, Iceland, Italy, Israel, France, Australia, and several other countries. It would seem that some of our health care dollars are not well spent.

Part of the problem is that, as health care consumers, we want every service, every pill, every treatment we can get. But the inescapable fact is that there is no way everyone can get every medical service they want. It would cost billions more than employers and insurance companies, and ultimately American citizens, are already paying. And it wouldn't make sense. Not every medical service that is conceivable under a particular set of circumstances is worth doing.

Medical services have to be rationed—somehow. Now, rationing is a dirty word in medicine, something we would never want to take place. But it's already happening. The problem is, rationing is happening in a haphazard way that doesn't prioritize the types of health care that will provide the most benefit with the most efficient use of limited dollars.

One form of rationing we tolerate, to our shame, is to allow 15 percent of Americans to go without health insurance. The rest of us get a bigger piece of the medical care pie because the uninsured get only the barest emergency treatment.

We are experiencing other forms of rationing as well. There are many medical services that insurers limit or simply don't cover at all. Among these are certain preventive screening procedures and treatments. Most of us don't complain about not getting these services because we feel OK, and we don't realize they could make us healthier in the long run. Health insurers limit which pills they'll pay for, and impose co-payments and deductibles to discourage us from seeking expensive care. Insurers and providers erect bureaucratic obstacles that make it more inconvenient and time-consuming to get medical attention, imposing burdens on our time and patience. The high cost of nearly

everything limits the procedures and medicines we can afford and forces us to make choices about health care even though we may not know which treatments we can most afford to do without.

There is a more rational way to ration health services. We have the scientific tools to help us figure out which investments in health care will provide the most benefit in the most efficient ways. Value analysis can quantify the health improvement in terms of the number of years of life expectancy gained, in relation to the cost of various health improving strategies. Analysts can even adjust for the quality of those lives by a measure called the quality-adjusted life year (QALY), which reflects the relative value people attach to various states of health, from symptom-free to living with chronic or episodic acute pain, or to being sightless, paralyzed by stroke, afflicted with Alzheimer's dementia, etc.

Not every medical service that's conceivable is worth doing.

With such information, it is possible to rank medical services according to how much benefit they offer per dollar spent—that is, how much health value they produce for the money. The services that offer the most health value for money would be delivered most freely, and other forms of treatment could be dispensed starting from the top of the list, until the money runs out. This would be rational rationing.

Consider some widely recommended cancer screening tests. Mammograms to detect breast cancer do save lives, but given on an annual basis they cost the health care system \$50,000 to \$100,000 per quality-adjusted year of life. In contrast, a colonoscopy administered once every five to 10 years to screen for colon cancer, which ranks just behind breast cancer as a cause of death among women, buys a quality-weighted life year for only about \$15,000 to \$20,000 apiece. Dollar for dollar, it would save more years of life to give mammograms every two years instead

of every year, and use the money saved to give every woman a colonoscopy.

Here is another example. Compare the costs and benefits of taking Pap smears every year to detect signs of cervical cancer versus every few years. The extra life expectancy obtained by yearly Pap tests rather than every three years is just a few hours. But the expense of all those extra tests—and the abnormal results that some of them produce, requiring still more follow-up tests—is huge, \$20 billion nationally, an enormous amount to pay for negligible benefit.

More examples of relative valuation: Flu vaccine for the elderly is actually a cost saver; more value is recovered in health care savings than the intervention costs. A diabetes screening program for adults costs between \$50,000 and \$100,000 per quality-adjusted life year saved. Computed tomography and MRIs for children with headaches and intermediate risk of a brain tumor cost more than \$500,000 per quality-adjusted year of life.

There is resistance from patients, who want all the treatment available.

Hundreds of these analyses have been conducted on a wide universe of health care interventions. A growing library of such studies allows us to compare the costs of various approaches to improving health with the value we get for the money. These studies could guide wiser health care spending and go a long way toward controlling the spiraling cost of health care in the United States. Value analysis can help us stretch our health care dollars so they'll do us more good, and it can make the health care rationing we're already doing much more informed, rational, and fair.

Although we have these tools, so far we have shied away from putting them to work, for a number of reasons. Physicians, who have an ethical responsibility to offer the best available medical care to each patient they see, can't be expected to weigh the well-being of the patient in the office against efficiencies and cost control which might inure to the benefit of anonymous patients elsewhere in the future. There is resistance from patients, too. They may like the idea of cost control when it comes to keeping premiums down, but when it comes to receiving medical care themselves, they want all the treatment available.

As for policy-makers, they know full well the political dangers in the valuation approach. Valuation analysis was rejected as a criterion for covering new medical technologies in Medicare, and the attempt to ration health

care services in Oregon had to drop cost-effectiveness analysis as a way to figure out how. The only thing harder, it seems, than telling people their health care costs are going up is telling them they can't have every last form of health care available.

This has to change—and it's beginning to. Doctors are now starting to think in terms of value for the money. Major medical journals publish cost-effectiveness studies on a regular basis, and expert committees that develop clinical practice guidelines cite evidence of value for money to support their recommendations. And we should encourage this, through medical education that reinforces the responsibility of physicians as gatekeepers of resources. We should want our doctors to help us get the most value from our health care dollars. Consideration of the value-for-money aspects of health care will help us maximize the availability of the most effective forms of care for all of us—including the millions of Americans who are currently uninsured.

Of course, physicians alone cannot be expected to bear the full burden of allocating health care resources. Their primary responsibility lies with individual patients. Surely, the organizations in which they deliver health care, including hospitals, and the ones that pay for it—including government and health insurance companies and the employers who, in many cases, pay the bulk of the insurance premiums—have to play a role. But American consumers trust their doctors to make health care decisions, more so than they trust these organizations. The more that physicians, rather than insurance executives or government officials, support and apply a valuation approach, the more the public will accept it as in their best interest.

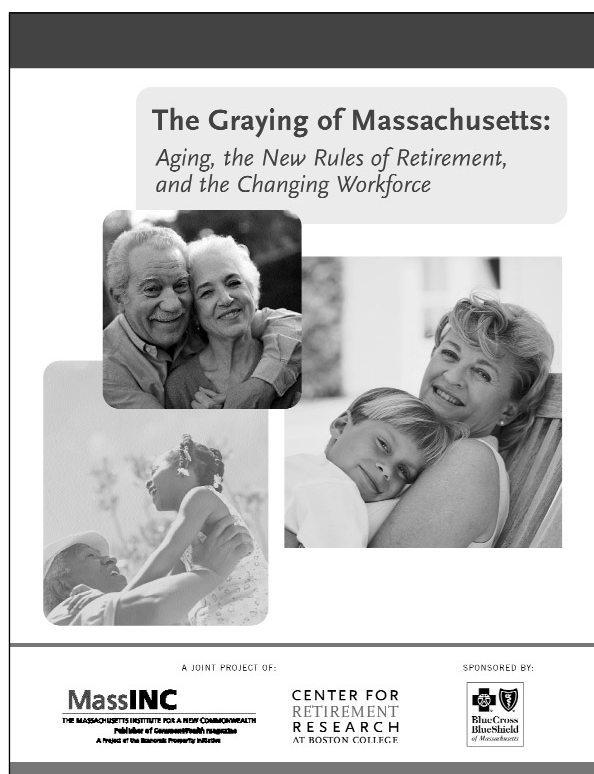
Decisions about how to spend our health care dollars will always be challenging. They will never be made purely on the basis of economics. They are emotional, often life-and-death issues, and in a democracy, decisions about who can get what kind of health care and when must take into account moral values, not just economic ones. But resources are finite. Just ask the 15 percent of Americans who have no health insurance, and the millions more who struggle to pay for theirs.

Politicians campaign on promises to solve the health care crisis, by which they mean the health care cost crisis. The "value" crisis is largely ignored. With a little courage, our political leaders can adopt valuation analysis as a powerful approach to optimizing the value of our health care spending. ■

Peter J. Neumann is associate professor of policy and decision sciences and Milton C. Weinstein is Henry J. Kaiser professor of health policy and management at the Harvard Center for Risk Analysis, which is part of the Harvard School of Public Health.

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Back to the future

In caring for the elderly, low-tech can be cutting edge

BY ADAM BURROWS

There are several ways to mark your way through Dorchester, Boston's largest neighborhood. Savin Hill to Fields Corner to Codman Square. St. William's to St. Ambrose to St. Matthew's. Irish stout to Vietnamese pho to Trinidadian roti. Upham's Corner Health Center to Dorchester House Multiservice Center to Codman Square Health Center.

I was explaining our route to two Boston University medical residents on an overcast Monday morning. Like nearly all the physicians-in-training who come to work with me, they were bright, enthusiastic, and bewildered. The pair had barely arrived at the day center, our base of operations, when I handed my brown leather home-care bag to one, a voluminous chart to the other, and hustled them into my 1996 Audi station wagon.

A call had been forwarded to me moments earlier from Azela, our receptionist. Mr. Monroe (not his real name) had blacked out again. Was it a seizure, a convulsion? Or syncope, a transient loss of consciousness due to a precipitous drop in blood pressure? Was it a manifestation of low blood sugar? He had a history of all three. Over the phone, I asked Loretta, his daughter-in-law, a few questions, established that Mr. Monroe was stable, gave some brief instructions, and assured her that we would be out shortly.

I've been Mr. Monroe's physician for more than six years. He and his wife, born and wed on the Caribbean island of St. Kitts, are both enrolled in the Upham's Elder Service Plan, a program of the Upham's Corner Health Center. Mr. Monroe is 90 years old; his wife a few years younger. Regardless of the weather, Mr. Monroe wears a crushed felt fedora and a brown trench coat. He is strong-willed and unfailingly polite. Mr. Monroe suffers from the consequences of multiple chronic medical conditions, and, like all the patients I care for in the Elder Service Plan, requires assistance with activities of daily living. Despite his own disability, Mr. Monroe is vigilant in directing attention to the needs of his wife, who has Alzheimer's disease and is prone to outbursts of belligerence when her mood sours.

As we trail the school buses and garbage trucks through the streets of Dorchester, I brief the residents on Loretta's call and Mr. Monroe's medical history. The residents, whose

training is firmly rooted in the conventions and attitudes of the academic medical center, express surprise. Their training has taught them that nonagenarians who lose consciousness are the responsibility of the emergency room and the hospital ward, not the subject of a breakfast-hour home visit. This will not be the last time during the month, or even the day, that their assumptions are challenged.

We pull up in front of a large single-family home on a one-way street. Despite peeling clapboard and rusty chain-link fences, the neighborhood proclaims a proud message of hard-won habitation. Loretta greets us at the door and thanks us for coming. As we climb the broad staircase, I ask about her recent vacation, a much-deserved break from her responsibilities as wage earner, household manager, and caregiver for her father-in-law, mother-in-law, paraplegic son-in-law, and 4-year-old granddaughter. With a smile, she

Home visits can be better than the emergency room.

assures me that she enjoyed her holiday, which was made possible by a nursing-home respite stay for the Monroes, a benefit of the Elder Service Plan.

We find Mr. Monroe in the small, tidy room that he shares with his wife, twin beds lining opposite walls. Loretta has propped him up with pillows, and he leans forward to wish us good morning in a slightly muffled West Indian lilt. That initial encounter reveals much of what we need to know, but we continue our evaluation, obtaining a detailed account from Loretta of what transpired, conducting a thorough physical examination, and performing basic bedside laboratory tests, pulling equipment from the home-care bag like rabbits out of a hat. It's not quite what would have taken place in an emergency room, but, with the advantage of having cared for Mr. Monroe through prior episodes, it is sufficient to make a provisional diagnosis of recurrent syncope and assure Mr. Monroe and Loretta that he's safe. It's happened before and is likely to happen again, but it's been fully evaluated, and there's nothing further that we need to do now. I leave Loretta with some instructions and let her know that I'll call later to check up.

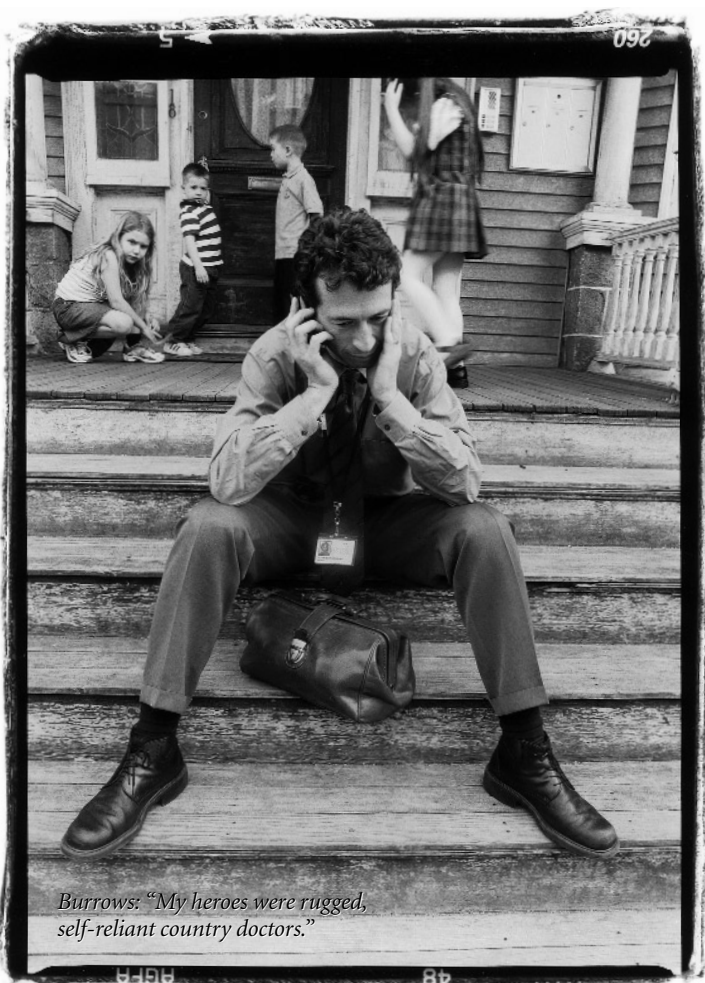
When I was a medical student in New York City and a resident at Boston City Hospital, my peers marveled at the wonders of fiberoptics, balloon catheters, and magnetic resonance imaging, while I looked backward in time and outward in space. My heroes were rugged, self-reliant country doctors struggling to practice modern medicine in the small towns of rural America. I imagined settling with my wife in a splendid valley between snow-capped mountains, raising a family, hanging out a shingle, and weaving myself into the fabric of the community. But it was just a fantasy. I was a city boy, more comfortable on a darkened subway platform than a moonlit dirt road. I would have to fulfill my ambitions in a different way.

As we ride back to the center, the residents reflect on our home visit, describing the sequence of events they would have expected to flow from Mr. Monroe's blackout: the worried call to 911, the paramedics, the emergency room, and the inevitable hospital stay. The consultants, CAT scans, monitoring, and procedures. I ask them: What would all that mobilization of institutional and technological resources have accomplished that our visit to Mr. Monroe's bedside did not? And what would it have cost? I invite them to consider other ways those health care dollars could be spent. How many hours of home health—home health aides, personal care attendants, homemakers—would it purchase? How many trips to the day center, where the patient could get the benefit of fellowship as well as a watchful medical eye? How much availability of primary care providers, nurses, therapists, and social workers would it buy, allowing them to respond to needs as they arise, in familiar and less institutional settings? How many extra minutes for doctors to get to know their patients, to help them turn personal relationships into therapeutic alliances?

This calculus is the logic behind PACE, or Program of All-Inclusive Care for the Elderly, the model of care being implemented by the Elder Service Plan. PACE is the kind of program that gives managed care a good name. Focus on the most frail, complex, disabled, and vulnerable elderly patients. Develop interdisciplinary teams that are devoted exclusively to their care. Combine a fully integrated, capitated financing system—fixed dollar amounts per enrollee that cover everything—with a fully integrated, comprehensive care model. Grant the program total flexibility to allocate resources as needed to support function and well-being. Practice state-of-the-art, evidence-based medicine to control chronic medical conditions, like diabetes and heart failure. Prevent unnecessary emergency room visits, prolonged hospital stays, and premature nursing home

placements. Take the savings and redirect them toward the community-based health, social, and rehabilitative interventions. Save money for Medicare and Medicaid, and provide the care that patients and families want in their homes and their neighborhoods.

Back at the day center, a renovated former warehouse on Dorchester Avenue, participants are arriving. Van drivers have returned from their morning runs and are wheeling, escorting, and guiding the participants into the center. Health aides are greeting people in four languages and serving coffee. The activities staff is leading exercises to a calypso beat. Nurses are circulating in the day room, checking vital signs and administering medications. I spot Mrs. Monroe, who's concentrating on her buttered



Burrows: "My heroes were rugged, self-reliant country doctors."

toast, and let her know I've been by her house to see her husband, who's doing fine.

I check in with the day center manager and give her a report on Mr. Monroe. She's already compiled a list of patients for me to see, filtering off-hours reports, telephone calls from

caregivers, and observations from drivers and health aides. Over the next several hours, the two residents join me as I encounter the variety of problems and ailments that makes the medical specialty I practice so compelling, rewarding, and challenging to an intellectually peripatetic generalist. Geriatric medicine requires knowledge and skills from the domains of medicine, psychiatry, and neurology, as well as an awareness of the social environment. The patients are complex, and it takes a careful sifting through many layers of possibility to get to the root of their problems.

We first meet with Mrs. Grant, a former hairdresser who is tall and graceful even in her wheelchair. Since her stroke, Mrs. Grant has been hemiplegic, paralyzed on her right side, and aphasic, unable to speak except for a few monosyllables. Over the course of many encounters like these, however, she has found ways to communicate with me through signs, sounds, and facial expressions. Today she's having chest pain. Is it her heart? A blood clot? Or acid reflux? Is it a muscle strain deriving from her exclusive reliance on her left arm for her mobility and functional needs? In the eight years I've known her, Mrs. Grant has had chest pain caused by each of these.

Doctors rely heavily on the history, the patient's story about their pain or other symptoms. When it started, how

it started. What makes it better, what makes it worse. Where it's located and whether it moves. What other symptoms come along for the ride. Through a careful history, doctors can generate a hierarchy of diagnostic possibilities. The physical examination, lab tests, and imaging studies that follow merely confirm our diagnostic impression or allow us to distinguish between likely possibilities. In geriatric medicine, the capacity of patients to provide a complete history is often limited by cognitive impairment, and we must rely on surrogate informants. Mrs. Grant's aphasia offers a different challenge. Fortunately, I've been through this before.

In the day center's clinic, my residents and I evaluate Mrs. Grant. We obtain the history from the patient as best we can, question other staff, perform a detailed physical examination, and apply the technology available in the clinic—pulse oximetry, an electrocardiogram, blood tests. We suspect the pain is muscular, but we can't entirely dismiss the possibility that it's her heart. Fortunately, we'll have all day to observe Mrs. Grant at the center, giving us plenty of opportunity to assess her response to treatment. Still steeped in their hospital training, my residents would be more comfortable if we immediately transferred her to the emergency room, but they agree to suspend judgment.

Next we see Mrs. Morse, blind and stooped over her

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wooden cane, dressed sharply in a charcoal grey wool suit and cap. Her daughter is concerned about Mrs. Morse's hallucinations, which have taken a nasty turn. In the past, Mrs. Morse has told me of the comfort these apparitions give her. She has proudly pointed to her dead sister swooping in through the window for a visit. Not this morning. Today Mrs. Morse is angry, guarded, and suspicious, and she thrusts her cane into the air as if to ward off threats.

What has caused this transformation in the character of her visions? Is it an expression of physical discomfort? Is there an acute medical problem? Is she depressed? We evaluate Mrs. Morse, enlisting the cooperation of her social worker, and begin to sort through the possibilities. I call her daughter and propose a treatment plan that includes pharmacologic and behavioral approaches, a low-dose antipsychotic accompanied by reassurance and redirection from the family and the team. The plan is designed to relieve Mrs. Morse's distress and keep her safe, while we continue to look for an underlying cause.

As the day continues, the day center participants play bingo, make crafts, and watch a movie. They discuss the Bible and eat a hot lunch. We see a succession of patients, some for routine check-ups, some for follow-up of stable problems, others with new issues. I call Loretta to inquire about Mr. Monroe. He ate well and is listening to the radio. We check in on Mrs. Grant. The pain is gone, and she's having her nails done. We join Mrs. Morse at her table. She's still absorbed in her visions, but now quiet and more relaxed.

After the residents and the participants leave for the day, I return phone calls, fill out paperwork, then head out through a light rain. Meeting House Hill to Grove Hall to Egleston Square. St. Peter's to St. John—St. Hugh's to Our Lady of Lourdes. Upham's Corner to Roxbury Comprehensive to Dimock Street.

I stop at a senior housing complex on a street of auto salvage yards to pay a final visit to Mrs. Grant. Her evening health aide opens the door to the small studio apartment, which is spare and uncluttered. Peering through the window and into the dusk, I can see all the way to a cluster of angled rooftops that marks the street where I live. Mrs. Grant smiles, gives me an OK sign with her thumb and forefinger, and manages to say, "all right." I go over some instructions, remind her to press her Lifeline if she gets into trouble, and assure her that I'll see her tomorrow at the day center.

Mrs. Grant's health aide clears away her dinner, and I head home to mine. ■

Adam Burrows, MD, is medical director of the Upham's Elder Service Plan and an assistant professor of medicine at the Boston University School of Medicine. He lives with his wife and two children in Jamaica Plain.

Settling accounts

A survivor emerges from his health care wars without answers

BY DAVID BRUDNOY

I am named after my maternal grandfather, the medical examiner and sole doctor in a small Minnesota town. He died before I was born, and his photograph, on the living room mantel in our house, was almost venerated by his widow and by his daughter and sons, both of whom went into medicine, and admired by his son-in-law, my father, who did as well. I grew up respecting doctors, too squeamish to follow in their footsteps but aware of their significance, in my family and in the world. But never did I, any more than any other healthy child, imagine that one day I would know the medical world from inside, as a patient, nor that I would one day owe my life to doctors—doctors

The pricing structure bears no resemblance to reality.

like those who saved mine in the literal nick of time, in 1994, and those who, last fall, did battle (inside me) against a rare form of cancer, emerging from the fray with what I'm told is a score of Brudnoy 1, Cancer 0.

That ought to be the end of the story—naïve faith in doctors vindicated, in spades, by personal experience of the lifesaving power of modern medicine. But it's not. Health care in this country is, invariably, an issue, and in this issue, I have immersed myself well beyond my own experience. Over nearly 30 years on radio, I've interviewed hundreds of doctors and examined no end of medical arcana. What I've learned is that we don't have a medical crisis but, instead, an insurance crisis.

Dictators may rail against America, but when in dire need it's *our* hospitals they flock to. Canadians, proud as they are of the low cost of health care to *patients*—the cost to the taxpayer is another matter; 22 percent of Canadian taxes go to medical care—know that if they require access to a myriad of top-shelf machinery, they scurry here rather than wait their turn and die back home. (As professor Pierre Lemieux of the University of Quebec reports in the *Wall Street Journal*, the average waiting time from referral by a general practitioner to actual treatment in Canada is more than four months;

breast cancer patients wait eight weeks for post-surgery radiation therapy, while the median wait for an MRI is three months and the median wait for oncology treatment is more than six weeks, excluding radiation, which is longer. My own wait from diagnosis to the start of chemotherapy and throat radiation was one week, and that only because I requested time to inform my friends, colleagues, listeners, viewers, students, and employers.)

There's nothing wrong with medical care here, only how we manage it. And this we have mismanaged badly, starting with a pricing structure that, like the cost of airplane tickets, seems to bear no resemblance to reality. The care we receive is unparalleled, but who can figure out the costs? Perhaps, gruesome though it is to suggest this, our eyes open only when we undergo serious hospitalization. Only from within can patients begin to comprehend what our medical system amounts to. Here, then, is my comprehension.

For no patient is medical care all a matter of dollars and cents. It did not take me long in a hospital to figure out that we have a shortage of nurses; anyone who has implored a nurse to hurry to his room knows that the wait can be interminable—and sometimes embarrassing. A nurse's work is daunting, and the compensation nurses receive for it comes nowhere near to matching the energies expended and expertise demonstrated. We also have a misallocation of doctors. In Boston, we may wait awhile to see a specialist, but they're all here, whereas in some parts of the country we suffer a dearth not only of specialists but of generalists as well.

But no patient can understand the rituals of medical procedure and protocol, beginning with that minor but infuriating social chasm that separates physicians, who routinely introduce themselves as "Dr. God"—or they might as well—and patients who, no matter their ages, invariably become "Jack" or "Bertha." This obliviousness to the barrier of exaltation they erect by insisting upon their title while they reduce their patients to a diminutive name, irrespective of age, can be maddening, if not demeaning. The last thing a patient needs added to his

terrifying experience in a hospital—and none but hypochondriacs or women about to give birth come to hospitals filled with joy by the experience awaiting them—is to be alienated from the doctors who, perhaps unwittingly but nonetheless habitually, build a wall of nomenclature between themselves and the wretched souls obliged to wear that hideous piece of “clothing” that opens in the back. The rationale for the repulsive “johnny” eludes me, and few patients understand why they’re subjected to such humiliation. If you’ve spent time in a hospital you know what I mean, and if you haven’t but live long enough, you will come to know.

The indignities begin immediately, but the mysteries arise later. What befuddles most patients is how hospitals and doctors get paid and somebody is... charged. Granted, we live in a world in which inflation has made a tendency to reminisce about the “good old days” into crankiness. A friend born, like me, in the Midwest showed me the hospital bill for his own delivery, a normal birth with no complications. The invoice covered his mother’s *10 days* in the hospital—common before people were cast into the streets after minutes in the hospital—including the delivery itself, the doctor’s daily visits to her, and medications and food. The total bill, in April 1940, was \$54 (you read correctly: fifty-four dollars). Now, we don’t buy coffee for five cents a cup today either, and a first-class postage stamp, then three cents, is 11 times more today. But is the cost of 10 days in the hospital for birthing and post-partum care 11 times what it was then—a mere \$600 today? You know the answer—or, at least, you think you know. The true cost of a day at Hotel Massachusetts General, based on my three recent stays there, will be divulged at the end of this article.

Not that those visits have bankrupted me. Fortunately, I have good insurance. During two long hospitalizations, in 1994 and 2003, I was wonderfully cared for at a cost that far exceeds the money I have put into my insurance. I have the benefit of a good insurance plan through my principal employer, Infinity Radio (a subsidiary of Viacom), and owing to the advice of a friend back in the mid-’80s, I also bought and have continued to fund a private insurance plan, which picks up some of what the company plan doesn’t. Both are costly but nowhere near what my medical care would cost me if I were on my own. It’s no exaggeration to say that if I had had no insurance, I would by now be at or near insolvency. This is a scary reminder of how those without insurance are at great danger of

Brudnoy: “Few patients understand why they’re subjected to such humiliation.”



losing all that they have if catastrophic illness strikes.

These days, nobody really sees a doctor’s bill. Mostly, we see statements of what has been charged to our insurance companies, an “explanation,” no matter how mystifying, of what things have cost. Who is that doctor, whose name you don’t recognize, and what did he do for you? What is it, exactly, that happened nine months ago, which the document in your hand is recalling to your memory? My own primary care physician doesn’t know some of the doctors whose names are on these mysterious non-bills. Would it crash some advanced information-technology system if these documents said: “9/14/03, you saw your doctor, Bill Smith, for anemia and fatigue, and your bloods were analyzed by Dr. Sam Jones”? Is it inconceivable that the documentation of your care be clear about who was involved, and what they did to get paid?

What we see in these non-bills may have meaning to hospitals and insurance companies but rarely to patients. If you’ve spent months in hospitals, as I have, and seen dozens upon dozens of doctors in hundreds of office visits over the years, you’ve most likely long since given up trying to figure out who was who and what was what. The

health care system today seems to think we ought to wash our hands of such trivialities, and I, for one, am happy to do so. But is ignorance, and disregard for cost, the solution to our health care woes?

Anyone who has spent seven weeks in hospitals in one serious health crisis, as I did in 1994, and a month, in three separate episodes during a two-month period, as I did last fall, comes away with stories to regale the grandchildren, or, in my case, the functional equivalent of grandchildren—at least if one wants to give them nightmares. In 1994, shortly after I was released from intensive care at Mass. General and sleeping soundly in my room, a doctor I had never seen came in, introduced himself as a neurologist, and asked if he could feel my feet. What could I say? He felt them, and mumbled to himself with that “oh my” sort of mumble that alarms any patient. I asked, “What are you feeling my feet for?” He asked me if I wondered why I hadn’t been out of bed in the days since I awoke from my nine-day coma. I said something like, “Well, yes.” He said, “I think it’s unlikely you’ll ever walk again.” And he left.

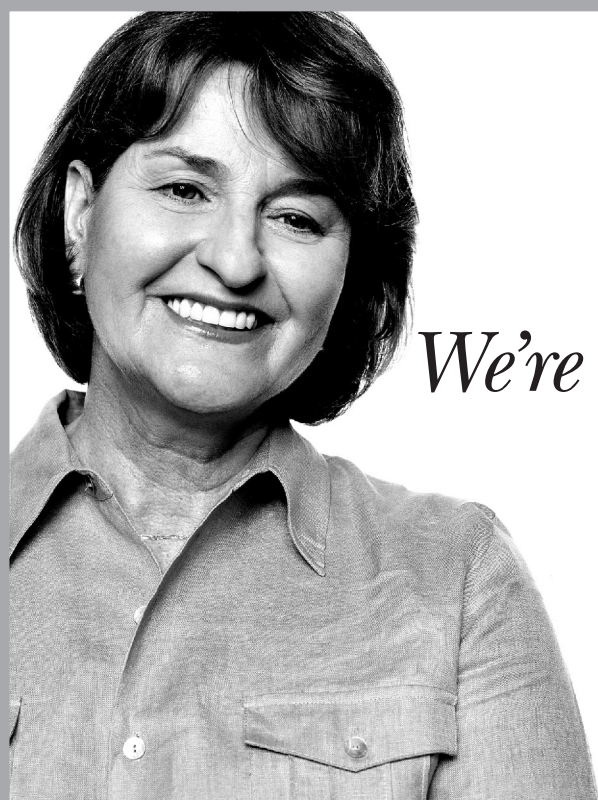
Great bedside manner. Thank you, Dr. Excellent News.

Nice way to interrupt one’s sleep.

I was terrified. I had images of a life in a wheelchair, and began to wonder just how much of this I was strong enough to handle. I decided to turn on *Nightline* and try to figure this out. I flipped on the TV and there was the tail end of the news on Channel 5—it was Monday and WCVB carries Monday night football, so the news runs late and *Nightline* even later. Chet Curtis was wrapping up the show and concluded with this: “We have encouraging news about our good friend David Brudnoy. He’s out of intensive care and is now in guarded but promising condition. Get well, David!”

I desperately needed someone to talk to and it was well after midnight, so I called Chet at the station. He said, “Don’t believe the worst, David. There’s always hope.” Something like that, and heartfelt. Chet is a dear man, excellent friend, and he said more than that, but the details are lost. I know only that I was in a panic and I needed the calming encouragement of someone who has known me for decades and, I knew, was not a stranger to adversity.

The next day, after I told this to my doctors, a woman named Mica Rie, a physical therapist and one-time member of the Finnish Olympic fencing team, came in, yanked me up to a sitting position, and gave me a stare of deter-



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mination and warmth. She said, and these words are verbatim: "Doctors aren't always right. You *will* walk again. Know that. Believe that. You *will* walk again!" Within two days she had me up on a walker, moving me a foot or two—my "stupid human trick," as I called the maneuver when I showed my friends. In coming days I moved a bit more, then, after nearly a month at Mass. General, was transferred to Spaulding Rehabilitation Hospital. In three intensive weeks of therapy, I learned to walk, first with a walker, then with a cane, slowly, unsteadily, and with apprehension that, skeletal as I was, if I fell, which seemed a likely prospect, I'd break bones *and* be paralyzed for life. Gradually, over the next two years, I regained my ability to walk. Now, no limp remains, and while I still have neuropathy, a combination of sometimes intense pain and numbness in my feet, no one could tell, watching me walk, that a specialist in neurology had all but condemned me to a life of permanent paralysis and incapacity to propel myself along on shanks' mare.

On the other side of the ledger, during hospitalizations last fall, I insisted on continuing my daily radiation therapy, which required making clear to everyone that I *must* be taken to the radiation lab daily, at the appointed time, that I was required to have six straight weeks of the throat

radiation and if I had a chance to kill the cancer, this was not something that could be postponed, and that I was not going to miss even one of those sessions, brutal though the treatments were. One day, I languished for over an hour in the radiation area after the treatment, needing desperately to go to the bathroom, throbbing with anxiety and growing alarm that I had been forgotten. The transport department simply did not come for me.

Finally, after dozens of people—nurses, doctors, others—had passed me by and paid no attention to my increasingly shrill requests, then implorings, then demands that someone come get me, I buttonholed a very young woman, who was, she told me, training to be a nurse and had been observing the radiation clinic. I said: Either somebody gets me, on this gurney, back to my room, or I'm getting up, yanking out the IVs, and, if need be, crawling back to my room. (I may seem like an easygoing fellow, but there are times when I am impossibly direct and will not stand to be ignored. This was one of them.) Thankfully, this kindly nurse and a male colleague—I don't know whether he was an intern, an aide, or what—cheerfully got me back to my room.

Sometimes the indifference, understaffing, and sheer callousness of medical personnel can undo anyone's gen-



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eral sense of gratitude for, and admiration of, the way a great hospital works. Someone ought to give thought to making sure that an episode like that never happens to a patient. The next day I asked one of the nurses on my floor if she would stay with me during radiation and get me back to the room. I was hooked up to so many machines, I couldn't go by myself. She did so, and in coming days no one made me wait for this daily therapy. Although I probably was not the most popular patient on my floor, I had become tiger-like in my determination. Passivity will get you nowhere in a hospital setting, of that I've no doubt.

I don't know what the solution is for the cost of medical care in America. The fantasist who imagines that some socialized medical system will provide the same level of care yet still be cheaper ought to look into the taxation rates of countries that have these systems and why, in many of them, people who can afford to do better eschew governmental systems and entrust their care to doctors whom they pay directly, often in the United States. (In Canada, it is illegal to buy private medical insurance, so the wealthy pay for first-rate care cash on the barrel-head.) Maybe some form of single-payer system would do the job, but no one in America has figured out what that system ought to be. Bemoaning the complexity and inefficiency of our system has become as addictive as *The Apprentice*, but no one has come up with a better approach, at least not one that has convinced a critical mass of movers and shakers, much less a significant number of ordinary Americans, that they've got the answer.

Those of us who find ourselves critically ill generally survive hospitalization, unless our condition is hopeless or we are in that critical last half-year of our lives, when the end of the road, metaphorically, becomes the end of the road *literally*. Our doctors are terrific—mine have been, and you know yours are, though we wonder about everyone else's—and our nurses are angels of mercy, albeit underpaid and short-handed. We've every machine available to our diagnosis, our care, and the prolongation of our lives. We cannot do better than in our country and—I'm not a mindless Massachusetts booster saying this—we cannot do better than here in the Bay State.

But paying for what we need is beyond the means of most of us, excepting the rich or those who have the best insurance plans available. Our medications, certainly, have become extraordinarily expensive. After each of my four weekends of chemotherapy infusion, from October to December, I injected myself with a tiny dose of something costing \$2,500 *each*, and that's just for starters. Providing for prescription drug coverage for the elderly and the poor seems to have become like defeating terror-

ism—a worthy goal that's apparently unachievable. The costs accelerate in a gruesome imitation of the inflation of the Deutsche mark in early 1920s, beyond any reason or sense. These costs—not necessarily directly to each patient, but to this Platonic concept, The System—shoot up and show no sign of ever hitting a ceiling.

But who am I to complain? In 1994, I was minutes away from death when rushed unconscious to a hospital, suffering from cardiomyopathy and *Pneumocystis carinii* pneumonia occasioned by HIV, and later visited by the added horrors of shingles and a number of other nasty things that make me shudder to recall. Last fall, I was treated for a rare cancer, metastatic Merkel cell carcinoma, by chemotherapy combined with throat radiation. This was gruesome; getting well involved grappling with bouts of terror that made me wonder seriously whether I could endure the treatments themselves.

Well, to paraphrase W.C. Fields's famous remark about Philadelphia, on the whole I'd rather the alternative—in this case, being alive. I cherish those who carried me through these hideous periods and, in gratitude, I'll advocate for physicians and nurses the rest of my life.

Passivity will get you nowhere in a hospital.

I'm not a specialist in medical care, but I'm not uneducated and have an at least average ability to comprehend the things that swirl about me. But I don't understand why health care costs what it costs and, talk show know-it-all I may be, I never even try to come up with an answer to the question I'm asked repeatedly: What can we do about all this?

I just don't know. Do you?

By the way, one day at Mass. General, for "R/B," which I presume means room and board—board meaning weeks of "food" received intravenously, since I couldn't swallow and hence couldn't eat; this charge does not include blood transfusions, doctors' visits, procedures, machinery, tests, and medications—amounted to just over \$5,000. *Five thousand dollars a day*. I was in the hospital for 31 days in November and December. Do the math.

If you've even the glimmer of a sensible idea about how we can contain these costs and continue to receive the first-rate medical care that this country provides, shout it from your rooftop, or call my show and shout it at me. The lines are open. ■

David Brudnoy is a professor in the College of Communication at Boston University, a WBZ radio talk show host, and the film critic for Community Newspaper Company's chain of weekly and daily papers.



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Political science

Is Massachusetts losing its grip on federal research dollars?

BY SHAWN ZELLER

It is no secret that Massachusetts, with its powerhouse universities and academic medical centers, gets more than its share of federal funding for scientific and medical research. The Bay State is one of the top five state recipients of federal research grants, mostly from the National Institutes of Health and the National Science Foundation. In total, the federal government spent \$19.2 billion on academic research in 2001, the most recent year for which statistics are available, and Massachusetts, as one of the primary beneficiaries, has used the federal funding of knowledge production as a key lever for building not only stellar institutions of higher learning but a knowledge-based economy.

But the Massachusetts idea industry loses its bragging rights when it comes to research funds written directly into the federal budget. More than 700 colleges across the country received some \$2 billion in funding last year by means of earmarks, or money allocated for specific projects in congressional spending bills, according to the *Chronicle of Higher Education*, a weekly newspaper that focuses on the ivory tower. Despite its academic muscle, Massachusetts came in 19th among the 50 states in 2003, winning just \$35 million in earmarked funding.

When it came to individual institutions, only one Massachusetts college finished in the top 100 in these federal set-asides. That was University of Massachusetts–Amherst, which

placed 45th, taking home \$10.7 million in earmarked grants. That was, in fact, a better showing than in 2002, when Boston University was the Bay State's top finisher at 111th; UMass–Amherst was next, at 188th. (The *Chronicle* rankings do not count earmarks that are shared between universities, or between universities and business or government laboratories, unless the dollar amount for each institution was specified. In 2003, MIT did receive two earmarks, one of \$7 million, which it shared with Harvard, and another for \$6.75 million, shared with nine other institutions.)

Scientists have long criticized the earmarking process, arguing that federal dollars should be doled out only through government agencies like NIH and NSF, which fund the



rel. In the mid-1990s, Massachusetts was among the top 10 state recipients of federal research earmarks. But in the last few years the Bay State has slipped, finishing 20th among the states in 2001, 27th in 2002, and 19th last year. Between 1997 and 2000, the state took in an average of \$33.3 million per year. Since then, the average Massachusetts take has fallen to \$26.7 million.

That may be because earmarks follow congressional clout, a fact that bodes ill for Massachusetts and its

‘Pork-barrel’ spending is a growing slice of the federal research pie.

most worthy investigations based on a peer-review process. Earmarking is a more political way to fund research, and it's often derided as “pork-barrel” spending. These dedicated funds still represent a small portion of federal research funding—only about 10 percent. But they are a growing slice of the pie. According to the *Chronicle*, earmarks have grown sixfold in the past seven years, expanding much faster than the federal research investment overall.

Massachusetts has not always fared so poorly in the academic pork bar-

rel. In the mid-1990s, Massachusetts was among the top 10 state recipients of federal research earmarks. But in the last few years the Bay State has slipped, finishing 20th among the states in 2001, 27th in 2002, and 19th last year. Between 1997 and 2000, the state took in an average of \$33.3 million per year. Since then, the average Massachusetts take has fallen to \$26.7 million.

That may be because earmarks follow congressional clout, a fact that bodes ill for Massachusetts and its

all-Democrat delegation in an era of Republican control. George Washington University professor Steven J. Balla recently completed a study of federal earmarking for higher education that focused on the period following the GOP takeover of the House in 1994. Balla found that the Republican majority distributed earmarked funds widely, but saved the largest grants for districts represented by Republicans.

Hunter Ridgway, chief of staff for US Rep. John Olver, the only member of the House Appropriations Com-

mittee from the state, says Massachusetts has no reason to worry about being frozen out of federal research dollars on political grounds. He says that most research funding is awarded through the peer-review process, and therefore insulated from politics. And earmarks are doled out more by seniority than by party, he adds, with high-ranking Democrats, especially US Sen. Ted Kennedy, pulling a lot of weight. A bigger worry, Ridgway says, is that other states are gaining in the chase for research funds on grounds of merit. "It's a crowded field, so the pie is split up among more worthy winners," he says.

In 1985, the Bay State received almost 7 percent of all federal research spending, which includes funds

going to industry and federal labs, as well as to universities and university-affiliated teaching hospitals, according to a February report by Mass Insight Corp. and the Batelle Memorial Institute. By 2001, the Massachusetts share had slipped to 5.5 percent. The decline in research funding has been more precipitous for colleges and universities. Federal grants to Massachusetts institutions of higher education fell from 11.5 percent of total funding in 1982 to less than 6 percent in 2000.

"We traditionally have assumed we would win our share of projects without organizing as much as other states," says William Guenther, president of Mass Insight Corp. "We haven't had a strategy." Other states

have, he says, with state governments providing matching funds for federal investments and encouraging local universities and businesses to enter into partnerships for grant applications. They've also focused on building state public universities into top-notch research institutions, something he says Massachusetts has failed to do at UMass, which is only the 42nd largest research university in the United States.

Of course, there's one other traditional way of getting the most out of the federal budget: lobbying. An increasing number of universities are getting into the lobbying game. Between 1998 and 2001, lobbying fees paid by colleges and universities nationwide nearly doubled, from \$23 million to \$42 million, while the number of institutions hiring outside guns rose from 191 to 294, according to the *Chronicle*.

And it works, at least when these institutions have friends on the right congressional committees. A 2002 study by John M. de Figueiredo of MIT and Brian Silverman of the University of Toronto found that working with lobbyists pays off most when universities can also call on senators and representatives on appropriating committees. Indeed, de Figueiredo found that in cases where the lobbyists could call on both a Senate and House appropriations committee member, they were able to return nearly \$50 in funding for every \$1 in fees.

Massachusetts colleges and universities have generally been slow to jump on the lobbyist bandwagon. Harvard and the Massachusetts Institute of Technology, the state's largest research universities, have normally shunned lobbying for earmarked funding.

But one institution that has played the lobbying game with gusto is

CLASS RANK

Massachusetts colleges fared poorly in winning federal earmarked funding for research in 2003, according to a study by the *Chronicle of Higher Education* of 715 colleges that received funding.

PLACE	EARMARKED FUNDING	UNIVERSITY
45	\$10.7 million	University of Massachusetts—Amherst
152	\$2.7 million	Boston University
165	\$2.4 million	Brandeis University
224	\$1.5 million	Harvard University
231	\$1.5 million	University of Massachusetts—Boston
281	\$1.0 million	Urban College of Boston
303	\$900,000	University of Massachusetts—Dartmouth
313	\$900,000	Massachusetts College of Pharmacy & Health Sciences
322	\$800,000	Emerson College
362	\$700,000	Tufts University
433	\$500,000	University of Massachusetts (Central Office)
502	\$300,000	Stonehill College
515	\$300,000	Boston College
526	\$200,000	Suffolk University
549	\$200,000	Assumption College
568	\$200,000	Mount Wachusett Community College
610	\$100,000	University of Massachusetts—Worcester (medical school)
613	\$100,000	Salem State College
617	\$100,000	Southern New England School of Law

NOTE: These figures do not include earmarked funding that the recipient university was required to share with other colleges, businesses, or government labs.

SOURCE: *Chronicle of Higher Education*

FACULTY LOUNGE

Most Massachusetts colleges have shied away from lobbying for federal earmarks. Boston University is the biggest exception.

UNIVERSITY	EXPENDITURE (2003)	LOBBYING FIRM
Boston University	\$800,000	Cassidy & Associates
Massachusetts College of Pharmacy & Health Sciences	\$320,000	Carmen Group
MIT	\$258,000	In-house Washington office
Worcester Polytechnic Institute	\$240,000	Cassidy & Associates
Northern Essex Community College Foundation	\$200,000	Cassidy & Associates
Brandeis	\$140,000	Hogan & Hartson
Northeastern	\$120,000	Hale & Dorr (\$40,000) and O'Neill Athy & Casey (\$80,000)
Boston College	\$80,000	Cassidy & Associates
Harvard University	\$80,000	O'Neill Athy & Casey
Suffolk University	\$60,000	The Commonwealth Group
Tufts University	\$60,000	Dutko Group
Curry College	\$60,000	Holland & Knight (\$20,000) and Liberty Square DC (\$40,000)
Emerson College	\$54,000	The National Group
Massachusetts Maritime Academy	\$40,000	Patton Boggs
Assumption College	\$18,000	E. Del Smith & Company
Urban College of Boston	\$10,000	Moss, McGee, Bradley & Foley

SOURCE: Disclosure reports filed with the Senate Office of Public Records

Boston University, which for years has worked with the Washington firm of Cassidy & Associates. BU paid the firm \$800,000 in 2003, when the university took in about \$2.7 million in earmarked funding, mostly for a research project on photonics, the use of light for applications like data

own Washington government relations office, as many major state universities do. But with western Massachusetts Congressman Olver, a former UMass professor himself, on the House Appropriations Committee, the state university's flagship campus has nailed a few earmarks. In 2003, it

in the race for federal research funds. Late last year, the Romney administration and state lawmakers appropriated \$100 million for economic stimulus, with \$60 million set aside as matching funds to attract federal investment. Guenther says that he's seen a "sea change" in the attitude of Massachusetts leaders toward the research-and-development pipeline, both corporate and academic, and that he hopes to see increased funding for UMass along with state-sponsored research collaboratives between Massachusetts universities and businesses.

"The fact that there is money on the table that needs to be invested is a wonderful focusing device," says Guenther. Whether it's enough to shift the outgoing tide of federal research funds remains to be seen. ■

UMass-Amherst has never hired a lobbyist but has nailed a few earmarks.

transmission and data storage. Former BU Chancellor John Silber has long advocated earmarking as a way to break the grip of the nation's most prestigious colleges—including those across the Charles River—on peer-reviewed grants.

One university that, according to de Figueiredo's study, would have much to gain from leveraging the advantage of a well-placed representative, UMass-Amherst, has never hired a lobbyist or maintained its

won funding to study methods of preventing seafood spoilage; pests that damage cranberries and blueberries; and pollution in the Connecticut River Basin, along with funding for the Pioneer Life Sciences Institute, a biomedical-research program with Bay State Medical Center, in Springfield.

Lobbyists notwithstanding, Mass Insight's Guenther says that Massachusetts has made some recent moves that are likely to bolster its position

Washington correspondent Shawn Zeller is a staff correspondent at Government Executive.

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Prognosis: anticipation and anxiety

BY ROBERT KEOUGH

When the Greater Boston Chamber of Commerce installed Dr. James Mongan, president and chief executive of Partners HealthCare, as chairman of the board in May, the symbolism did not go unremarked. “Much of the future in terms of economic policy within our region is going to come from the life sciences sector,” chamber president Paul Guzzi told *The Boston Globe*. “Health care as an industry intersects with every business in the Commonwealth,” commented consultant Ellen Lutch Bender in the *Boston Herald*. All true—and all the more reason to ponder the impact of the health care sector on the Bay State economy, which is prodigious, but mixed.

In Massachusetts, the health care industry is both an economic engine and a financial drain. It is an industry we rely on today for jobs and economic stimulus and one for which we have even higher hopes in the future. But it’s also one whose rising costs, which seem to know no bounds, come largely at the expense of other segments of the economy.

Health care is a major industry in Massachusetts, and its institutions loom even larger on the local level. Massachusetts General Hospital is the largest private employer in the city of Boston, and the Partners system it’s part of is the largest private employer in the state, with a payroll of 30,000 people. UMass Memorial is the largest private employer in Worcester, as is Bay State Medical Center in Springfield. A total of 136,300 workers labor in Massachusetts hospitals, the seventh densest concentration of hospital employment per capita in the 50 states.

That’s just for starters. According to a 2003 study of the economic contributions of the industry, prepared by the Milken Institute for the New England Healthcare Institute, the health care sector overall employed a total of 393,000 people in the Bay State in 2001, enough to tie with Rhode Island as the second-densest concentration of health care jobs in the country. Then there are all the jobs in supplier industries (168,000), and the jobs created when all those employees spend their money in the local economy (288,000)—nearly 850,000 jobs, all told, for a total economic impact of \$60 billion. Among metropolitan areas, the Greater Boston area (which reaches up to southern New Hampshire) had the highest concentration of health employment in the country, ranking in the top 10 in nearly every occupational category.

Health care employment is not expanding as rapidly here as it is in some parts of the country, if only because the Massachusetts population is growing so slowly. But employment is still growing steadily, in bad times as well as good. From January 2001 to January 2004, a period spanning the recent recession, health-services jobs grew 6 percent, and hospital jobs 12 percent, compared with a decline of 7 percent in non-health jobs—sufficient for the Massachusetts Hospital Association to cite the health care industry as a “stabilizing force in economic downturns.” Even during the consolidation of the hospital industry in the 1990s, when the supply of acute-care beds fell from 22,000 to 16,000 statewide, hospital employment rose by 4.1 percent, according to the Milken Institute.

But this bounty in jobs and revenue comes at a price to the rest of the Massachusetts economy. In a 2002 report, the Massachusetts Business Roundtable noted that medical plans in Massachusetts were among the most expensive in the United States and their costs were rising by 12 percent that year. “Accelerating inflation on a higher-than-average cost base leaves Massachusetts employers and providers at a competitive disadvantage when compared with other regions in the country,” the business group declared.

The health care industry is both an engine and a drain.

Last year, the Massachusetts Taxpayers Foundation cited the return of high annual premium increases, following a period of moderate increase in the late 1990s, in its report—published in partnership with Associated Industries of Massachusetts and the Greater Boston Chamber of Commerce—on the high cost of doing business in Massachusetts. Although that report found the differential between Massachusetts health-insurance costs and those in other states to be narrowing, family plan premiums here were still 8.4 percent above the national average in 2000, third highest of the 40 states reporting individually, and higher than all seven high-technology states used for comparison. In 2001, the average family-plan premium rose 15.4 percent in Massachusetts, to more than \$8,400 a year, versus 12.7 percent nationwide; single-plan coverage jumped 18.8 percent, to \$3,500, compared to 15.5 percent across the country.

If we have managed to constrain the increase in health costs at all in recent years, it is by putting the system of care under strain. Even as spending careens out of control, the industry reminds us that in Massachusetts alone, of the 50 states, hospitals are paid less than the cost of service by all three major payers—Medicare, Medicaid, and private insurers. Lately, cost control has been accomplished mostly by fiat and hard bargaining, not by innovation in care delivery or management. In the Balanced Budget Act, Congress simply declared that Medicare would pay less, while Medicaid's habitual underpayment for services has only worsened, with reimbursement rates falling from 85 percent of provider cost in 1985 to 71 percent in 2000; private payers got savings by means of discounts for hospital and other services demanded and obtained by major insurers. Nursing homes—those that have not yet shut their doors—teeter on the edge of bankruptcy even as the largest population cohort in history ages toward eventual infirmity. Meanwhile, the Massachusetts Medical Society's annual survey reveals a steady deterioration in physician satisfaction. Even as we seem to pay too much for health care, there is reason to believe we are not paying enough.

The politics of our life-sciences future are getting complicated.

If the emerging "life sciences" sector makes good on its presumed business, as well as human, promise, this tension between hopes for growth and fear of its consequences will only get worse. The Milken Institute reports that Massachusetts dominates the medical "innovation pipeline," with the highest number of biotech drugs granted FDA approval per capita in the nation, and ranks with Connecticut for the highest concentration of medical-device approvals. The Massachusetts Biotechnology Council estimates that Massachusetts-based companies account for 8 percent of the world's pharmaceutical pipeline. Based on brave projections of how many "downstream" manufacturing jobs could be retained in the Bay State, the biotech trade group claims that this still-young industry could produce more than 100,000 additional jobs by 2010. That's a big payoff to the Massachusetts economy, but with those innovations likely to yield the most expensive additions to the health care menu yet, that bonanza will come at a high price.

The politics of the Bay State's life-sciences future are already getting more complicated. With the Massachusetts biotech industry entering adolescence, it is attracting the attentions of major pharmaceutical manufacturers, with drug giants like Abbott, AstraZeneca, Merck, and Pfizer establishing research facilities here, and Novartis

locating its global research headquarters in Cambridge; some firms, like Wyeth in Andover, have even used the acquisition of biotech start-ups (in this case, Genetics Institute) to set up manufacturing operations here. But even the growing presence of Big Pharma in their back yards has not kept the municipalities that are counting most heavily on a biotech future, like Boston and Worcester, from jumping on the bandwagon of buying cut-rate prescription drugs across the border; even drug-reimportation pioneer Springfield is hoping to incubate a biomedical industry, through collaboration between Bay State Medical Center and UMass-Amherst. Meanwhile, the lawmaker leading the charge for Canadian drugs is a state senator whose district extends almost to Kendall Square (see *Argument and Counterpoint*, CW, Winter '04). In health care, it seems, we cannot help but bite the hand that feeds us.

"Biotechnology and biomedicine may mean to the first half of the 21st century what electronics and computers meant to the latter half of the 20th century," declares the Milken Institute. That is an exciting, but also worrisome, prospect. The information-technology and telecommunications revolutions that drove the US (and Massachusetts) economy to dizzying heights in the 1990s also improved productivity in every industry that purchased its wares. It is hard to see the coming biomedical boom setting off a similarly virtuous cycle as it ripples through the economy.

We are blessed to live in a time when medical breakthroughs that improve the lives of millions take place every day. And we are blessed to live in a place where those breakthroughs promise to make millions for local institutions, researchers, and entrepreneurs, providing a bounty that we all share through a robust Massachusetts economy. But as long as we buy personal access to the health system principally by means of employer-based insurance—a vestige of the federal decision in the 1940s to exempt non-wage benefits from wartime price controls—most of the dollars that go into the pocket of our flourishing health care industry will come out of the pockets of employers in every other industry. Never before have we counted so heavily for our economic future on a sector whose growth we are so anxious to restrain.

How that paradox will be resolved is far from clear. Health care payers, providers, and experts are playing it by ear in this post-managed care era, in hopes of improvising their way toward a new system that will restrain costs without compromising care or impeding progress. But it puts health care at the top of the agenda, public and private, for the foreseeable future. My hope is that this special issue of *CommonWealth* helps to define that agenda. ■

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A public health mayor shows pluck in policy, restraint at the table

BY MICHAEL JONAS

When John Auerbach was in charge of the state Department of Public Health's AIDS program in the 1980s, Larry Kessler, the director of the non-profit AIDS Action Committee, came to him all excited about an unlikely ally he'd found for an early, and controversial, effort to combat the spread of HIV. "There's this great city councilor from Hyde Park, of all places, who's taking the lead on supporting needle exchange programs," Kessler told Auerbach, who is now the executive director of the Boston Public Health Commission.

If Tom Menino defied the expectations of those who pegged him as a middle-of-the-road district city councilor from a middle-class Boston neighborhood who would never stray far from conventional sensibilities, as the city's mayor for the last decade he has done nothing less than blaze a trail as one of the nation's most forward-looking leaders on municipal health.

Menino nourishes a reputation as the "urban mechanic," but he may go down in Boston history as the public health mayor. From his early championing of controlled distribution of syringes to intravenous drug users to enacting a citywide ban on workplace smoking, a man not known for grand plans has distinguished himself by pushing the envelope on health.

Boston is "probably the leading city in the nation and I think he's probably the leading mayor in the nation in terms of making public health a city issue," says Judith Kurland, who was director of the city's Health and Hospitals Department under Menino's predecessor, Raymond Flynn.

"This guy is legitimately an unsung hero," says Geoff Wilkinson, executive director of the Massachusetts Public Health Association, a statewide nonprofit advocacy group. In April, the association recognized Menino with its highest honor, the Paul Revere Award, named for the patriot leader whose credits include serving as Boston's first public health officer.

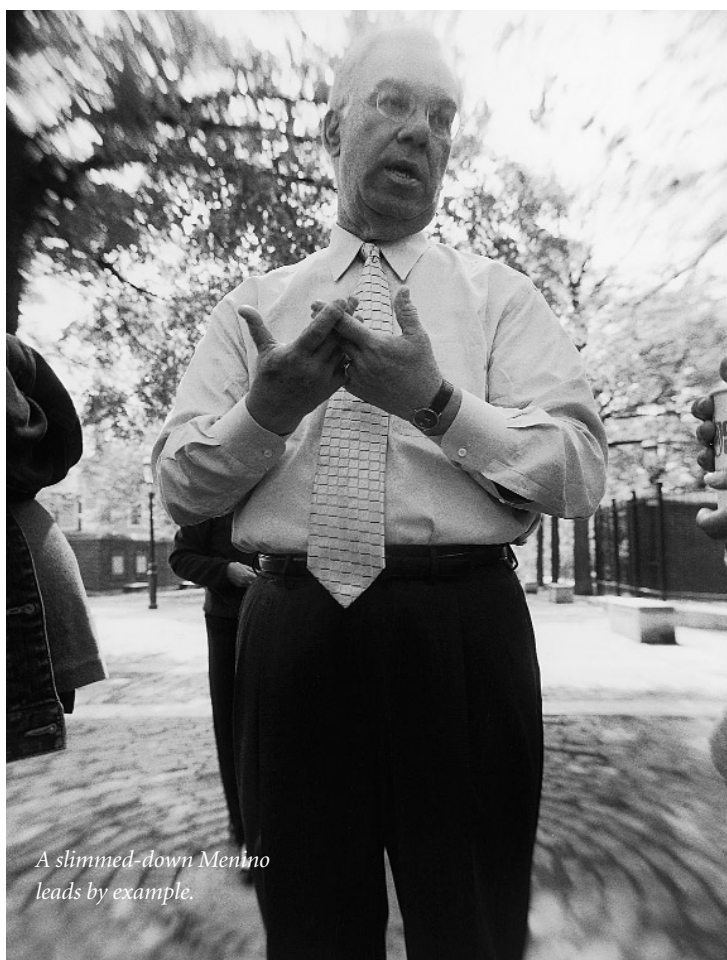
While Boston boasts the oldest public health department of any US city, it can also lay claim to one of the newest. The 1996 merger of Boston City Hospital and Boston University

Medical Center to form Boston Medical Center forced a reorganization of the city's health services. With the 132-year-old public hospital spun off as part of a new private, not-for-profit hospital, the city had a fresh slate for public health programming, one focused more on community-based initiatives. In 1998, Menino tapped Auerbach to direct the newly organized public health commission, and he told him to follow his best instincts.

"He said, 'I want to have the best health department in the country, so you can make whatever recommendations you want to make from a public health perspective, and I'll be supportive,'" Auerbach says.

And supportive Menino has been. Shortly after Auerbach came on board, the public health commission approved regulations that banned smoking in restaurants. "It was risky for the mayor to take that on," says Auerbach. "He heard from a lot of angry restaurants that thought they would all go out of business." A year ago, Boston extended the smoking ban to include bars and all other workplaces.

Under Menino, the city has taken its expanded view of



A slimmed-down Menino leads by example.

public health to everything from a 1999 lawsuit against gun manufacturers to asthma control initiatives, not to mention heart disease and cancer prevention programs. Responding in part to findings of high air particulate pollution counts in some city neighborhoods, the public health commission imposed strict new controls on the operation of waste transfer stations, junkyards, and recycling facilities, many of which are centered in low-income areas of Roxbury and Dorchester.

With the running room and support he's been given, Auerbach says he is the envy of other city public health directors. "People think I've died and gone to heaven," he says.

For his part, Menino calls himself nothing more than a "cheerleader" for the efforts of Auerbach and his staff. "I told him I would back him up. I'd be the front guy," says Menino. "Give me the reason to do it, and if it makes sense, we're going to do it."

Last fall, Boston was one of 12 cities nationwide awarded funding from the federal Department of Health and Human Services to establish programs to combat diabetes, obesity, and asthma. Among the projects the city is funding with the \$1.2 million award is the expansion of a three-year-old program for neighborhood-based walking clubs. The city has awarded grants of up to \$2,000 to 60 different groups of walkers. The clubs include Somalian women who bought sneakers for their walks in traditional dress on the outdoor track at English High School, senior citizens in Chinatown who hired a tai chi instructor to lead warm-up exercises, and a South Boston contingent who take their exercise while they take in the salt air at Castle Island.

'IF IT MAKES SENSE,' MENINO SAYS, 'WE'RE GOING TO DO IT.'

"All they need is a pair of sneakers," says Menino. "They don't need to join any fancy health club."

When it comes to pounding the pavement for good health, Boston's mayor doesn't just talk the talk. He often heads out of his Hyde Park home at 5 a.m. for a brisk stroll. "I did 55 minutes this morning," says the city's perambulator-in-chief. "It's my private time. It's time for me to clear the webs out of whatever brains I might have."

And it's paid off for the mayoral waistline. "I honestly don't go on a scale," says the slimmed down mayor, claiming he can't put a number on the weight he's walked off, aided by a new food consciousness. (The best guess of those who see him regularly is that he's shed 40 to 50 pounds.)

"It's not Atkins or South Beach," says the mayor, scoffing at the faddish programs that America's flabby class has flocked to. "It's the Menino diet," he says. "It's push back"—a reference, apparently, to his chair in relation to the dining table. "It's food in moderation." ■

On racial disparities, biggest gap is between talk and accountability

BY MICHAEL JONAS

That there are big racial disparities in health care no one disputes. Blacks are less likely than whites to undergo bypass surgery. The time between an abnormal mammogram and follow-up testing for breast cancer is more than twice as long for black, Hispanic, and Asian-American women as for white women. Black and Hispanic preschoolers hospitalized with asthma are prescribed medication to prevent future episodes at rates far lower than white children. A 2002 report from the Institute of Medicine, an independent research organization that advises Congress, found that such gaps exist even between those with similar levels of education and insurance coverage.

The cause of those disparities—and what to do about them—is a different matter. The IOM report said that, while there are many factors at play, "some evidence suggests that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care." But not everyone is convinced.

"I think the jury is still out on that," said psychiatrist Sally Satel at a panel discussion on the subject at Harvard's Kennedy School of Government in February. Satel, a fellow at the American Enterprise Institute in Washington, DC, has emerged as a lightning rod of dissent, penning an essay in *The Weekly Standard* provocatively titled, "Don't Despair Over Disparities." At Harvard, Satel suggested that lack of access to care and inadequate "health literacy"—a topic that was the subject of another IOM report earlier this year—probably explain more of the racial health care gap than does discrimination.

Even when officials try to address the problem head on,

controversy ensues. The US Department of Health and Human Services issued a report last year on racial health disparities, but in January, Health and Human Services Secretary Tommy Thompson was forced to apologize for changes in the report that sought to soften its tone and emphasize positive news; he pledged to publish the original version. Senate Majority Leader Bill Frist, a Tennessee Republican and a Harvard-trained heart surgeon, filed legislation in February to increase support for the federal Office of Minority Health and authorize a series of demonstration projects to test various "cultural competency" training programs. But even Frist's bill drew fire for expanding the scope of health disparities initiatives to include underserved white populations with poor health status, such as those in Appalachia.

Dr. Joseph Betancourt, program director for multicultural education at Massachusetts General Hospital and a member of the Institute of Medicine committee that produced the 2002 report, acknowledges that alteration of the HHS report was "quite troubling to many folks," and that the Frist bill was seen by some minority leaders as an attempt to take some of the spotlight off racial disparities in health.

But Betancourt, a Puerto Rico-born physician who calls himself "an incrementalist," says he's glad for every bit of attention the issue gets. Betancourt also applauds recent action by the Massachusetts Legislature to create a special commission on racial and ethnic disparities in health care, as well as a task force that Boston Mayor Thomas Menino announced in April.

But all of these efforts fall short of bringing to the health care system accountability for addressing racial disparities.

MOST INSTITUTIONS DON'T EVEN COLLECT DATA ON RACE.

In areas as varied as banking, housing, and the criminal justice system, there are now varying degrees of legally mandated reporting for the purpose of rooting out racial bias in everything from lending to traffic stops.

Similar measures of accountability are needed in health care, Betancourt says. But so far, most health care institutions don't even collect data on race. Some private-sector

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firms are ahead of government and nonprofit hospital providers, Betancourt says, citing the decision of Aetna, the nation's largest health insurer, to begin collecting race and ethnicity data.

"There's lots of talk about safety and cost and quality," he says of the movement to make the health care system more transparent on those issues. Addressing racial and ethnic disparities, he says, "should fall into that rubric." ■

Is fraud a hidden factor in the rise of health costs?

BY DAVID S. KASSEL

In the preface to the first edition of his 1996 book *License to Steal: Why Fraud Plagues America's Health Care System*, Malcolm Sparrow states that of all the research projects he has undertaken, this one was the most lonely. A professor at Harvard's Kennedy School of Government, Sparrow often found himself the lone academic at national conferences on health care fraud. When he went to visit law enforcement agencies, he was frequently asked to wait outside when it came time to discuss a confidential investigation. Within the health care industry itself, Sparrow's presence was scarcely more welcome. The insurance industry is more concerned with efficiency in claims processing than with rooting out fraud, according to Sparrow. And the medical profession, defensive about its reputation, has little interest in investigative activities that might reveal fraud committed by its members, he says.

Yet most analysts agree that the opportunities for fraud are boundless in the nation's trillion-dollar-a-year health care industry. In his book, Sparrow describes numerous such schemes—from pharmaceutical "recycling" scams, in which physicians bill Medicaid for expensive medications that they've prescribed to homeless or drug-addicted people whom they've recruited for that purpose, to durable medical equipment fraud, in which unscrupulous suppliers bill insurers for more expensive versions of equipment than are actually used.

This spring, 11 current and former employees of TAP

Pharmaceutical Products stood trial in US District Court in Boston, accused of offering bribes and kickbacks to doctors for prescribing the company's prostate cancer drug, Lupron. The scandal has partially ensnared Burlington's prestigious Lahey Clinic, where top officials allegedly took advantage of payments by TAP for a clinic Christmas party, golf tournaments, seminars, and other perks, according to *The Boston Globe*.

Nicholas Messuri, chief of Medicaid Fraud Control Unit, says Attorney General Thomas Reilly has "prioritized the investigation and prosecution of health care fraud from day one, and has given me all the resources I need to go about the job in a professional and thorough way." He says his unit has more than 100 ongoing health care fraud investigations.

While fraud gets plenty of attention in terms of enforcement, it doesn't get figured into the economics of health care, and Sparrow says that's a mistake. A former detective chief inspector with the British Police Service, Sparrow maintains that fraud may well be a "hidden factor" in the growth of Medicaid, Medicare, and health care spending in general.

"Health care economists have for decades tried to identify the factors that account for health care cost inflation," says Sparrow. "Their models always fail to account for all the growth. I press them to consider fraud and abuse. Their reply is usually, 'We don't think that's significant,' and 'By the way, we have no data on that.'"

Sparrow thinks it's high time we had that data. In the fee-for-service part of Medicaid budgets, in particular, he maintains, it isn't difficult to measure the fraud rate, and some states are already doing so. According to Sparrow, many Medicaid agencies around the country have been testing various types of sampling protocols for insurance claims

'WHY NOT MEASURE IT,' ASKS SPARROW, 'JUST TO BE SURE?'

submitted by health care providers, and the federal Centers for Medicare and Medicaid Services has been encouraging such measurement.

But Massachusetts has not been taking part in such efforts. Health and Human Services Secretary Ron Preston maintains that while "in every system there's almost certainly some fraud," he doesn't believe it's a major factor in rising health care costs. Furthermore, Preston argues, even if all fraud could be eliminated, it would be a one-time saving. "Meanwhile," he says, "every year, health care would march against you at 10 percent a year [in inflation]. So it's

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no solution.”

Richard Powers, a spokesman for Preston’s office, says the state’s Medicaid program, known as MassHealth, is constantly on the lookout for wrongdoing, and when evidence of fraud appears the case is referred to the Attorney General’s office. He adds that “efforts undertaken by MassHealth to combat fraud, waste, and abuse are carried out in all program areas, and include information systems features to identify outlier behavior before paying for services, utilization management, and program review.”

Sparrow calls that response “a standard example of what I call ‘defense by display of functional apparatus.’ The story is, ‘Look at all the things we have and do. In view of those, we couldn’t possibly have any serious [fraud] problem.’ In which case I say, ‘Why not measure it, just to be sure?’”

In his book, Sparrow presents a “model” fraud control strategy, which includes systematic measurement of the extent of the fraud problem, as well as a “problem solving approach to fraud control,” in which insurers, law enforcement agencies, and policy-makers work together to identify fraud problems and to search for new patterns of deception. As part of that approach, fraud control teams would undertake a series of “focused reviews” prior to payment of claims, including routine random selection of a small proportion of claims for validation. “Every claim submitted for payment,” Sparrow says, “should suffer some risk of review for fraud, regardless of its dollar amount, regardless of its medical orthodoxy, and regardless of the reputation of the claimant.”

For a system under great pressure to control costs, fighting fraud could have a big payoff, says Sparrow. “If the industry learns the art of fraud control, [it] will have learned a discriminating way to save money, by investing in the capacity to distinguish between legitimate and illegitimate claims,” he says. “The alternative is to use less discriminating methods, such as across-the-board reductions in benefits, further restrictions on eligibility, or lower reimbursement rates for providers.”

Those methods, he says, “hit the honest and the genuinely needy much harder than the dishonest,” who can “easily adjust their billing patterns and patient lists to fit the new rules.” As a result, honest providers will be driven away from the major public programs like Medicare and Medicaid because they can no longer afford to participate. Says Sparrow: “Ultimately, in a vicious cycle of decay, only the crooks will remain, and important public programs will be destroyed.” ■

David S. Kassel is a writer in Harvard.



*GVNA executive director
Elaine Fluet stresses the
“public health point of view.”*

Needle bleaching makes clinic a sticking point in Fitchburg

BY JASON LEFFERTS

With an influx of millions of dollars in state funding, a plan to revitalize Fitchburg’s sleepy downtown is in place. The urban renewal money is helping to build a new parking garage for the center-city commuter rail station, along with improving a downtown business core that offers very few enticements to shoppers.

What the downtown revitalization plan doesn’t call for is the Gardner Visiting Nurses Association’s drop-in clinic on Main Street, where drug users can stop by and pick up bleaching kits to clean their needles. Health advocates say

the kits are an important part of a larger program to reduce the spread of HIV and other diseases through intravenous drug use. But city officials counter that handing out the kits on Main Street has made the downtown a magnet for crime, including prostitution and violence, and they want the clinic gone.

“We don’t feel that it has been helping in the reduction of addiction to injected drugs,” says Mayor Dan Mylott. “We feel that what it has done is concentrate the whole population—or a majority of the population—of people who are using intravenous drugs into one part of Fitchburg. We don’t think it’s right. We don’t think it’s fair.”

So unfair that Mylott has asked the state to cease funding for the clinic. Mylott himself calls the move “extreme,” but the battle over methods of preventing intravenous drug users from infecting themselves and each other with dirty needles is nothing new, and it’s not limited to Fitchburg. The state Department of Public Health, which encourages needle swaps, operates programs in Boston, Cambridge, Northampton, and Provincetown. In a number of other communities around the state, private clinics run programs

like the VNA's. In other cities, like Springfield and Worcester, officials have rejected efforts to create programs.

State health officials believe that programs that promote the safe use of hypodermic needles, which cannot be purchased legally in Massachusetts without prescription, are imperative. They point to the rapid spread of HIV and other diseases through heroin and oxycontin users. They say bleaching kits and other programs that prevent the swapping of infected needles are an important part of a larger battle against disease.

"If you read about the toll on life heroin and oxycontin are taking, there are a lot more things to be concerned about than the use of a bleach kit to bring people into treatment," says Roseanne Pawelec, a spokesman for the Department of Public Health. "The issue is skyrocketing death rates due to heroin and oxycontin use in Fitchburg and other parts of the state."

In Fitchburg, city officials are less concerned with the public-health program than they are with the critical mass of drug users who are drawn to the clinic, and the problems they bring with them. This issue came to the fore in March, when a man walked into the GVNA office and stabbed a client.

Local officials are not opposed to the program continuing, but they want the bleaching kits distributed by mobile programs in the neighborhoods, not a centralized site downtown. Talks are continuing. But, for GVNA, the pressure is on.

State Sen. Robert Antonioni, a Leominster Democrat whose district includes Fitchburg, would not say whether he would move to shut off state funding from the association, but he does say the drop-in clinic needs to change its ways. "My hope is they will retool," says Antonioni. "I think they are going to have to. The support is not there in the city of Fitchburg for the program."

Elaine Fluet, who became executive director of GVNA on March 29, two weeks after the stabbing, says she is meeting with city officials to try to address their concerns. But she does not want to give up distribution at the center. She says the VNA already does some mobile distribution of bleach kits, but giving them out at the center allows workers to make better contact with clients, whom they hope to draw into treatment.

"I understand fully the mayor's concern about crime and drug use, and I share his concern, but we don't come at it with a criminal justice point of view," says Fluet. "We come at it from a public health point of view. Maybe we can do [distribution] differently. I'm open to suggestions."

The city's hard-line gambit may or may not catch hold at the State House. State Rep. Emile Goguen, a Fitchburg

Democrat, says he hopes the two sides can reach an agreement to change the program to fit the liking of both. But in his mind, resuscitating downtown is the main goal to be pursued.

"I worked to get \$13 million in urban renewal money for downtown Fitchburg, and if this is smack in the middle of the improvements, I can't see [downtown] going," says Goguen. "People don't want to go into that end of town, and it's their town. I don't think they should be deprived going where they want to go." ■

Jason Lefferts is a reporter for the Lowell Sun.

First, do some good is the motto at this Berkshire agency

BY B.J. ROCHE

When Fran Alibozek of Adams learned she had colon cancer three years ago, she didn't know which was more frightening, the fight she had ahead of her or the bill she'd undoubtedly run up in the process. Alibozek, who was 63 at the time, was working as a bagger at Stop & Shop, but only part-time, with partial benefits.

"I was in a panic," she recalls. "I didn't have time to think about the cancer. I just felt, what am I supposed to do? Die now, because I can't afford anything?"

Alibozek turned to Ecu-Health Care, a nonprofit agency based at North Adams Regional Hospital. Ecu-Health had helped her out years before, when she lost her job at General Electric in Pittsfield, and with it, her health insurance. Back then, Ecu-Health enrolled her in its low-cost care program, which provides medical services on a sliding scale, thanks to 60 physicians—20 primary care doctors and 40 specialists—who agree to take patients for reduced fees. This time around, the staff found she was eligible for the state's free care pool, which covers hospital care for low-income uninsured patients, and they helped her fill out the application. With her \$4,000 hospital bill covered, Alibozek, who makes about \$10,000 a year at Stop & Shop and receives \$7,000 in Social Security, is paying off \$4,000 in doctor bills in installments of \$25 per

month. Today, she's not only healthy, but grateful.

"They were a great relief," she says of the Ecu-Health Care staff. "It was a comfort knowing that someone is out there working for you."

Alibozek is one of thousands of northern Berkshire County residents who have been helped by an agency whose tiny size—a staff of three—belies its impact on the health care of the region's working poor. Ecu-Health was started in 1994, after a local minister, David Mangen, wrote an article in the North Adams *Transcript* about the challenges of meeting the needs of the region's uninsured. Dr. Douglas Karrel, then an internist in Adams, read the piece and the two got together; soon they were recruiting area doctors to serve uninsured patients for reduced fees. "Ecu" stands for "ecumenical," reflecting the organization's roots as a joint venture between the clergy and medical communities.

Since then, Ecu-Health has served more than 7,500 residents of Northern Berkshire County. Its corps of volunteer doctors has provided nearly \$1 million worth of health care to 1,900 patients, and it has referred more than 5,000 individuals to publicly funded health programs, including MassHealth, the Children's Medical Security Plan, and the state's pharmacy programs for the elderly and the disabled.

"It's been absolutely thrilling," says Charles "Chip" Joffe-Halpern, a social worker who has been with the program since its beginning, initially splitting his time between Ecu-Health and the Visiting Nurse Association. "We were able to organize doctors' charitable impulse."

THE ECU-HEALTH APPROACH ISN'T STRICTLY CHARITY.

But the Ecu-Health approach isn't strictly charity. Rather, it's a double-barreled approach that provides direct care but also helps patients gain access to publicly funded health care programs they don't even know they're eligible for. Under Ecu-Health's low-cost care program, volunteer doctors tend to patients while Ecu-Health staffers do intake interviews and handle paperwork. Clients receive a card, much as they would at an HMO, and pay their doctors fees ranging from \$2 to \$25 per visit. But every client who comes into the office looking for low-cost care is also screened for eligibility for public programs ranging from WIC to dental health.

"We said, instead of having doctors give out more free care, let's get these kids and families enrolled in programs

they're eligible for," says Joffe-Halpern. Though some 4,000 people in the region lacked private health insurance, he says, many were eligible for programs like MassHealth and the Children's Medical Security program but had never applied. For that reason, outreach and education became the most important components of the job.

It's a job Joffe-Halpern has taken to. In 1996, he talked editors at the Springfield *Union-News*, now the *Republican*, into writing front-page stories about the North Adams program. The agency also broadcast ads on the cable television community-access channel that featured, over the years, local pols like state Rep. Daniel Bosley, state Sen. Andrea Nuciforo, then-Lt. Gov. Jane Swift (a North Adams resident), and US Sen. Edward Kennedy.

"We spend up to \$15,000 a year on media, and it's not frivolously spent money," says Joffe-Halpern. "It's how you reach people."

When it comes to reaching people, Joffe-Halpern is not above any stunt. Take the time he and the Ecu-Health crew tried to set a record for the number of people brushing their teeth at the same time. Their feat didn't go down in the *Guinness Book of World Records*, but it certainly highlighted the lack of dental care among low-income children. "We were short by a mile, but we got great press," notes Joffe-Halpern.

Ecu-Health operates on a budget of about \$170,000 a year. The group receives \$40,000 a year from the state's Division of Health Care Finance, \$50,000 from the Blue Cross Blue Shield Foundation, and grants from the United Way and assorted local health care groups.

The Ecu-Health Care model is also catching on elsewhere. Similar programs have been launched in Amherst—Northampton, Gardner, and Martha's Vineyard, and plans are in the works for a program in Athol. Joffe-Halpern says the program works best in areas with a strong community hospital that can coordinate care. Also required: a physician who has the trust of his or her colleagues who can sell the program to the local medical establishment.

Meanwhile, at Ecu-Health, business is booming. Last year, the agency received 3,161 inquiries, an increase of 15 percent over 2002; volunteer physicians provided more than \$150,000 worth of free medical care to 672 area residents. The agency referred more than 553 people to the state prescription-drug program, an increase of 23 percent over 2002. But this kind of success the small agency in the Berkshires could do without.

"Our programs should never be seen as a substitute for universal health care," says Joffe-Halpern. "I'd love to see the day when we don't exist." ■

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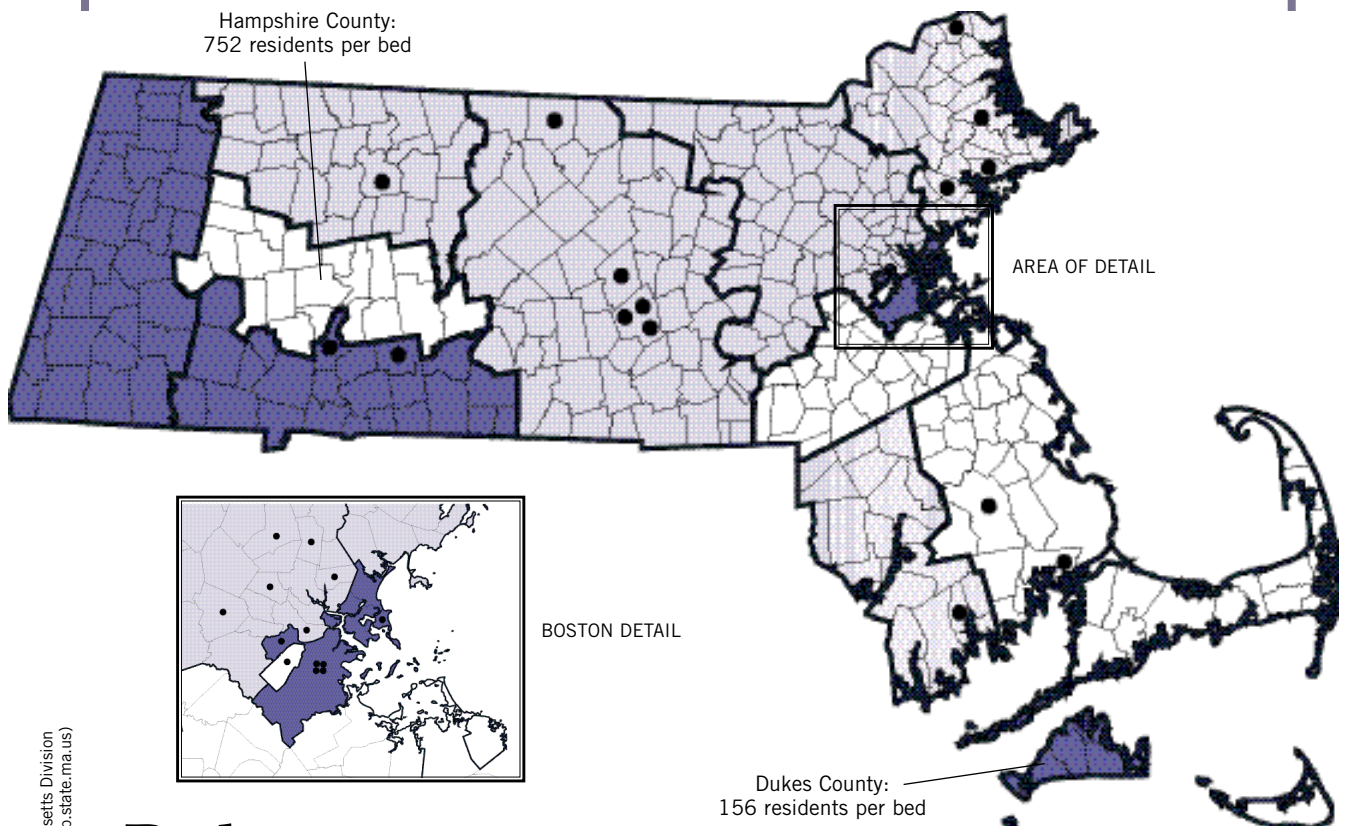


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Bed scores

Unlike Dunkin' Donuts outlets, hospitals don't necessarily mirror population trends. According to the most current figures from the American Hospital Directory, staffed beds are relatively plentiful in Berkshire and Hampden counties (which have been bleeding residents in recent years) and relatively scarce in fast-growing southeastern Massachusetts. Hospitals are shrinking in number, and the Massachusetts Hospital Association counts 28 acute-care facilities in the state that have been closed or converted to "other health-care related uses" since 1980. Only two such facilities were in arguably underserved Barnstable, Norfolk, and Plymouth counties, suggesting that the consolidation process does have some relation to demand.

In 2001, average occupancy rates at Massachusetts hospitals varied widely—from 21 percent at Nantucket Cottage Hospital to 90 percent at the Lahey Clinic in Burlington. Other hospitals with low bed-occupancy rates (Harrington General, in Southbridge; North Adams Regional Hospital; Athol Hospital) are also in relatively less-populated regions, and the fact that they cover large geographical areas may make them unlikely candidates for closure. Meanwhile, the most crowded facilities (Faulkner Hospital, the Dana Farber Cancer Institute,

and Brigham and Women's Hospital, all in Boston) are in densely developed areas where hospital expansion may become prohibitively expensive.

Switching from hospital beds to the doctors who stand beside them, we find a geographic pattern similar to that of hospital beds. According to the state Department of Public Health, there were 18,349 certified physicians on the job in Massachusetts in 2002, and fully 33 percent (or 5,984) of them worked in the city of Boston. Per capita, however, the greatest concentration of physicians was in the Lahey Clinic's Burlington (360 in a town of 22,876). The biggest towns without any doctors were Wareham and East Bridgewater, both in the southeastern part of the state—as is Fairhaven, the biggest town with only one practicing physician.

—ROBERT DAVID SULLIVAN

STATISTICALLY SIGNIFICANT

BY ROBERT DAVID SULLIVAN

BIG SALES FOR LIGHT READS

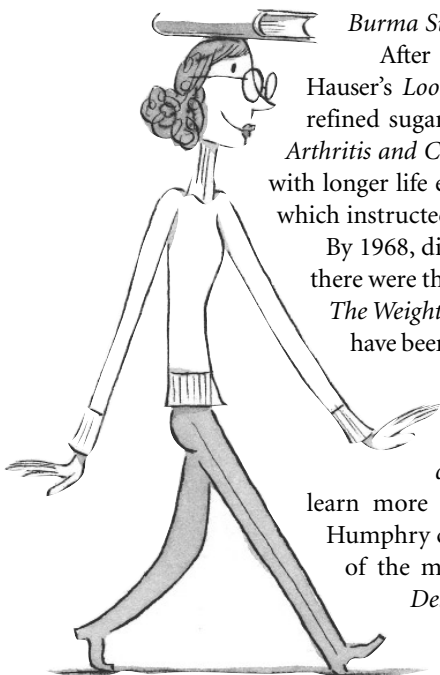
In any given week, as many as half of the nonfiction bestsellers in the US are health-related—with diet books the most common subgenre. That wasn't always the case, and a look at *Publishers Weekly* annual bestseller lists over the past century shows that the reading habits of the health-conscious have changed quite a bit over the years.

Actually, there was *one* hugely popular diet book during the 1920s. Lulu Hunt Peters's *Diet and Health with a Key to the Calories* recommended chewing your food *very* slowly—possibly to make eating such a chore that it loses its appeal. But during the next two decades, many bestsellers focused on public health and on the heroic efforts of doctors to battle pestilence. There was Hans Zinsser's *Rats, Lice, and History*, a greatest-hits book about microbial diseases; Victor Heiser's memoir *An American Doctor's Odyssey*, about conquering leprosy in the Philippines; and Gordon Seagrave's autobiographical *Burma Surgeon*, about bringing modern medicine to a remote region of Asia.

After World War II, "self-help" books came into their own. In 1951, Gayelord Hauser's *Look Younger, Live Longer* denounced "empty" foods full of white flour and refined sugar. In 1956, the top nonfiction book of the year was Dan Dale Alexander's *Arthritis and Common Sense*, signaling a big audience for books about problems that come with longer life expectancies. Four years later, the top seller was D.C. Jarvis's *Folk Medicine*, which instructed people on how to treat minor ailments without seeing a doctor.

By 1968, diet books overshadowed all other kinds of medical topics. For the first time, there were three diet books among that year's top 10: *The Doctor's Quick Weight Loss Diet*, *The Weight Watcher's Cook Book*, and *Better Homes and Gardens Eat and Stay Slim*. They have been ubiquitous since then, with *Dr. Atkins' Diet Revolution* in 1972 and *The Complete Scarsdale Medical Diet* in 1979 standing out as especially big sellers.

But a more recent phenomenon is what might be called the extreme self-help book. In 1980, Norman Cousins's *Anatomy of an Illness as Perceived by the Patient* pretty much ended the presumption that you could learn more from doctors than from the people they treated. And in 1991, Derek Humphry challenged the idea that one's doctor should have the last word, writing one of the more surprising bestsellers of all time: *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*.



IN WITH THE NEW

Earlier this year the Department of Public Health released "Massachusetts Births 2002," its annual report on all things maternal in the Bay State. According to the DPH, a record 28.2 percent of all births in Massachusetts were delivered by cesarean section in 2002. Since 1997, c-sections have increased by an average of 7 percent per year. Also on the upswing are multiple births (twins, triplets, etc.), which accounted for 4.9 percent of all births in 2002—almost double the 1990s rate of 2.6 percent.

Massachusetts is ahead of the curve in the increasingly common practice of putting off childbirth until later in life. The average age of first-time mothers here in 2002 was 28.0 years, considerably above the national average of 25.1 years.

WALKING TALL

The American Podiatric Medical Association recently designated Boston as the third best "walking city" in America, behind New York and San Francisco. Boston scored especially high in the number of people who walk to work (13 percent of the population) and the number of health clubs per capita. Where was it lame? The number of podiatrists per capita.

DIRECTIONAL SIGNALS

In April, the state Department of Public Health released its annual “Profile of Health Among Massachusetts Adults” (five months earlier and 10 pages longer than the previous edition), and reminded us that statewide figures often mask regional differences. Based on a telephone survey of nearly 7,500 Massachusetts residents conducted in 2002, the report noted that an unlucky 13.3 percent described their health as “fair or poor,” up from 12.1 percent the year before. That figure was highest (14.7 percent) in the southeastern part of the state and lowest in Metrowest (10.6 percent). Boston proper was the only region not to see an increase from year to year (it dropped from 15.4 percent to 14.1 percent), but the city is helped by its relatively youthful population. When the DPH adjusted for regional differences in age distribution, Boston actually ranked highest, with 17.1 percent of its inhabitants reporting fair or poor health.

In several respects, Boston’s population skews toward the healthier side. The number of respondents with “six or more teeth missing” ranged from 11 percent in Boston to 23 percent in western Massachusetts. Overweight respondents ranged from 46 percent in Boston to 59 percent in the central part of the state. But on the delivery of certain health services, Boston comes up short. In Metrowest, 70 percent of children received dental sealant (a procedure to prevent tooth decay), but only 43 percent of Boston children got the same benefit.

One of the most striking regional differences was limited to women who had been pregnant in the previous five years. Only 10 percent of respondents in Metrowest reported an “unplanned” pregnancy, whereas 37 percent of those in the southeastern part of the state said that their pregnancies had been unplanned.

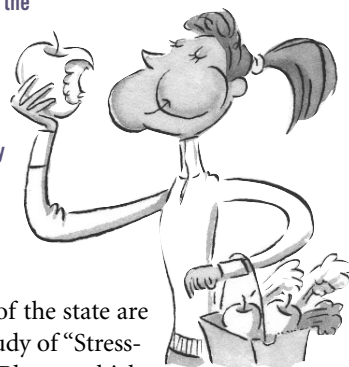


MIND YOUR PEAS AND KUMQUATS

One of the few questions on the Department of Public Health’s telephone survey that produced a large gender gap had to do with diet. Thirty-five percent of the female correspondents claimed to eat at least five servings of fruits and vegetables per day, but only 24 percent of men said the same thing. Overall, 29.7 percent of the state’s respondents said they eat like Popeye.

The DPH data was integrated into the Centers for Disease Control’s annual health survey, which put Massachusetts in a tie for second place with Maryland, and just behind Connecticut, in the percentage of residents saying that their “average frequency of fruit and vegetable consumption” is more than five times a day. At the other end of the scale, only 14.4 percent of people in Oklahoma made the same claim.

Either Bay Staters have unusually responsible diets or they know how to give pollsters unusually responsible-sounding answers.



SLEEPLESS IN NEW BEDFORD?

The Hub may be calm, but other parts of the state are feeling a bit tense, according to a new study of “Stressful Cities” in America. Sperling’s BestPlaces, which publishes a variety of “where to live” guides, measured such factors as divorce rates, commuting times, alcohol consumption, and cloudy days to conclude that Boston is only the 77th most stressful of 100 metropolitan areas in the US. Springfield was a bit more jittery, but at 63rd place it was still more easygoing than most large cities. Tacoma, Wash., was the most stressful (all that rain or all that coffee?), and Albany, NY, was at the blissful bottom.

But the picture wasn’t as mellow for a couple of smaller Massachusetts cities. Lawrence was the 41st most stressful out of 114 mid-sized metro areas, and New Bedford ranked 34th out of 117 smaller metro areas.

The Sperling study didn’t rank entire states, but a federal Centers for Disease Control survey in 2001 placed Massachusetts almost squarely in the middle (tied for 21st) in the percentage of residents reporting “poor mental health” within the previous month. Thirty-four percent of Bay State respondents said they had had the blues, compared with 43 percent in first-place Utah and 16 percent in last-place Hawaii (or did people in the “island paradise” feel too guilty to admit they were depressed?).



PHOTO: RICHARD HOWARD

Staff members of Codman Square Health Center

Since the early 1970s, the Boston Foundation has provided funds to establish and support many of Boston's neighborhood health centers, in the process helping to make our city a national leader in community-based health care. Not only do these centers provide accessible health care to residents of Boston's neighborhoods – they also function as dynamic engines of local economic growth, generating more than 6,400 jobs and stimulating more than \$345 million in economic output every year.

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Under coverage

Massachusetts has one of the lowest percentages of people without health insurance, but it might do even better if more private employers picked up the tab. According to a recent report in *Governing* magazine, almost 72 percent of adults under 65 working in the Bay State receive insurance at their workplace (as of two years ago), but that's significantly lower than in next-door New Hampshire, where 78 percent of the workforce gets insurance from employers, the highest rate in the country. Because state programs in New Hampshire insure relatively few people, its overall coverage rate is still lower than that in Massachusetts. But all four states that do better than the Bay State at insuring its citizens—Delaware, Iowa, Minnesota, and Wisconsin—also have higher percentages of people receiving insurance through employers.

Governing also calculated that Massachusetts ranks 14th in the percentage of adults receiving insurance through public programs including Medicaid—11.2

percent versus the national average of 9.2 percent. Tennessee ranks first in this category, with 16.6 percent insured through government programs (see *Innovations* sidebar, page 48), an effort that greatly compensates for the relatively high number of jobs that don't offer coverage. Maryland ranks last, with only 4.9 percent of adults insured through government programs—a fact that explains why this relatively wealthy state has a mediocre standing (24th) in terms of the percentage of its population with any health insurance at all.

Self-financed health insurance is most popular—or, at least, necessary—in western states. In Montana, which ranks first by this measure, 12.7 percent of all adults under 65 pay for health insurance completely out of their own pockets; only 57 percent are covered by employer plans. Massachusetts ranks 35th in the percentage of adults with individual plans (4.9 percent), somewhat below the national average of 5.7 percent.

—ROBERT DAVID SULLIVAN

Rank	State	% of adults under 65 with health insurance	% of adults under 65 with health insurance through an employer (rank)
	US total	80.9	66.1
1	Minnesota	90.0	75.5 (2)
2	Delaware	88.4	74.1 (3)
3	Iowa	88.3	72.4 (9)
4	Wisconsin	88.0	73.1 (6)
5	Massachusetts	87.9	71.7 (13)
6	Rhode Island	87.7	70.5 (15)
7	Hawaii	87.4	71.4 (14)
8	New Hampshire	86.9	78.1 (1)
	Pennsylvania	86.9	72.8 (8)
10	Nebraska	86.7	68.3 (22)
11	North Dakota	86.3	67.5 (25)
	South Dakota	86.3	65.3 (32)
13	Connecticut	86.2	73.5 (4)
14	Vermont	86.1	67.1 (27)
15	Michigan	85.6	72.4 (9)
16	Tennessee	85.4	63.2 (37)
17	Maine	85.0	66.6 (29)
18	Kansas	84.9	69.9 (17)
19	Missouri	84.6	72.3 (11)
	Ohio	84.6	70.3 (16)
	Virginia	84.6	69.5 (18)
22	Indiana	84.1	73.1 (6)
23	Kentucky	83.6	68.3 (22)
24	Maryland	83.4	73.3 (5)
25	South Carolina	83.3	66.1 (31)

Rank	State	% of adults under 65 with health insurance	% of adults under 65 with health insurance through an employer (rank)
	US total	80.9	66.1
26	Oregon	83.1	63.3 (36)
27	Washington	83.0	66.3 (30)
28	Alabama	82.9	67.8 (24)
29	New Jersey	82.6	71.8 (12)
30	Illinois	82.4	69.4 (19)
31	Utah	81.9	69.2 (20)
32	Montana	81.4	56.7 (49)
33	Colorado	80.8	66.9 (28)
34	West Virginia	80.7	61.6 (40)
35	Georgia	80.3	67.2 (26)
36	North Carolina	79.7	64.7 (34)
37	New York	79.0	63.4 (35)
38	Nevada	78.8	68.9 (21)
39	Arizona	78.7	61.1 (42)
40	Wyoming	78.3	65.0 (33)
41	Mississippi	77.9	58.7 (46)
42	Alaska	77.8	63.2 (37)
	Idaho	77.8	62.4 (39)
44	Arkansas	77.5	58.8 (45)
45	Florida	77.2	60.9 (43)
46	California	76.5	61.4 (41)
	Oklahoma	76.5	59.7 (44)
48	Louisiana	74.4	57.9 (48)
49	New Mexico	71.7	55.0 (50)
50	Texas	70.3	58.6 (47)

Community care

The 44 million Americans without health insurance get newspaper headlines and the attention of political candidates. But there are 36 million Americans (half of them with insurance) who lack access to health care because they live in communities without enough providers. That's the conclusion of *A Nation's Health at Risk*, a study released in March by the National Association of Community Health Centers. Not surprisingly, the study recommends community health centers as a relatively inexpensive way to reach underserved populations.

Massachusetts has already taken this idea to heart. According to the NACHC, the Bay State is one of a handful where more than 95 percent of residents have adequate health care services in their communities, thanks, in part, to an extensive network of community health centers. Massachusetts ranks highly (sixth place) in the percentage of low-income, uninsured individuals who use such centers as their regular providers, as well.

But the two—access and health centers—don't always go together. Though Massachusetts ranks in the top 10 in both categories, it's bested by a totally different set of states in each instance. Several states have achieved near-universal proximity to adequate health care without much reliance on community health centers—mostly northeastern states such as Maine, Maryland, and New Hampshire. Other states have relatively low populations that are “medically served” even though their community health centers care for most of their uninsured—particularly rural states such as Montana, South Dakota, and West Virginia. Only Alaska, Hawaii, and Rhode Island are comparable to Massachusetts in relying so much on community health centers to achieve near-total health care service.

Cambridge may be the best-served city in the Bay State; it has 12 community health centers, or almost half the number (27) in five-times-larger Boston. The smallest towns with such clinics, Worthington and Huntington, are right next to each other in Hampshire County. The largest cities without community health centers are Newton and Waltham, which are right next to each other in the Metrowest region. While most of the Bay State's centers are in urban areas, the NACHC notes that, at the national level, one-fifth of all adults living in rural areas get their primary care through community health centers—which is about twice the rate as that of urban residents.

—ROBERT DAVID SULLIVAN

% of population that is “medically served” (2003)		% of low-income uninsured served by community health centers (2003)	
1. Hawaii	99	1. Alaska	62
2. New Hampshire	98	2. West Virginia	55
Rhode Island	98	3. South Dakota	53
4. Alaska	97	4. Colorado	47
Connecticut	97	Montana	47
Maryland	97	6. Massachusetts	44
7. Maine	96	7. Mississippi	43
Massachusetts	96	8. Hawaii	42
9. Illinois	95	9. New Mexico	40
Washington	95	Rhode Island	40
11. Arizona	94	11. Washington	38
Colorado	94	12. Connecticut	35
Delaware	94	13. North Dakota	32
New Jersey	94	14. Iowa	29
Vermont	94	Oregon	29
16. California	93	16. Missouri	28
17. Minnesota	91	South Carolina	28
Oregon	91	18. Alabama	27
Pennsylvania	91	Kentucky	27
20. Ohio	90	20. California	26
21. Michigan	89	Idaho	26
New York	89	Utah	26
23. Iowa	88	23. Illinois	24
Wisconsin	88	New Hampshire	24
25. Indiana	87	Vermont	24
Kansas	87	26. Kansas	22
Virginia	87	Nebraska	22
28. Florida	87	28. Arkansas	21
West Virginia	87	Maine	21
30. North Dakota	85	30. Minnesota	20
31. Montana	84	31. Pennsylvania	19
32. Missouri	82	32. Michigan	18
New Mexico	82	33. North Carolina	17
Oklahoma	82	34. Florida	16
South Carolina	82	New York	16
Texas	82	Tennessee	16
37. South Dakota	81	37. Wyoming	16
Utah	81	38. Delaware	15
39. Idaho	80	New Jersey	15
Kentucky	80	40. Arizona	14
Nebraska	80	Indiana	14
Nevada	80	Maryland	14
North Carolina	80	Nevada	14
44. Tennessee	79	44. Georgia	13
45. Georgia	78	Virginia	13
46. Arkansas	77	46. Oklahoma	12
47. Wyoming	76	Wisconsin	12
48. Alabama	71	48. Ohio	11
49. Mississippi	67	49. Texas	10
50. Louisiana	64	50. Louisiana	9
US total	88	US total	20

Physical education

By several criteria, Massachusetts is in the vanguard of healthy living. According to the Centers for Disease Control and Prevention, we have among the country's lowest rates of obesity and smoking, and we rank among the highest in seeing our doctors on a regular basis. But our healthy rankings are at least partly attributable to our demographics. Massachusetts is a relatively affluent and well-educated state, and people with more money and more degrees tend to have healthy habits wherever they live. When you look at members of specific groups, however, the Bay State isn't always at the doctor-recommended end of the spectrum. For example, Massachusetts ranks 48th in the percentage of adults who are current smokers (18.9, considerably below the national average of 23.0). But in the percentage of residents without high school diplomas who smoke, we do less well (30.7, versus 34.6 at the national level and barely below North Carolina's 32.0).

Massachusetts ranks third in the percentage of adults who have had their teeth cleaned in the past year (78.9 percent, versus the national average of 69.2 percent) but in the percentage of college graduates who have had their teeth cleaned recently, we drop to ninth (85.0 percent versus 79.2 percent).

Educational differences are especially noticeable in the percentage of individuals who don't include exercise in their leisure activities—and thus may be at greater risk for heart disease, among other conditions. Overall, Massachusetts ranks 35th by this measure, and its 22.7 percent of citizens who are sedentary is well below the 26.3 percent at the national level. But while Bay State college graduates are more active than their counterparts elsewhere (with only 12.8 percent abstaining from exercise, compared with 14.5 percent nationally), residents who have not advanced beyond high school match up almost exactly with the national sample, with 32.6 percent in both groups admitting they have no leisure-time physical activity.

At least in this case, climate may play a role in minimizing or exaggerating differences by educational level. Blue Hawaii has the smallest gap between high school graduates and college graduates in terms of exercise rates, and often-snowy Nebraska has the greatest gap. While most states with high rates of inactivity are in the South, it's notable that New York has high inactivity rates at all educational levels—but the survey didn't determine whether New Yorkers lack time, proximity to green space, or affordably priced health clubs.

—ROBERT DAVID SULLIVAN

		% of adults with no leisure-time physical activity	% of HS graduates with no leisure-time physical activity	% of college graduates with no leisure-time physical activity
1	Louisiana	35.8	40.6 (3)	21.0 (1)
2	Tennessee	34.7	41.0 (2)	17.9 (6)
3	Mississippi	33.5	38.0 (5)	20.0 (2)
4	Kentucky	33.3	35.9 (9)	16.6 (11)
5	Oklahoma	32.5	36.3 (8)	19.3 (4)
6	West Virginia	31.3	34.2 (14)	19.5 (3)
7	Nebraska	31.2	43.1 (1)	17.8 (7)
8	Alabama	31.1	36.3 (7)	15.9 (12)
	Arkansas	31.1	38.2 (4)	18.8 (5)
10	New York	28.6	34.8 (10)	17.3 (8)
11	Georgia	27.6	34.6 (12)	13.6 (23)
12	Texas	27.3	31.4 (26)	14.0 (21)
13	Missouri	27.2	31.2 (28)	14.5 (19)
14	Florida	27.1	33.3 (18)	17.3 (9)
15	California	26.6	32.1 (25)	15.0 (17)
	Illinois	26.6	37.7 (6)	15.7 (13)
	South Carolina	26.6	33.3 (19)	13.6 (24)
18	Kansas	26.4	33.5 (17)	17.0 (10)
	New Jersey	26.4	34.1 (15)	15.4 (15)
20	North Carolina	26.3	34.6 (13)	13.2 (28)
21	Indiana	26.1	33.0 (20)	13.1 (29)
	Ohio	26.1	32.9 (22)	13.1 (30)
23	New Mexico	25.9	33.8 (16)	11.3 (42)
24	Delaware	25.6	34.7 (11)	15.4 (16)
25	Iowa	25.5	32.3 (24)	14.7 (18)
26	South Dakota	25.0	30.5 (32)	13.5 (25)
27	Rhode Island	24.6	30.7 (29)	12.5 (34)
28	Maryland	24.3	31.2 (27)	15.7 (14)
29	Pennsylvania	24.1	28.0 (37)	14.2 (20)
30	Connecticut	23.8	32.9 (21)	13.6 (22)
31	Virginia	23.4	30.6 (30)	13.3 (26)
32	Michigan	23.3	29.1 (34)	11.6 (39)
33	North Dakota	23.0	27.6 (40)	12.2 (36)
34	Maine	22.9	28.1 (36)	11.7 (38)
35	Massachusetts	22.7	32.6 (23)	12.8 (32)
36	Alaska	22.4	30.5 (31)	11.7 (37)
37	Arizona	21.9	26.0 (42)	10.6 (43)
38	Montana	21.5	27.6 (38)	10.4 (44)
39	Wyoming	21.3	25.5 (43)	13.3 (27)
40	Idaho	20.9	25.4 (45)	12.8 (33)
41	Oregon	20.6	25.4 (46)	10.0 (46)
	Wisconsin	20.6	25.4 (47)	11.5 (40)
43	Nevada	20.4	29.4 (33)	12.4 (35)
	Vermont	20.4	28.4 (35)	8.5 (48)
45	New Hampshire	19.6	27.6 (39)	9.8 (47)
46	Colorado	19.4	26.5 (41)	11.3 (41)
47	Hawaii	18.8	25.4 (44)	13.1 (31)
48	Minnesota	17.1	24.3 (49)	8.4 (50)
	Utah	17.1	24.5 (48)	10.4 (45)
	Washington	17.1	24.3 (50)	8.4 (49)
	US Total	26.3	32.6	14.5

Death takes a holiday

Perhaps because of better diets, less cigarette smoking, and more exercise, Massachusetts has outpaced the nation in reducing the rate of death from heart disease. Based on a three-year average of age-adjusted data from 1998 through 2000, the Bay State ranks 38th in the number of heart-related deaths per 100,000—down from 26th in 1990. While the national rate dropped from 321.8 to 268.7, the decline was considerably sharper in Massachusetts: from 309.1 to 226.7.

Deaths from cancer have been tougher to reduce. Nationally, the death rate is at 205.3 per 100,000, a slight drop from 216.7 in 1990. In the Bay State, the rate of cancer deaths has actually risen, from 209.1 to 211.4, placing us 19th highest in the nation. At this rate, Massachusetts may soon join Minnesota, which is now the only state where one is more likely to die from cancer than from heart disease.

Overall, Massachusetts has the third lowest rate of

“premature death” (based on the number of years lost by individuals who die before the age of 75) according to 2000 figures, behind only Minnesota and New Hampshire. On that count, we were helped not only by our low rate of heart disease but also by our ranking of 44th in deaths attributed to strokes and 50th in occupational fatalities.

But on some other ailments, Massachusetts doesn't do as well. In 2002, the Bay State ranked 19th in the rate of AIDS cases, and 18th in the rate of infectious disease. And Massachusetts makes a rare appearance at the wrong end of a health chart when it comes to asthma. Though there is no consensus on why the rate here is so high (better detection may be one reason), there seems to be a geographical pattern to this respiratory ailment: Every New England state except Connecticut is in the top 10 for asthma rates, and almost all of the states in the bottom 10 are in the South.

—ROBERT DAVID SULLIVAN

	Cancer deaths per 100,000 population (rank)	Heart deaths per 100,000 population (rank)	Percentage of adults diagnosed with asthma (rank)
Alabama	213.3 (18)	299.5 (7)	6.3 (43)
Alaska	189.0 (42)	211.8 (45)	7.3 (24)
Arizona	186.1 (44)	231.8 (36)	8.3 (8)
Arkansas	214.5 (13)	291.1 (10)	7.0 (32)
California	191.9 (40)	264.4 (22)	7.2 (29)
Colorado	177.2 (48)	202.1 (47)	8.0 (15)
Connecticut	196.1 (37)	244.5 (31)	7.9 (18)
Delaware	219.1 (5)	265.3 (21)	7.5 (22)
Florida	196.0 (38)	250.4 (28)	5.8 (46)
Georgia	203.8 (28)	282.5 (14)	7.2 (30)
Hawaii	162.3 (50)	194.0 (48)	7.3 (25)
Idaho	183.7 (45)	222.8 (40)	8.0 (16)
Illinois	214.3 (14)	274.4 (16)	7.9 (19)
Indiana	221.9 (4)	283.1 (13)	7.5 (23)
Iowa	203.3 (31)	252.7 (26)	6.7 (38)
Kansas	197.3 (36)	243.8 (32)	8.1 (13)
Kentucky	231.6 (1)	310.9 (4)	8.3 (9)
Louisiana	224.8 (3)	290.3 (11)	5.3 (49)
Maine	216.7 (10)	249.6 (29)	9.4 (2)
Maryland	210.8 (20)	256.7 (24)	7.1 (31)
Massachusetts	211.4 (19)	226.7 (38)	9.5 (1)
Michigan	206.0 (23)	291.5 (9)	9.0 (5)
Minnesota	198.2 (34)	189.7 (50)	6.6 (39)
Mississippi	217.7 (9)	338.9 (1)	5.5 (48)
Missouri	214.6 (11)	299.0 (8)	8.2 (12)
Montana	203.7 (29)	217.1 (42)	8.0 (17)

	Cancer deaths per 100,000 population (rank)	Heart deaths per 100,000 population (rank)	Percentage of adults diagnosed with asthma (rank)
Nebraska	194.0 (39)	238.9 (34)	5.8 (47)
Nevada	218.6 (7)	274.1 (17)	8.3 (10)
New Hampshire	210.3 (21)	227.4 (37)	8.4 (7)
New Jersey	214.3 (14)	271.3 (19)	6.2 (44)
New Mexico	178.7 (47)	215.5 (43)	6.9 (34)
New York	197.8 (35)	303.9 (5)	7.3 (26)
North Carolina	204.9 (27)	262.2 (23)	6.4 (41)
North Dakota	188.9 (43)	208.9 (46)	6.8 (37)
Ohio	218.5 (8)	286.5 (12)	7.3 (27)
Oklahoma	214.1 (16)	324.2 (2)	6.9 (35)
Oregon	205.1 (25)	212.6 (44)	8.1 (14)
Pennsylvania	214.6 (11)	280.6 (15)	7.3 (28)
Rhode Island	213.6 (17)	250.6 (27)	9.4 (3)
South Carolina	205.1 (25)	270.5 (20)	6.5 (40)
South Dakota	179.7 (46)	236.2 (35)	5.3 (50)
Tennessee	219.1 (5)	302.2 (6)	6.9 (36)
Texas	201.0 (32)	273.3 (18)	6.1 (45)
Utah	164.5 (49)	191.8 (49)	7.0 (33)
Vermont	200.4 (33)	241.8 (33)	8.8 (6)
Virginia	209.0 (22)	254.4 (25)	6.4 (42)
Washington	203.4 (30)	221.0 (41)	7.7 (21)
West Virginia	228.4 (2)	321.3 (3)	9.3 (4)
Wisconsin	205.7 (24)	244.6 (30)	7.8 (20)
Wyoming	191.1 (41)	226.3 (39)	8.3 (11)
US total	205.3	268.7	7.2

Leading the way?

Maine's Dirigo Health is the latest state attempt to offer health coverage for all. Will it work?

BY REBECCA GRIFFIN

There is an old Yankee expression: "If it ain't broke, don't fix it." A corollary might be: "If it is broke, fix it right." There's not much doubt that the health care system in the state of Maine is broken, especially for the 140,000 people who have no health insurance. What remains to be seen is whether the state's bold new plan to provide affordable health insurance, which goes into effect late this summer, is the fix Maine's citizens are counting on—and other states are looking for.

"Legislatures in other states are looking to Maine and saying, 'Gee, is this a workable model?'" says Richard Cauchi, senior policy specialist for the National Conference of State Legislatures.

Maine's model is called Dirigo Health, named after the state's Latin motto, which translates as "I lead." What Dirigo Health is leading with is \$53 million, seed money state leaders hope will grow into a health system that will provide affordable insurance coverage, relieve hospitals of the burden of charity care, and, in future years, pay for itself through cost savings.

Supporters say Dirigo Health will work because it addresses the root problems of the system, including wastefulness, rising costs, and small businesses that don't provide insurance. All the major players—health care providers, insurance company representatives, small-business leaders, and advocates for the uninsured—were involved in the design. The result is a plan that Dirigo architect Trish Riley describes as "comprehensive."

"We wanted to build on what we had to get something better," says Riley, who heads the state's Office of Health Policy and Finance. "A state representative here called it 'elegant,' and I think it is, because it assumes what the unintended consequences will be and cuts them off at the pass."

But as the launch, which could take place around Labor Day, draws near, skepticism is mounting. "There's no definition as to what the plan is right now," says House Minority Leader Joseph Bruno, a Republican who represents the town of Raymond in the Sebago Lake region. Bruno originally supported the plan but now says he has

too many unanswered questions. "All that we know is that it's going to be expensive."

TAKING THE LEAD ON COST, COVERAGE

There are familiar elements in the health care conundrum Dirigo Health tries to solve—namely, rising costs and out-of-reach coverage. Currently, about 10.8 percent of Maine's 1.3 million residents are uninsured. That's the highest percentage of any New England state but still below the national average of 14.7 percent. (The uninsured rate in Massachusetts is about 9 percent.) Then there are the underinsured—thousands of Maine residents who barely hang on to emergency insurance plans with deductibles running into thousands of dollars.

The Mainers least likely to have insurance are employed, but earning less than twice the federal poverty level, according to a 2002 survey by the Edmund S. Muskie School of Public Service at the University of Southern Maine in Portland. The study also found that 27 percent of the state's self-employed and 31 percent of those working for businesses with 10 or fewer employees lack insurance.

All the major players were involved in the design.

Health care costs are on the rise everywhere, but particularly in Maine, which can hardly afford it: The state ranks 36th in per-capita income. Health care costs have increased at an average of 9.7 percent annually over the past two decades, compared with 9 percent nationally, according to the Maine Economic Growth Council, a non-partisan planning agency whose members are appointed by the governor and by legislative leaders. As of 2002, the state's emergency-room use was 43 percent above the national average. Mainers also suffer high rates of "preventable" diseases such as heart disease and stroke. It doesn't help that nearly a quarter of Mainers smoke—the highest percentage of any New England state.

Dirigo was born of Gov. John Baldacci's campaign

promise to address the state's health care woes. After he took office in January 2003, the Democrat initiated extensive negotiations with health care providers and the insurance industry to develop the plan, which was approved by the Legislature last June. The state plans to enroll 31,000 residents in the program's first year and sign up the remaining uninsured by 2009.

Dirigo calls for the state to:

- Contract with a private insurance company to create a policy for the state's uninsured that will carry the Dirigo name;
- Subsidize the cost of Dirigo insurance for low-income residents;
- Offer businesses with fewer than 50 employees an opportunity to purchase Dirigo;
- Expand eligibility for the state's Medicaid program, which provides free health care to the state's poorest residents; and
- Monitor residents' access to health care, ensure quality, and keep costs down.

The idea behind Dirigo is to gather up the state's uninsured so that they can qualify for a "group" rate on health coverage. The state will call on private insurance carriers to bid on the chance to provide coverage under the Dirigo Health brand, introducing a new competitor to the state's

private insurance market.

Competition and market leverage are vital to correcting the imbalances of Maine's health care marketplace, state leaders say. In the report *Dirigo Health: Health Reform in Maine*, published by the state last year, "monopolistic" insurance and hospital markets, which "diminish the capacity of purchasers to negotiate lower prices," are blamed for individuals and small businesses getting priced out of health care coverage. The report points out that 31 of the state's 39 hospitals belong to or are affiliated with the state's four largest hospital systems.

Meanwhile, one insurance company—Anthem Blue Cross Blue Shield—provides 87 percent of the state's individual insurance plans. Anthem also holds 49 percent of the small-group market, with Aetna carrying another 30 percent. Anthem, an Indiana-based health-benefits company whose subsidiaries operate under license from the national Blue Cross Blue Shield Association in nine states, became the state's major insurance player three years ago, when it bought the financially struggling Maine Blue Cross Blue Shield carrier.

Competition is something Anthem welcomes in Maine, says company spokesman Bill Cohen. "We'd like to see more to come," he says. "We believe a good, strong competitive marketplace is a good way to build a good market."

Self-employed sculptor Christopher Strassner, 36, who

MANY ATTEMPTS, NO SUCCESSES

Maine is far from the first state to try to extend health care insurance to all its citizens. Among those that have attempted to do so are Hawaii, Massachusetts, Oregon, Tennessee, Vermont, and Washington. In the 1980s and early 1990s, most states expanded Medicaid eligibility with the help of federal money. After 1997, most states also improved coverage for youngsters through the Children's Health Insurance Program, again with federal assistance. But the goal of universal health coverage has proved elusive in every state.

"It's certainly technically feasible for a state to provide universal coverage, but whether it is politically feasible is the more difficult question," says Christopher Conover, a professor at Duke University's Terry Sanford Institute of Public Policy. The following is a summary of major state attempts to extend health coverage to all:

Hawaii broke ground in 1974 by requiring employers to provide insurance to full-time employees. This employer mandate is coupled with a public purchasing pool for individuals, available to those making up to three times the federal poverty

level. The federal government has since passed a law that restricts states from interfering with employers' health plans; Hawaii was able to continue its program thanks to a special exemption. As a result, the Aloha State is the only one with an employer mandate. Even so, the uninsured rate in Hawaii has averaged 9.7 percent over the past three years.

Massachusetts and **Oregon** adopted a "pay or play" approach to health insurance in the late 1980s, requiring that employers either insure their employees or pay a tax to fund such coverage. Neither state's pay-or-play plan ever took effect, due to a weakening economy and resistance from small businesses. However, both states did follow through with plans to expand their Medicaid programs. Massachusetts' MassHealth plan, passed in 1997, also includes a tax credit for low-wage small businesses that offer health insurance.

Vermont attempted to achieve universal coverage in the early 1990s, but a commission charged with choosing a plan was unable to reach a decision. Options included a "single-payer" approach and a more market-oriented approach that may have



Dirigo Health architect Trish Riley calls the plan “comprehensive” and “elegant.”

lives in the southern coastal city of Saco, is one Anthem customer who'd like to see more alternatives. “I buy into Anthem right now because there's no other options,” says Strassner, taking a break at his shop in nearby Biddeford. “Some level of competition is necessary.”

Strassner has insurance thanks to his wife, who works for an architecture firm in Portland. As long as he covers the company portion of his insurance, he gets the employee group rate. Even with this arrangement, he pays more than \$500 a month for health coverage. He hopes he can get a better deal from Dirigo, but won't be sold until he sees the rates for himself. “Once it's here and I can see what it's going to do for me, then we'll see.”

State leaders hope Dirigo will appeal to the likes of Strassner. The estimated price of a Dirigo plan with a \$1,750 deductible is \$260 per month for an individual or \$779 per month for parents with children. Plus, many will be eligible for discounts and

compared with Arkansas at 15.6 percent, Louisiana at 18.6 percent, and Texas at 24.1 percent.

included a pay-or-play model. In the end, no consensus was reached and the only proposal that went into effect was an expansion of Medicaid, particularly for children.

Washington also tried to set up universal coverage in 1993 with a plan that included a pay-or-play provision and an individual mandate. But most of the plan was repealed before it took effect. What survived was the Basic Health Plan, which subsidizes, on a sliding scale, coverage for families with incomes below 200 percent of the federal poverty level.

Tennessee, in 1993, passed the nation's most ambitious program to date. TennCare channeled Medicaid recipients into managed care, then used the savings to subsidize insurance for those who earn up to 400 percent of the federal poverty level. In recent years, budgetary limitations have forced the state to tighten eligibility requirements. The state still has a lower uninsured rate than most southern states—11 percent,

California adopted a pay-or-play model last year, with Democratic Gov. Gray Davis signing the plan into law shortly before he was ousted in a recall election. Starting in 2006, businesses with 200 employees or more must provide health insurance or pay a tax. By 2007, the requirement will apply to businesses with more than 50 workers. By then, smaller businesses could be affected as well, but only if the state adopts a tax credit subsidy to help cover the cost of premiums.

Compiled by Rebecca Griffin with the help of Christopher J. Conover, professor at Duke University's Terry Sanford Institute of Public Policy; Howard Berliner, professor of health policy at the Milano Graduate School of Management and Urban Policy, New School University, in New York; and Access for the Uninsured: Lessons from 25 Years of State Initiatives, a report prepared by Trish Riley and Barbara Yondorf for the National Academy for State Health Policy.

lower deductibles, depending on their ability to pay. The state will subsidize plans for those who earn too much to qualify for free care but not enough to afford insurance—those earning up to three times the federal poverty level. Individuals who make up to \$27,930 per year and families of four that earn up to \$56,550 will qualify for assistance. The amount of the subsidy will be determined on a sliding scale according to income.

Under the Dirigo plan, more residents will also qualify for MaineCare, the state's Medicaid program, with the limit for individuals raised from the federal poverty line (\$9,310) to 125 percent of poverty (\$11,638) and for a family of four from 150 percent of poverty (\$28,275) to 200 percent (\$37,700).

AN OFFER THEY CAN'T REFUSE?

Starting with Hawaii in the 1970s, many states have tried with mixed success to insure more residents. As of yet, no state has achieved universal coverage. (See "Many attempts, no successes," page 48.) Indeed, Maine's approach is to provide universal access to affordable insurance rather than to mandate universal coverage.

One key group targeted for Dirigo coverage consists of businesses and municipalities with fewer than 50

employees—fully 90 percent of Maine businesses. To qualify, employees must work at least 20 hours a week and their employers will have to cover 60 percent of the total premium.

"We're going to put out a health care policy that, essentially, they find so attractive that they want to buy it," says Senate Majority Leader Sharon Treat, a Kennebec County Democrat.

Employers predict failure if premiums are too high.

Susan Lakari is one small-business owner who hopes Dirigo will offer her a better deal. As co-owner of Material Objects, a clothing boutique on Congress Street in Portland, Lakari had to switch insurance plans because of rising rates, and she still feels that she's paying a lot—nearly \$500 a month for one adult and two children.

"We'll definitely be looking at Dirigo and seeing what they come up with," says Lakari.

Joyce Pepin, 57, will also be looking at Dirigo, but from a vantage point of greater desperation. Pepin's 55-year-old husband owns his own business, providing traffic-

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controllers (flag men) to construction sites. The couple recently dropped their insurance coverage because they couldn't afford payments approaching \$6,000 a year.

"I don't think there's anything out there for the small-business man who really can't afford it. We toughed it out for a few years and then we couldn't do it anymore," says Pepin, who works at a general store in the York County town of Lyman. "I'm interested in finding out more about the program. We are kind of looking forward to signing up, knock on wood."

But business leaders say Dirigo won't be successful if the premiums are too high. "Much will depend on whether

expansion, since Maine's Medicaid reimbursement rate is roughly 60 percent (compared with 50 percent in Massachusetts). Beyond the first year, Dirigo Health is supposed to start supporting itself with premiums paid by customers and with savings generated by a more efficient health care system.

Here's how it's supposed to work. Insurance carriers are slated to pay a tax of up to 4 percent on premium revenues. In theory, if more people are covered by health insurance, that will reduce the estimated annual \$275 million in free care and bad debt that providers now pass along to insurers. The tax on insurance carriers will direct

some of those savings to Dirigo. But this tax only kicks in if the projected savings materialize, as determined by the Dirigo Health Agency and the Governor's Office of Health Policy and Finance. State leaders are still working out the details of how these savings will be determined.

If Dirigo fails to enroll enough Mainers to relieve the cost of bad debt and charity care, and insurance companies do not save money, state leaders plan to examine why Dirigo was not attractive enough to sustain itself and then redesign the program.

Savings are also supposed to come from restraint in hospital spending. The state has asked hospitals to voluntarily cap cost increases at 3.5 percent per year, and operating margins

at 3 percent, as part of a "cooling-off" period. Hospital officials have agreed to work toward this goal as a sign of good faith in the Dirigo initiative, but the degree to which they can stick to the voluntary caps will inform later policy. The state has also strengthened its Certificate of Need program, which requires health care providers to demonstrate a legitimate need before purchasing high-cost technology or building new facilities.

"The way this whole thing works is to say, 'There's a whole lot of money in the health care system that could be used more efficiently, and it's being wasted,'" says Sen. Treat, a Dirigo backer.

The idea that Dirigo Health could pay for itself out of the savings it generates has some experts scratching their heads, with one calling it "delusional."

"No one should think that providing coverage is going



House Minority Leader Joseph Bruno (far right): "I think it's going to fall on its face."

or not small businesses buy the Dirigo Health Insurance product once it is offered," according to an e-mail statement from the state's Chamber of Commerce. "Once again, the affordability of the product is likely to affect whether or not small employers purchase the coverage."

FUZZY MATH

Whether small businesses will be able to afford Dirigo Health coverage is one question. Whether the state of Maine can afford it is another. Riley says the budget for Dirigo insurance and expanded Medicaid coverage will total roughly \$90 million the first year. To cover this, the state will put up \$53 million in "seed" money; most of that funding will come from the federal relief package passed by Congress to reduce state budget deficits. Federal funds will also defray much of the MaineCare



Restaurant owner Troy Dickhaut doesn't have, or think about, insurance.

to be self-financing, because it's not," says Christopher Conover of Duke University's Terry Sanford Institute of Public Policy. "Someone is still going to have to come up with the money. It's just a matter of whose pocket it will come out of."

"I think it's going to fall on its face the way it's designed right now," says Rep. Bruno, a Dirigo supporter turned critic. "I think they are optimistic in the savings and they underestimate the cost."

IF YOU SELL IT, WILL THEY BUY?

Asked what she hopes people around the country will say about her program five years from now, Dirigo architect Trish Riley says, "Five years is a long time, but I hope that they will say we found a really innovative, effective way to deliver affordable health care that's sustainable over time, and that it's statewide and robust and doing great."

But even Riley admits there may be some pitfalls along the way. "It will depend on whether people sign up for it, whether it's affordable, and whether we can deliver on our promises," she says.

In a voluntary system, one that doesn't require employ-

ers or individuals to buy health care coverage, what's affordable is all in the eye of the beholder. "The problem is, if I'm not paying anything now, I can say the reason I'm not doing it is because it's too expensive," says Howard Berliner, a professor of health policy at the Milano Graduate School of Management and Urban Policy at New School University, in New York. "You can say you've made it cheaper, but it's still too much for me."

While working for New Jersey's health department, Berliner conducted a survey asking if people would buy health insurance offered at a 50 percent subsidy. He was surprised to discover how few were interested. "A lot of people, they just don't want to spend the money," he says.

Especially if they know they can buy coverage when they really need it. Some critics point to Maine's "guaranteed issue" provision, which requires carriers to cover all applicants, regardless of health status. They say this rule discourages people from buying insurance when they're healthy.

"For people who don't have a lot of money, often they don't buy insurance because they know that if something really serious happens, they can still get insurance," said Betsy Chapman, chairman of the Maine Public Policy Institute, a free-market-oriented think tank. "What we would like to do is see a task force created to review all of the mandates and repeal some of them."

Still, there is evidence of demand for Dirigo. As of March, the plan had a waiting list of more than 300, and the state's Office of Health Policy and Finance reports receiving between 10 and 15 inquiries a day concerning Dirigo, from both individuals and small businesses.

'A lot of people just don't want to spend the money.'

Whether Dirigo Health will be attractive to the likes of Troy Dickhaut, however, remains to be seen. Dickhaut, who is in his 20s, is owner of Little Lad's, a vegan restaurant in Portland. He had health insurance when he was a teacher, but doesn't have it now—and doesn't give it much thought.

"I never used it when I had it," he says. Asked how much health insurance would have to cost to pique his interest, he pauses to think, then says, "Twenty dollars a month." ■

Rebecca Griffin is a writer living in Medford.

Fear factor

Health news reported with an emphasis on danger skews reality—and threatens our well-being

BY DAVID ROPEIK

Several days after the first mad cow was found in America, when the fresh news was gone and the follow-up stories started, the *Wall Street Journal* carried an article headlined SCIENTIFIC DATA OFFER NO PROOF OF BEEF SAFETY. An important story, since most of what we eat from cows is the meat, not the brain and spinal cord, which are the known risk materials from mad cows. Reporter Antonio Regalado spent the first 17 paragraphs of his story reporting about hints that meat from mad cows might be a risk for humans. Not until the 18th paragraph did he reveal that years of studies, hundreds of them at the height of the mad cow epidemic in the UK, had overwhelmingly proved that the meat from animals with mad cow disease poses no risk.

It was a classic example of how the news media handle health stories. The threatening or frightening stories get more coverage. The threatening or frightening aspects of stories get more emphasis within each report. Small wonder, really. Since these are essentially stories about survival, and survival is pretty high on the human list of priorities, news about anything that threatens our chances of getting to tomorrow is going to grab our attention.

In short, stories about health risks sell. Newspaper editors and broadcast news directors want stories the public will notice, stories that sell papers and boost ratings. And reporters—who *aren't* concerned with corporate profits but *are* interested in their work getting the widest possible audience—highlight the aspects of their stories that seem particularly frightening. So health coverage tends to dramatize the risks of our behaviors, of what we eat and drink, of the things we're exposed to in the environment. As a result, we the public are left poorly informed about what is more dangerous and what is less, and poorly informed about what we can and should do to improve our health.

It's not a conscious process, this translation of every health report into a scare story. There's something instinctual about it, which is well explained by a field of psychology known as risk perception. Research into the way

humans subconsciously decide what to be afraid of and how afraid to be, by Paul Slovic of the University of Oregon, Baruch Fischhoff of Carnegie Mellon University, and many others, has shown that certain characteristics tend to make us more or less afraid of risks.

And every characteristic that makes people more afraid makes a journalist more excited. I know from personal experience. I was a journalist for 22 years. I saw the adrenaline rush that comes from a dramatic story firsthand, in nearly all of my TV and print colleagues, and certainly fell victim to it myself far too often. *Mea culpa*.

The more threatening stories get more coverage.

Here is a short list of fear factors:

Trust. The less we trust the people who are supposed to protect us, or the people telling us about a risk, or the people or companies who make the product or service that creates the risk, the more afraid we are; the more we trust them, the less afraid.

Control. If we control our own fate, we are less afraid than if we don't. When driving (even in Boston!), having the wheel in our hands produces a sense of control that causes us to downplay the risk of a crash, even though motor vehicle accidents kill more than 40,000 Americans a year.

Dread. Would you rather die by shark attack or by a heart attack in your sleep? The more awful death evokes more fear. That helps explain why many people fear cancer more than heart disease, even though heart disease kills roughly 160,000 Americans each year, or 26 percent more than cancer does.

Risk versus benefit. Imagine you are a paramedic or a nurse asked to take a smallpox vaccination. There is a one-in-a-million chance of death from the shot, and the disease, while life-threatening to anyone who contracts it, just isn't around. Although the Bush administration raised the specter of smallpox as a weapon of terrorism, most

“first responder” health care professionals said no to the risk, while low, of a vaccine that offered zero benefit. But imagine what would happen if there were a single confirmed case of smallpox in a Boston hospital. We’d all be lining up for the shot.

Children. Any risk to kids is scarier than the same risk to adults. How many news stories are there about abduction of *adults*?

Catastrophic versus chronic. A risk that kills a lot of people all at once in one place, like a plane crash or a terrorist attack, evokes more fear than another risk that kills the same number of people, but over time and space. For example: 2,899 Americans died on the fateful day of September 11, 2001. But 2,200 Americans die of heart disease every day. Who’s going to war over them?

There are other risk perception factors: We’re more afraid when things are uncertain, less afraid of risks we take by choice (talking on a cell phone while driving), more afraid of new risks (West Nile virus then) than ones we’ve lived with for a while (West Nile virus now), and more afraid of any risk we’re more aware of, either from news reports or from friends or family.

These factors affect journalists’ decisions about which health-related stories to cover and how to cover them.

Journalists—reporters, editors, and news directors—are people, too. They intuitively sense which health news is freighted with the factors that will make people pay attention—and they play those factors up. So a product that is a risk to *kids*, that might kill them in some *dreadful* way, which is produced by an industry we don’t *trust*, is sure to get media attention.

Consider Alar, the chemical sprayed on apples to help them stay on trees a bit longer so they can ripen more. The risk it poses is tiny, with the chance of any kind of harm probably well below one in a million. But Alar is a product of the chemical industry (low trust); it is associated with cancer (high dread); and it affects products we feed to our kids. Alar got extensive and alarmist media coverage in 1989, and I was one of the reporters sounding the false alarm.

In contrast, a risk that is *chronic*, that we make worse by our own *choices*, and that leads to a relatively *benign way of dying* won’t get the headlines. The best example, again, is heart disease, the leading cause of death in America, which is rarely covered as dramatically as Alar was.

In short, the psychological factors of risk perception seduce the news media to over-dramatize certain hazards while playing down other dangers that may be more of

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a threat.

And that's dangerous for public health. The media emphasis on perils that push our fear buttons causes us to worry about some things more than we need to, like pesticides on our food, and less about some things we should worry about more, like food poisoning. This can lead to dangerous behaviors by individuals (buying guns when crime is in the news, taking antibiotics we don't need because of reports about anthrax). And constantly hearing about these exaggerated dangers takes a health toll. An endless drumbeat of alarms can raise our underlying level of stress, and stress is associated with a weakened immune system, heart problems, gastrointestinal problems, decreased fertility, decreased ability to form long-term memory, osteoporosis, and development of Type 2 diabetes.

This alarmism distorts the public health agenda as well. As citizens, we demand more government protection from the higher-profile risks, even though they may not be the greatest threats. These priorities can be seen in the federal budget. Remember that heart disease kills 26 percent more Americans than cancer does. Yet the National Cancer Institute has an annual budget of \$4.2 billion; the National Heart, Lung, and Blood Institute has an annual budget of \$1.8 billion.

By the standards of journalism as I learned them, it is not the news media's responsibility to consider the effects of their coverage. It is their responsibility to report the truth, as best they can. But the truth is more than just getting the facts right, story by story. It's seeing the bigger picture of which health stories really matter, and reporting on them accordingly. It's being fair with the facts, so that information doesn't automatically get more play just because it's more frightening.

Television anchor Walter Cronkite used to sign off by saying, "And that's the way it is...." Indeed, all that most of us know about the way it is in the world beyond our own personal experience is what the news media tell us, filtered through our own knowledge and biases. A skewed sense of health risk is going to alter the way we live our lives and the pressures we put on health policy-makers to protect us from some risks more than others. Editors and reporters should provide health news that has both drama and balance. There is room, and a public need, for both. ■

David Ropeik is director of risk communication at the Harvard Center for Risk Analysis and a former reporter for WCVB-TV and science columnist for The Boston Globe.

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UNMANAGED

**Costs are soaring and
quality is in question.
Can we cure what ails
the health care system?**

Last summer, after 17 years as CEO of Tufts Health Plan, Harris Berman traded in the rough-and-tumble life of an HMO executive for the quieter confines of academia. But as he settles into his new post as chairman of the department of family medicine and community health at Tufts University School of Medicine, the 66-year-old infectious-disease physician has plenty of bumps

and bruises from his years in the health care industry trenches. “I felt pretty beat up the last half of the ’90s, with all this managed care bashing,” says Berman. “I get to be one of the good guys now.” Then he adds, “I thought we were then, too.”

Berman and other pioneers of the managed care movement thought of themselves as forward-looking social innovators, designing a system for comprehensive health care delivery that ensured that patients got all the care they needed, but not more than they needed. In the health care tumult of the 1990s, however, HMOs were unmistakably cast as the bad guys.

Denying care for vital services. Relentlessly focusing on the bottom line. Bean-counters ruling over doctors. In the end, the managed care revolution proved about as popular as a prostate exam.

The anti-managed-care backlash that swept the

country in the late 1990s stripped away many of the restrictions on access to care and specialists. Most patients were allowed to see almost any doctor

in their area and receive care at any hospital. “Utilization review” and “prior authorization,” the much reviled terms for the approval needed for certain services or prescription drugs, were cast aside, while patients’ “bill of rights” laws were enacted to give consumers leverage against health

maintenance plans.

These changes were the systemic response to the rallying cry of patients and providers—“put health care back in the hands of doctors.” That solution, however, turns out to have come with a not-insignificant catch: The doctors have no idea what they’re doing.

That may be overstating the case, but not by much. Increasingly, we are coming to realize that medicine is characterized by a split personality. On the one hand, the rapid pace of advances in care and technology has brought with it life-saving procedures and drugs, plus new tools to diagnose conditions with unbelievable precision. But the system for delivery of that cutting-edge care is a disorganized, often chaotic world of misaligned incentives, information systems that leave patients vulnerable to potentially harmful errors, and endless bureaucracy. As a result, for nearly every patient who receives the gift of a miracle breakthrough in modern medicine, there is one who fails to get the most basic treatment needed to control routine conditions.

“The rate at which health care produces really serious defects would drive a for-profit business out of town in about six months,” says Mark Chassin, chairman of the department of health policy at Mt. Sinai School of Medicine in New York and a leader in the movement to bring quality improvements to US health care. “Quality is really, really mediocre, across the board, so simply

CARE

BY MICHAEL JONAS

PHOTOGRAPHS BY MARK OSTOW

putting the care back into the hands of the doctors won't do the trick."

It's not that doctors don't know what the best care is—although that, at times, may be part of the problem. Rather, the system for delivering and paying for health services is structured in a way that, at best, impedes quality care and, at worst, actually rewards substandard levels of care. Hospitals and doctors reap no gain for keeping patients healthy, and if patients require further care or hospitalization because they weren't treated optimally to begin with, providers simply bill insurance companies again. Meanwhile, patients seeking the best care have no clue as to the quality of care provided by a particular clinician or hospital beyond the word of family, friends, and neighborhoods.

"We know more about the people who work on our cars than we do the people who work on our bodies," says William Van Faasen, chief executive of Blue Cross Blue Shield of Massachusetts, the state's largest health plan.

We shouldn't be surprised at that, or at the shortcomings of the care we receive. "Every system is perfectly designed to give you the results it is currently giving you," says Dr. Thomas Lee, president of the physicians network at Partners HealthCare, the parent organization that runs Massachusetts General Hospital and Brigham and Women's Hospital.

Recognition that the results generated by the system are far from optimal is fueling a new revolution in US health care. If the revolution has a manifesto, it is a 2001 report from the Institute of Medicine, a Washington, DC-based nonprofit research group. *Crossing the Quality Chasm: A New Health System for the 21st Century* calls for a redesign of the system for delivering and paying for care so that patients have information on the performance of physicians and hospitals, and so that providers can tap information technology to coordinate care and rid the system of huge inefficiencies.

Transforming the tradition-bound world of medicine into a well-oiled 21st century industry won't be easy. But with health care awash in expensive, new cutting-edge treatments, drugs, and medical devices, the imperative for change is growing. And the effort to tackle huge problems in the care delivery system is taking place alongside a parallel cost crisis of at-least-equal magnitude, one that is also being fueled by the ever-expanding array of medical treatments. Soaring health care premiums are swamping government payers, private employers, and US workers, while pushing coverage even farther out of the grasp of the 44 million Americans with no health insurance.

HMO BLUES

The backlash against managed care in the late '90s had as its target the cost-cutting imperatives that patients and doctors felt were driving every decision by HMOs. But cost cutting was the furthest thing from Harris Berman's mind in 1971

when, as an idealistic young doctor fresh out of the Peace Corps, he and a colleague founded the first prepaid health plan in New Hampshire.

"The reason that we did that had nothing to do with it being less expensive," says Berman. "What we offered was actually considerably more expensive than Blue Cross, but it had much better coverage." That coverage included annual physicals, "well baby" visits, prescription drugs, and other services that distinguished the new health maintenance organizations from the traditional coverage then offered by large indemnity insurers like Blue Cross, which mainly paid for hospital care. Though the new model was initially more expensive, Berman and other HMO pioneers were banking on the idea that their approach ultimately was better for controlling the growth of costs as well as for long-term patient health. "Because we were in organized systems, our rate of inflation wasn't as high as the rate of inflation of traditional plans like Blue Cross," says Berman. "And in the late '70s, what happened is the [cost] lines actually crossed and now we were less expensive."

"Harris and his colleagues really thought they were part of a social reform movement," says Nancy Turnbull, a lecturer at the Harvard School of Public Health. "They really thought they were part of an effort to make health care better."

For years, the HMO movement was viewed exactly in those terms. During the early 1990s, however, as a wave of mergers and plays for market share swept over both the

The first HMOs weren't about cutting costs.

hospital and health insurance industries, the ability of HMOs to win contracts with provider systems at deeply discounted prices made the prepaid plans increasingly attractive to employers, through which most working Americans obtain health coverage. Companies sought to lower their benefit costs by enticing, if not forcing, workers into the growing world of HMOs, complete with its restrictions on where patients could get care.

"The problem was it was a top-down revolution," says Robert Blendon, a health policy professor at the Harvard School of Public Health. "There was never any buy-in by the





To Nancy Bullet, right, her health plan is "another mortgage."

Employers, workers, and health plan administrators are reeling after several years of double-digit premium increases, driven by the rising cost of care as well as the increased utilization of expensive drugs, medical devices, and imaging tests. Health costs for Massachusetts firms employing more than 50 workers increased 37 percent from 2000 to 2003, according to a survey conducted by the state Division of Health Care Finance and Policy, with the price of an average family plan clocking in last year at \$818 per month, or nearly \$10,000 a year. Health care costs are by far the "number one concern" of Massachusetts employers, dwarfing taxes, workers' compensation rates, and energy costs, says

physicians and the public, so it had no support beyond the business community when it started restricting services." What's more, although the nonprofit Massachusetts HMOs such as Tufts and Harvard Community Health Plan stayed truer to the original managed care mission, nationally the industry developed a reputation for being more concerned with managing costs.

But the problem with breaking free of the managed care shackles is that nobody seems to know what to put in their place, says Paul Ginsburg, president of the Center for Health System Change, a Washington, DC-based, policy research organization. "We didn't like elements of managed care," says Ginsburg. "And at the time [in the late 1990s], we felt we were wealthy enough to simply discard them and not worry about what to replace them with."

PAYING THE PIPER

For a while, that no-worry attitude seemed perfectly reasonable. With the economy going gangbusters and hospitals and insurers engaged in a wave of mergers and consolidations to better compete on the increasingly market-driven health care playing field, a price war between payers and providers produced several years with virtually no increases in health care costs. But over the past several years, any thoughts that we could have our health care cake and eat it too have vanished.

Health care inflation has returned with a vengeance.

Rick Lord, president of Associated Industries of Massachusetts. Lord says one employer recently told him that his health care costs alone would equal the total payroll of a facility in Mexico.

Although premiums are expected to rise at a somewhat lower rate this year, the increases will remain far above inflation or wage growth. The federal Centers for Medicare and Medicaid Services estimates that health care costs as a share of the gross domestic product will increase from 14.9 percent in 2002 to 18.4 percent in 2013.

"We are going to test the limits of our willingness to pay for health care," says Dr. David Blumenthal, director of the Institute for Health Policy at Massachusetts General Hospital. US society is on a course "toward ever increasing consumption of health care resources," he says. "I don't think anything is in sight that will fundamentally alter that pattern."

That prognosis has people like William Conley fretting. As benefits manager at the College of the Holy Cross in Worcester, Conley is responsible for the health care coverage of about 925 employees. "I don't think anybody out there in their right mind is saying people shouldn't have adequate health care," says Conley. "But at what price?"

Holy Cross pays 90 percent of the premium for employees, but the school has upped co-pays for office visits and brand-name drugs in an effort to keep costs in check. In the end, says Conley, workers pay a price for rising health

care costs, one way or another. "You only have X amount of dollars to pay for benefits and salary increases, and what you pay in one place you can't pay in another," he says.

Holy Cross pays out \$8,340 per year to cover an employee with a family health plan. For someone making \$20,000, that's a huge fringe benefit, Conley points out. "But what are you going to do?" he asks. "Not give health care to your lower-paid people?"

That is exactly what some firms have done, by contracting out work such as custodial services to companies that provide less—or no—health insurance to their employees. Holy Cross has been approached by contractors on just that basis, Conley says, but the college has said no. "It is not within our tradition," he says of the Jesuit school.

Most employers are governed by more earthbound considerations, and the imperative they feel to rein in health care costs is growing. At Specialty Minerals, a North Adams subsidiary of Mineral Technologies (a multinational supplier to manufacturing industries), workers were informed last year that, as of January 1, the firm would no longer provide health care coverage for any employee's spouse who had insurance available through their own employer. That announcement sent a ripple through the local economy, as the wives and husbands of Specialty Mineral employees went scurrying to their own bosses.

Jeffrey Stevens, vice president for human resources at North Adams Regional Hospital, had six employees married to Specialty Minerals workers come to him to sign up for the hospital's health plan. Stevens doesn't knock the company for its decision. "The truth is, it's breaking a lot of companies," he says of rising premium costs. Still, when it comes to providing comprehensive family coverage, Stevens worries about employers like his becoming "the last man standing."

"LIMBO LAND"

One consequence of health care cost pressure is the largely invisible growth of a group of people whose coverage is incomplete. This group, best thought of as "underinsured," includes families only some of whose members have coverage and those with policies that cover only a portion of routine-care expenses.

"It used to be that you had coverage or you didn't," says Becky Derby, policy analyst at Health Care for All, a Boston-based advocacy organization. "Now there really is a third category."

Mia and Kevin Beal know this new world of underinsurance all too well. The young couple lives in West Yarmouth with their three children. Kevin Beal, 32, works in an auto body shop, which offers no insurance coverage. Mia Beal, 31, was on the verge of landing a job as an administrative as-

A NEW BEDSIDE MANNER

After two years as executive director of Harvard University's Interfaculty Program for Health Systems Improvement, Dr. Rushika Fernandopulle has good as well as bad news to report. The good news is that there are working models for a vastly improved system of health care, one where patients are the center of focus, and not just numbers in the harried world of assembly-line medicine, and where physicians can deliver cutting-edge care while giving patients the time and attention they deserve. The bad news, he says, is that it seems nearly impossible to get an entrenched health care system to put them into practice. So he decided to do so himself.

"We decided, instead of trying to convince other people to do it, let's put our money where our mouth is," he says. "Let's build it."

With loans taken out against their houses, Fernandopulle and his partner, Dr. Pranav Kothari, are investing \$1 million to open a new primary care practice, dubbed "Renaissance Health," which they hope will be one outpost in the battle to transform US medical care.

"The idea is the rebirth of primary care," says Fernandopulle, explaining the name. "It's a little bit of back-to-the-future." The 37-year-old native of Sri Lanka says the Renaissance Health practice, which opened this spring in Arlington, promises "the personal benefits of the classic small-town doctor with the

advantages of 21st-century advancements." Those advancements include the computer technology and systems improvements that have brought huge leaps in productivity to other industries, which he sees as the keys to freeing up physicians for the quality time and human interaction with patients that seem so rare today.

Fernandopulle and Kothari plan to sit down annually with each patient to prepare a "personal strategic health plan" outlining goals for the year—and a path to achieving them. Patients waste hours of their own workday going to the doctor to ask relatively straightforward questions about their health concerns, says Fernandopulle. To save patients—and himself—from such inefficiencies, Fernandopulle encourages patients to e-mail him with routine queries, promising a reply within 24 hours; patients also have the doctors' cell phone numbers and can reach them at any time. In addition, Renaissance Health accommodates patients with evening appointments and, when warranted, even that rarest of doctor encounters, an old-fashioned house call.

The young doctors' new venture is part of mini-revolution taking place in medicine, one that Fernandopulle researched during travels throughout the country while directing the Harvard health systems center. One thing he found was that much of the out-of-the-box thinking on health care delivery is

sistant in a dental office this spring that would provide coverage for her, but not her family. With 11,000 children on the waiting list for the state's Children's Medical Security Plan, she's been told it could take a year to secure coverage for her own kids. Meanwhile, the Beals are trying to tap the state's "free care pool" for help with an outstanding bill of \$8,000 from Cape Cod Hospital for the delivery of their infant daughter, Ashley, in February.

"You know, the ironic thing is if me and my husband didn't work, we'd have more rights," says Mia Beal, alluding to Medicaid coverage for low-income residents, which they earn too much to qualify for. With both parents working, but with neither job providing family health coverage, "you're in limbo land," she says. "I'm not super knowledgeable about it, but I do think everyone has the right to go to the doctor and everyone has the right to health care."

For Nancy Bullett, her coverage woes come with the added insult of being part of the health care world herself. A registered physical therapist who started her own private practice in North Adams three years ago, the 49-year-old single mother of

two says her business now clears about \$45,000 a year. But with that, the only family health coverage she could afford was a \$400-per-month policy from Mid-West National Life Insurance. The plan doesn't cover annual physicals, and it carries deductibles of \$5,000 for hospitalizations and \$2,500 for outpatient procedures. Bullett says she could get better coverage from Blue Cross Blue Shield, but that insurer's "Value Plan" would cost \$610 a month, more than she feels she can afford. "It's another mortgage," she says.

Obtaining affordable health care coverage has long been

a problem for low-income Americans, but that problem is now working its way up the economic ladder. "Working and middle-class people in America are experiencing, for the first time, medical financial insecurity," says Arnold Milstein, a national health care consultant and executive at Mercer Human Resource Consulting.



Dr. Rushika Fernandopulle has an improved model.

occurring in out-of-the-way places. "The innovative things are never at the Mass. Generals," says Fernandopulle, who trained and practiced at the renowned Harvard teaching hospital. "It's two guys in Oregon. It's one guy in a strip mall in Bangor, Maine."

That guy in the Bangor strip mall is Dr. Charlie Burger, a 67-year-old internist whose pioneering primary care practice has received notice in the popular press and in medical literature. A linchpin of Burger's practice is his use of decision-support "couplers," software that provides state-of-the-art information on diagnosis and treatment from variables entered about the patient's condition.

Burger still applies his own clinical judgment to the computer output, but he says such a tool is invaluable today. "Most medical problems are just too complicated for us to work through totally in our minds," he says. "If we get it right today, it's probably more luck than anything else." Rather than depersonalizing care, the computer-generated analysis frees him up to spend more time in office visits actually engaging patients and listening to their concerns.

But the road to change is not a smooth one. Payment systems treat medicine more like 19th-century industrial piecework than like the complex, systems-organization challenge it

is today. Most insurers pay doctors only for face-to-face clinical encounters, although Blue Cross Blue Shield recently announced it would begin reimbursing some physicians for e-mail (with a \$5 patient copay). And insurers are not likely to reimburse Fernandopulle and Kothari for the kind of time they spend helping patients devise their "strategic health plan," even though such efforts could lead to long-term savings.

For those reasons, Fernandopulle and Kothari are charging patients an annual fee of \$600 over and above what insurers pay for their services. They know that smacks of "concierge medicine," the new practices that have become popular among well-heeled patients. In order to get the kind of attention everybody wants, patients in concierge practices pay out-of-pocket fees of \$2,000 to \$20,000 a year.

Fernandopulle argues that his new venture will bring concierge-quality medicine to the masses. "The only reason we have to charge fees is because we want to do a number of things that we think are the right way to practice medicine but which insurers won't pay for," he says. "The goal of this whole endeavor is to redesign primary care, not for our patients, but for the country."

—MICHAEL JONAS

CAFETERIA CARE

Indeed, this financial insecurity is also creeping into even the most generous workplace-based health insurance. In the past, with employers picking up the tab for health coverage, most employees gave little thought to the particulars of their plan and whether it made the most sense for them. But the cost pressures of recent years—and the collapse of managed care as the solution—are forcing companies, and their insurers, to rethink the way they cover, and control, their employees' health care costs.

One new approach is to make employees and their families responsible for paying directly for some portion of their medical costs out of "health savings accounts," to which they and their employer both contribute. In January, Tufts Health Plan became the first Massachusetts-based insurer to experiment with this method, which has been dubbed "consumer-directed health care."

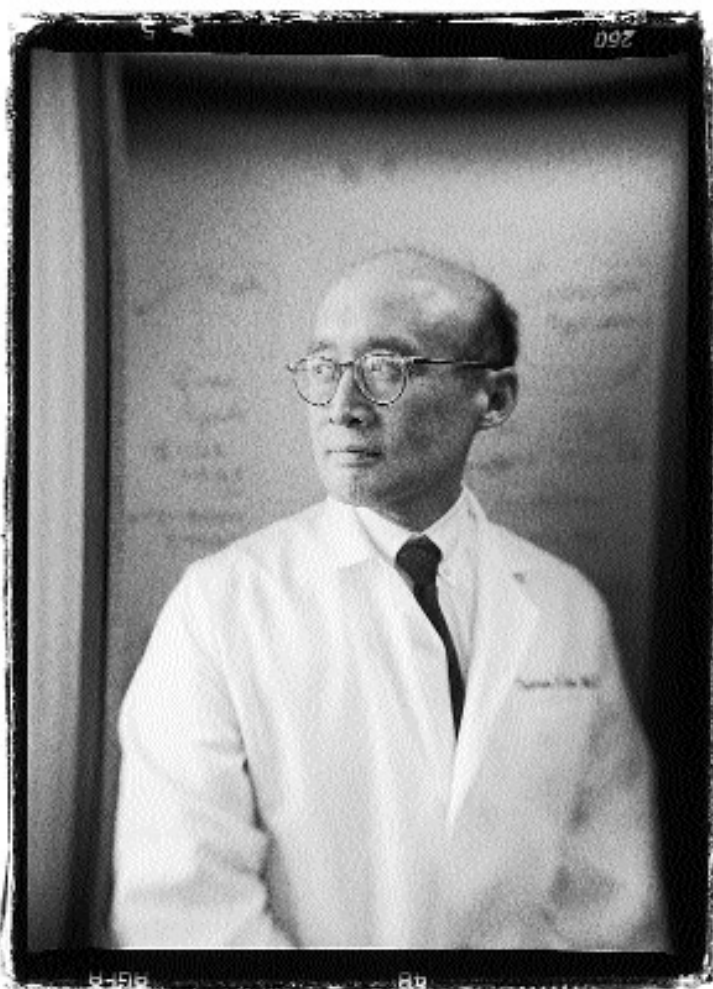
The Tufts "Liberty Plan" can be customized by employers, but the basic prototype calls for a health savings account of \$600, which the employee draws down for routine doctor visits and other outpatient care. After that sum is exhausted, the worker is on the hook for the next \$900 in expenses. If an employee's health costs exceed the full \$1,500 deductible, insurance kicks in to cover the remaining expenses.

The idea is to make the consumer more cost conscious, without discouraging routine and preventative care. Unlike the days when the lion's share of spending came from hospital care, costs today "are distributed much more broadly in many more small-ticket interactions," says Jon Kingsdale, senior vice president of Tufts Health Plan. "The only person there all the time is, in fact, the patient, the consumer."

Is an \$1,800 MRI really necessary to diagnose the cause of a jogger's knee pain, or might a few \$50 physical therapy sessions be worth trying first? That is the type of decision-making the new plans put into the hands of patients, with a strong incentive—their own money—to avoid unnecessary spending. Consumer-directed health plans are designed to "empower the consumer to be a more prudent consumer," says Kingsdale.

If some herald the plans as an important innovation in the drive toward greater "consumerism" in health care, others see in them the further deterioration of any type of social compact by which there is collective responsibility for the welfare of all. The new consumer-directed plans, say critics, will be appealing to relatively healthy workers who don't utilize many services, as well as those well-off enough

to comfortably handle the out-of-pocket deductible, should the need arise. Lower-income workers or those with lots of medical expenses will be inclined to stick with traditional plans that offer more comprehensive coverage. But if healthier workers opt out of those plans, premiums will rise as the risk pool fills with high-cost patients. This scenario led Stanford University economist Victor Fuchs, writing two years ago in the *New England Journal of Medicine*,



Dr. Lee: The system is "perfectly designed" to give us what we're getting.

to proclaim consumer-directed health care plans "another nail in the coffin of health insurance as a form of social insurance."

"It's like the water table is dropping," says Catherine Dunham, president of The Access Project, a Boston-based national nonprofit organization that promotes health care access to underserved populations. "There are no risk pools anymore. There are risk puddles."

Meanwhile, even in traditional health plans, out-of-pocket payments at the point of care, including office visit co-pays and hospitalization deductibles, are rising steeply,

passing costs to consumers rather than building them into the share of premiums paid by employers. “We’re going backwards in that once again sicker people are going to be paying more and more for their care,” says Derby, of Health Care for All.

James Robinson, a professor of health economics at the University of California-Berkeley, says that as health insurance becomes more costly, it is exposing an underlying reality. “Healthy people have never benefited from health insurance—because they’re healthy,” he says. “All they need is catastrophic coverage.”

‘Sicker people are going to be paying more.’

The conundrum, says Robinson, is that it’s probably a good thing for patients to have some financial stake in their health care spending—as long as it’s not too much. “I personally am mixed on it,” Robinson says of the shifting of more costs onto consumers. “It’s a regressive income transfer, and given that I’m a bleeding-heart liberal, I think that’s a bad thing. On the other hand, how are we going to convince Americans that health care is a precious commodity and that you can’t just get it without limits? People do tend to spend more wisely when they’re not spending someone else’s money.”

CARE MANAGEMENT

No matter whose money is being spent, we’re hardly getting the best bang for our health care buck. The great irony of US health care is that while it may be able to deliver increasingly sophisticated treatments and perform miraculous, life-saving feats of surgical wizardry, it does a remarkably poor job at delivering basic care to treat some of the most common, well-understood conditions. A study published last summer in the *New England Journal of Medicine*, which examined the medical records of more than 6,000 US adults, found that in only slightly more than half of all cases were patients receiving the appropriate care for common conditions such as asthma, high blood pressure, diabetes, and depression.

Mary Lemire is working hard to be the antidote to that problem. A nurse at Fallon Community Health Plan in Worcester, Lemire keeps in touch by telephone with 150 to 200 Fallon patients who have diabetes, coaching them on everything from proper dietary habits to stress management

techniques. If she does her job well, the patients won’t be making as many visits to their doctor or ending up in a hospital bed. “It helps them to remain independent and home with their families, doing the things they like to do,” says Lemire.

And it helps Fallon keep a lid on health care payments. Disease management programs for conditions such as diabetes, asthma, and congestive heart failure are growing rapidly among health plans. They represent the type of “win-win” situation all experts say we should be seeking out—strategies that can promote better health outcomes while also reducing health care costs.

Increasingly sophisticated “predictive modeling” programs allow health plans to not only target patients with individual conditions, but also to identify through claims records those patients with multiple conditions who are at greatest risk for hospitalization—and for consuming lots of health care dollars. “Care management” programs aimed at that small but very high-risk pool of patients have led to a “sustained 50 percent reduction in hospitalizations for these members,” says Dr. Roberta Herman, medical director at Harvard Pilgrim Health Care.

John McDonough, executive director of Health Care For All, says these advances could fulfill the original promise of health maintenance organizations. “This is the promised land,” says McDonough. “It is managed care, but it’s managed care done right.”

But managed care done right may be harder than ever, because the health care delivery system has become more unmanageable. “It’s a much heavier lift now than it was in the old days,” says Charles Baker, the Harvard Pilgrim chief executive.

In the old days, Baker’s company was known as Harvard Community Health Plan, and its members received primary care at a network of clinical centers operated by the health plan and staffed by salaried doctors and nurses. “The delivery system was really the product that people were offering,” says Baker, and that made it relatively easy to implement systematic guidelines for patient care. Today, Harvard Pilgrim and other HMOs are principally insurers, not care providers, and the patients they are targeting in their disease management efforts are being cared for by thousands of physicians in independent, private practices scattered across the region.

“We’re trying to create adherence to evidence-based standards of practice in a delivery system that is far more fragmented and less managed than 10 or 15 or 20 years ago,” says Baker. The disease management programs are an effort by insurers to graft elements of the managed-care ethos back onto a health delivery system that rejected the strictures of HMO-style medicine.

Harvard Pilgrim has also tiptoed back into the minefield of clamping down on excessive utilization of high-cost ser-

vices, announcing earlier this year that it would require doctors ordering any expensive non-emergency imaging test, such as an MRI or CT scan, to first seek approval from a radiology consulting firm hired by the insurer. Harvard Pilgrim's spending on advanced imaging tests soared from \$45 million in 2001 to \$73 million in 2003, and company officials say some of that is going toward cases of routine low-back pain or headaches, for which the expensive scans may not be medically necessary.

Not surprisingly, doctors are not happy with the move. "We've gotten a lot of angry calls from members," says Dr. Thomas Sullivan, president of the Massachusetts Medical Society. "It's another burden on physicians. It's a huge hassle." Though he agrees there may be some unnecessary use of imaging tests, Sullivan says Harvard Pilgrim has brought back a "blunt instrument from the 1980s" in trying to deal with the problem.

Besides, when it comes to reining in unnecessary health care costs, doctors aren't the only problem. Dr. Ann Loudermilk, an emergency room physician at Caritas Norwood Hospital, says even when she explains that an MRI is not likely to reveal anything that would change the course of treatment, patients sometimes plead for the test to allay their worries. "I call it radiation therapy," she says.

PERFORMANCE ANXIETY

While insurers might have the most obvious stake in keeping their subscribers out of the hospital, provider systems are also showing new interest in bringing sensible, evidence-based care to patients they treat—and a willingness to flex their muscles to do so. For several years, Partners HealthCare has operated a disease management program for patients hospitalized for congestive heart failure in any of its five hospitals. That condition, in which the heart loses pumping power, is the leading cause of hospitalization among those 65 and older, with more than 1 million admissions for the disease annually in the US. But Lee, president of the Partners outpatient network, says the voluntary program was consistently "undersubscribed." So Partners officials decided that, as of last January, "everyone will go into the program," unless their treating physician specifically opts out.

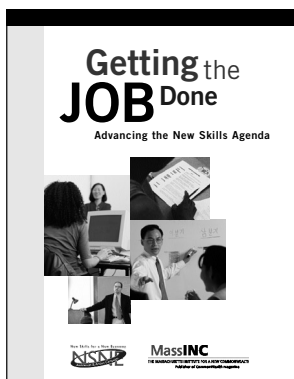
But Dr. William Dec, director of clinical cardiology at Massachusetts General Hospital, concedes "there has not been a uniform embracing" of the new policy. The reaction of some doctors, he says, has been "Are you crazy? You're not taking care of my patient."

"Doctors are being asked and strongly encouraged—and even forced—to function more as parts of teams that are

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designed to reliably deliver the best possible care,” counters Lee. “We don’t want to say we’re eroding physicians’ autonomy; we want to say we’re making best practices happen reliably.”

In today’s provider networks, which are as diffuse as they are vast, that’s easier said than done. “Doctors don’t like to be supervised,” says Alan Sager, a professor at Boston University School of Public Health. “They want clinical autonomy and financial autonomy. If they insist on having both, they will have neither.”

Still, there is one way to link clinical with financial outcomes that is starting to shake up the health care landscape.

blood pressure, diabetes, and other common conditions among their patients. They also must demonstrate that they have established disease registry systems that allow them to identify all patients with particular conditions and systematically apply advances in medical knowledge to their treatment.

Physicians in Massachusetts who meet the NCQA standards are eligible to receive bonuses of \$60 for each patient in their practice who is covered by GE, Raytheon, or Verizon. If a doctor cares for 200 patients from those three companies, that translates to a bonus of \$12,000—enough of an incentive, say company officials, to spur physicians to work

toward meeting the quality standards. Meanwhile, the companies believe their investment will be repaid in higher quality health care and lower insurance claims. “We’re pretty confident we’re going to at least break even, and we think we’ll do better than that,” says Francois de Brantes, director of GE’s health care initiative and chairman of the Bridges to Excellence board of directors.

THE RATING GAME

While pay-for-performance initiatives are aimed at driving providers toward improved quality of care through financial incentives, health reformers are also pushing to make data on the performance of hospitals and physicians publicly available. While nearly everyone in health care says such information is needed—

and more of it will be coming—there have already been some bumps in the road to transparency.

In March, Blue Cross unveiled a new Web site that rates hospital performance in various areas of treatment. The move immediately created a stir, however, when it was reported that in caring for heart attack patients, four Boston-area community hospitals performed better than did Massachusetts General Hospital, Brigham and Women’s Hospital, and Beth Israel, all of which are world renowned for their cardiac care.

One of the biggest challenges in rating the performance of health care providers is adjusting for differences in the severity of their patients’ conditions. Without such weighting, providers that care for sicker patients will fare worse on such scores. That’s exactly what’s wrong with the heart



GIC executive director Dolores Mitchell: “It can’t be business as usual.”

“Pay for performance” is the new watchword, promising financial rewards for providers based not on the number of patients they see, but on the results they achieve. That concept, say some observers, could turn the status quo on its head. “[Now] we don’t pay for quality,” says David Blumenthal of Mass. General’s Institute for Health Policy. “You earn more if you screw up.”

One of the more ambitious pay-for-performance initiatives is being carried out by a group of large employers led by General Electric. The “Bridges to Excellence” program rewards primary care physicians for meeting five standards of good care established by the National Committee for Quality Assurance, a nonprofit organization established in 1990. Physicians must complete surveys reporting, by objective measures, how well they are controlling high

attack data, says Lee, the Partners network president. In fact, he says, every patient with a severe heart attack who is admitted to Winchester Hospital or Melrose Hospital, two of the hospitals that were ranked above the Partners hospitals, is transferred to Mass. General as a matter of policy. “They’re smart people and they’re well-intentioned people, but their data are far from perfect,” says Lee of the Blue Cross rating gurus.

“The rush to get something out there has overwhelmed the desire for scientific accuracy and meaningful data,” agrees Sullivan, the Mass. Medical Society president.

But Sharon Smith, vice president for health care services at Blue Cross, says there’s good reason to rush. “The reality of having something out there is that people will work toward improvement,” says Smith. “If you didn’t start with something, you wouldn’t get to anything.”

David Blumenthal, of the Institute for Health Policy, says that if providers have problems with the precision of rating data that’s available today, they have only themselves to blame. “We, as providers, have been much too slow to take the lead” in devising measures of quality, he says. As a result, he says, insurers and other reform advocates may think “the only way to get providers to engage is to hit them with a two-by-four.”

The lumber certainly came down in March, when the state’s Group Insurance Commission, which oversees health care benefits for 265,000 state workers, retirees, and family members, announced that its coverage plans will introduce hefty surcharges for choosing care in hospitals or doctor practices that score poorly on a measure of health care efficiency that considers both cost and quality.

“It can’t be business as usual,” says Dolores Mitchell, executive director of the GIC, pointing to the state’s soaring health care costs for workers and retirees, which are approaching \$1 billion a year.

The state agreed to different timetables for the various insurers who cover state workers to roll out new performance-based fee schedules. Tufts Health Plan is the first insurer to adopt the changes. Starting in July, all state-covered employees who elect Tufts coverage will pay a \$200 co-payment if admitted to a hospital in the plan’s “preferred tier,” based on a combination of cost and quality. Those seeking care at a hospital in the nonpreferred tier will pay a \$400 co-pay.

The idea has come up before. Two years ago, the Associated Industries of Massachusetts, an association of large employers, invited a Minnesota company to conduct a feasibility study of implementing just such a tiered system in the Massachusetts health insurance industry, but the plan met with resistance from providers—led by Partners, because its high-cost teaching hospitals wound up in the least-preferred category. Under the Tufts plan, many of the state’s prestigious hospitals once again are

placed in the less preferred tier for the three types of services that were rated (adult general care, pediatrics, and obstetrics). The Massachusetts Hospital Association, in a statement issued following the announcement of the new state initiative, said it “remained concerned” that the tier system “may not yet be fair to hospitals or reliable for consumers.” But Dr. James Mongan, chief executive of Partners, says he had concerns about the ranking methods used by the Minnesota company but is “supportive of going ahead” with the new state plan.

Berman, the former Tufts Health Plan CEO, calls acceptance of the tier system “a seminal event,” all more significant because it “wasn’t the health plans trying to push this on the providers, it was an employer—in this case the state—saying this is what we want.”

For her part, Mitchell says she felt no choice but to start challenging the status quo. “You can sit here watching that train chugging down the track and the prices getting higher and higher,” she says. “Or say, damn it all, let’s try it a different way and stand outside of the box.”

It’s hard to argue against the idea of making information available to consumers about the performance of health care

Surgery patients may not want to have to search for a ‘best buy.’

providers. But some wonder whether that’s really what patients are looking for. It’s one thing to consult the *Consumer Reports* ratings when shopping for a new washing machine. Looking for a “best buy” when you’re faced with major surgery or an odd-shaped mole that has suddenly appeared on your back is quite another.

“The idea of comparison shopping or being on the Web when you’re being taken to the CCU—I don’t think so,” says Gerald O’Connor of Dartmouth Medical School.

Even the strongest advocates of transparency in health care acknowledge that we could fast be heading toward information overload. Arnold Milstein, the Mercer health care consultant who helped devise the GIC plan, says the ideal would be for these new initiatives to pave the way to a new level of health care quality where patients are not required to think about whether a hospital or doctor is

up to snuff.

"Do people just want to leave it to their doctors and nurses? Absolutely," says Milstein. "The question is, how do you get there? If you had very, very robust pay-for-performance levels, doctors and hospitals would be out of business if they didn't deliver very high quality care."

Some see the ultimate goal of the transparency transformation now underway in health care as a system similar to those that oversee industries like commercial aviation. Airline passengers don't want to be "sorting through a whole lot of data on safety records when they decide whether to buy a ticket from American or United," says Chassin, the Mt. Sinai Medical Center researcher. "We want to feel someone else has taken care of that. That should be the model we have in health care."

While there are ample grounds for gloom over the costs of care and the challenge of bringing the fruits of technology and innovation to the health care delivery system, there is some reason to hope that addressing the latter will help to address the former. Wendy Everett, president of the New England Healthcare Institute, a nonprofit health research organization, says waste and inefficiency account for as much as 30 percent of the \$1.4 trillion spent nationally on health care, more than enough to provide health coverage for all Americans. But, beyond the Herculean task of wringing such savings from our health care system, directing them toward the coverage of all Americans would involve political decisions that we don't necessarily seem ready to make.

"All parties have to come to the table with an understanding that even with \$50 billion [in Massachusetts health care spending annually], dollars are finite and pathology is infinite," says BU's Sager. "How do you make decisions and make tradeoffs? No one is taking responsibility for marshalling the \$50 billion-plus that's available for health care in Massachusetts and making sure that the 6.5 million of us get good care."

As for the changes being brought to the system for delivering and paying for health care, they represent "an industrial revolution and a cultural revolution," says Lee, the Partners HealthCare network president. It will require wholesale change in the way doctors and other providers think about and perform their jobs, the way insurers pay for services, and the way patients receive care. Getting there will be rough, says Lee, but he's confident the journey will be worth it.

"We are going to cross the quality chasm. We are going to have a safer, better, more efficient health care system by the end of the decade—and it's going to be brutal, believe me," he says. "No one who ever lives through a revolution enjoys it." ■



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Being Ron Preston

The state's human-services chief
knows how to shake things up.
But does he know how to solve the
health care coverage conundrum?

BY B.J. ROCHE

It's an early Thursday morning in mid-March, and 11 floors below Ron Preston's Ashburton Place office a group of Latino and black teenagers holding signs that read MARRIAGE = 1 MAN + 1 WOMAN are already posted in front of the State House. Nearby are satellite trucks that will broadcast the day's culture-war battle all over the world.

There is no camera crew looking over Preston's shoulder as he meets with his young staff of four women and two men, but the topics discussed here in the Executive Office of Health and Human Services are at least as weighty as gay marriage. If the view of the Charles River from Secretary Preston's office is breathtaking, so is the agenda of this typical weekly meeting. First up: a new psychiatric hospital. It's been 50 years since the state has built one; in the past decade, the number of state mental hospitals has gone from 11 to four, and Preston is angling to close two more, in Worcester and Westborough. Some replacement capacity is clearly needed. But should the state construct a new building or renovate one of two dilapidated facilities now available? The sentiment leans toward building anew—something modern and up-to-date, if smaller than what some mental health advocates are hoping for. But what will it cost?

Next: the Department of Youth Services. The female population has exploded in a system that is designed to manage male adolescents. (A week later, there would be this headline in the *Boston Herald*: POLS CALL ON ROMNEY TO TACKLE DYS' DEADLY CRISIS. It's the caper to a series on suicides in juvenile-justice facilities. In the story, Gov. Mitt Romney vows to do something about the situation. Who's he gonna call?) Then there's the turf battle between private ambulance companies and local fire departments.

The subject moves to health care, the public policy Godzilla that dominates Preston's wide-ranging secretariat. Romney calls Medicaid, the state's health program for the poor and disabled, a "financial beast" that is "eating the rest of state government." But that didn't stop the governor from giving Preston, in his first month in office, an even more challenging health care assignment: developing a plan to provide basic coverage for the state's half-million uninsured. No other state has yet been able to accomplish such a feat; all attempts have been stymied by cost and opposition from entrenched interests.

To Preston, who sometimes seems like an absent-minded-professor and is given to heavy sighs and gloomy pronouncements, slaying the health care dragon is just one more thing on his endless to-do list. "As is often the case in government," he says, half to his staff, half to a visitor, "we'll come up with something that everyone is a little unhappy with."

Welcome to Ron Preston's world, located in a high-



To Ron Preston, slaying the health care dragon is just one more thing on his endless to-do list.

growth region of state government somewhere between the proverbial rock and hard place. It is one crowded piece of real estate, with a population of about a million of the state's neediest people, from foster kids to the elderly. Among Preston's charges are juvenile detainees, the disabled, the blind, the mentally retarded, the mentally ill, the uninsured, and the working poor. Then there are the two dozen or so nonprofit groups that advocate for the needy and the scores of public and private institutions and contractors that care for them. Preston's world is organized, if you can call it that, around 17 separate agencies—sometimes referred to as “fiefdoms”—that employ 24,000 people,

and until recently, operated largely on their own, with only the barest coordination from Health and Human Services.

Preston's is a world where the mental health system has a waiting list so long that advocates claim the state has stopped keeping track, and where Medicaid costs are rising 10 percent per year but some community hospitals are so starved for funds that they're on life support themselves. And though Health and Human Services has a budget bigger than the GNP of some Third World nations—totaling nearly half the state's total spending—there's never enough. Eleven billion dollars looks like big money only until it's time to pay the bills. And no matter how you spend that money,

PHOTOGRAPHS BY MARK OSTOW

you can't win.

"Most of the time in this job, you're never any better than your worst mistake," says Charles Baker Jr., who held the secretary's job in the Cellucci and Weld administrations and is now CEO of Harvard Pilgrim Health Care. "It's a relatively high-visibility job, and you don't get much credit for what goes right. You have to get used to it."

Get used to taking lumps, he means. Even compliments are often a setup for complaints—against Preston, or his boss. "Ron has done a lot of thinking about these issues and wants to do a very good job, and help people get help on health coverage who don't have it," says Phillip Johnston, another one of Preston's predecessors, who now runs the state Democratic Party. "He cares about abused children and all the people who fall within his secretariat. The problem is, there's not a lot of money right now, and he's working for a governor who would refuse to spend it if he had it."

Preston's accustomed to this line of attack—and to defending his boss. "The governor understands that this is a generous state, and he's fine with that," says Preston. "On the other hand, he also appreciates that [health-and-human-services spending] can't grow by \$1 billion a year, because taxpayers can't keep up with it. It pushes out roads, it pushes out schools. Basically, what he wants to do is balance it. He made \$500 million more available to us this year, but what do you do when programs want to be [up] a billion dollars?"

Preston put the "compassion" in Romney's fiscal conservatism when he got 36,000 people who had been booted off MassHealth back on the rolls. But as he struggles with Romney's audacious promise of health care coverage for the state's estimated half-million uninsured residents without raising taxes, Preston is finding his name mentioned alongside the term "mission impossible" as often as Tom Cruise's. Only Preston has no special-effects guru, and many observers are betting that the script he comes up with will be rejected as too expensive to be produced. At stake is the well-being of the state's battered health care system—and Preston's legacy.

"Ron's about to become the point person for what will be potentially the most controversial, bold, reckless—or all

of the above—programs," says John McDonough, who heads Health Care for All, an advocacy group for expanded health-care access.

But if Preston has any reservations about the assignment, or the administration he works for, he doesn't express them publicly. "If you remember," he says with a fleeting smile, "in the movie, and in the TV show, they always accomplished the mission."



Preston: "Everyone's holding onto his part of the elephant."

SHOW TIME

Talk to advocates and providers in health and human services circles, however, and another Tom Cruise movie comes to mind: *Jerry Maguire*, with its recurring line: "Show me the money!"

These advocates and the people they represent have been demoralized by three consecutive years of deep budget cuts, some of which predate the Romney administration. This is especially true in public health, which has been hard hit in the budget battles. Romney's fiscal '05 budget recommends even more reductions: Funding for school-based health centers and school nurses, already reduced by 56 percent over the past three years, would be totally eliminated under his spending plan. Environmental health, immunization, domestic violence, and antismoking programs have all sustained deep cuts.

To this group, Preston is the human face of an administration that is dismantling a public health system once considered among the best in the country. They, along with

former Department of Public Health employees who have quit in frustration, warn that the resulting “brain drain” and cuts in public health infrastructure—data collection, immunization, and other programs—will have consequences when and if the state has to contend with a large-scale epidemic, or an act of bioterrorism. Even DPH Commissioner Christine Ferguson, who reports to Preston, testified in a legislative hearing that she was “heartsick” over the shriveling of prevention programs.

“It’s the most amazingly shortsighted and reckless policy I’ve ever been involved with, and I’ve been doing this for 20 years,” says Geoff Wilkinson, executive director of the Massachusetts Public Health Association, an advocacy group. “We’ve lost over one-third of the Department of Public Health budget for core public health services, not including the hospitals. If you include the hospitals, we’re talking about over \$145 million in three years. For FY05, it’s more than \$30 million, or more than 8 percent.”

Preston has heard it all before, and though he’s not unsympathetic, he is unmoved. “Is there pain in the provider community? Are we facing a reduction in some of the things we can do? Undoubtedly,” he acknowledges. “Were these things of value? Yes, they are of value. Is it a loss to lose them? Yes, it is. But on the other hand, to mix all my metaphors,

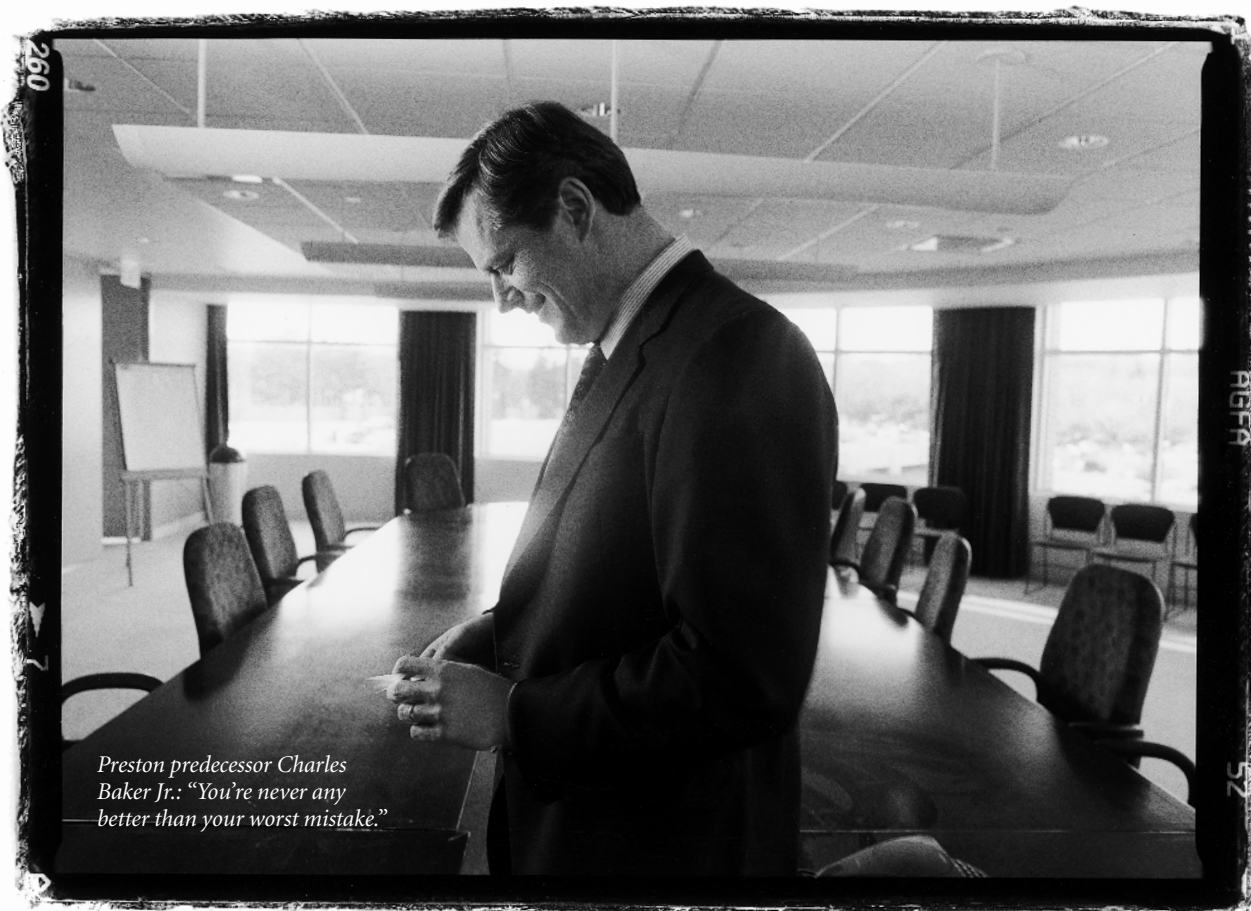
everyone’s holding onto his part of the elephant.”

Preston says that the public health system and its advocates need to adjust to the 21st century. In his view, instead of lobbying to prop up a laundry list of tiny DPH prevention programs, each pursuing its own narrow mission from

‘Ron’s about to become the point person.’

inside its own bureaucratic box, these advocates should be helping him figure out how to integrate the work of public health into primary care, through the vehicle of entitlement programs like Medicaid. Besides, given the funding constraints he’s faced with, he says there are tradeoffs to be made. And Preston is comfortable with his.

“Having billboards on buses to get people to stop smok-



Preston predecessor Charles Baker Jr.: “You’re never any better than your worst mistake.”

ing is nice,” says Preston. “But if there’s someone in a wheelchair who needs a personal care assistant, I want to have the assistant.”

MADE FOR THE JOB?

If you were casting the part of secretary of health and human services, you could hardly do better than Ron Preston. Raised in West Newbury, Preston graduated from Phillips Academy at Andover in 1969, and then from Columbia University. He holds a master’s degree in sociology and a Ph.D. in medical sociology from Yale. He lives with his wife, Karen, who is a nurse, and his daughter just over the border, in South Hampton, NH. His résumé includes 13 years in the US Department of Health and Human Services, where he worked in health care administration, most recently as New England’s regional administrator for Medicare and Medicaid Services. Preston began his career as a policy fellow for a North Carolina legislative committee on aging. He later moved to Washington, where he worked on the staff of Republican US Sen. Orrin Hatch of Utah.

The man knows health care, Beacon Hill, and Capitol Hill. Most people with his background would be in consulting by now, as Preston is the first to point out, and making the big money. But he’s hooked on the public sector.

“It’s hard to talk about it without sounding corny,” says Preston. “I like the idea of working for the citizens. I like the idea of being involved in efforts to serve needy people, and if you asked any of the senior-level people here—a lot of them could be doing any number of things, some of them were actually out in the private sector for a time, but they’ve come back because they feel it’s worthwhile work to do.”

That Preston is well qualified and committed, no one disputes. And it’s clear that, in the world Romney’s put him in charge of, Preston is king. “Preston’s predecessors were basically powerless figureheads,” says McDonough, a former lawmaker. “Ron Preston is the most powerful health and human services secretary in the state’s history, bar none. Other secretaries just idly at 2 in the morning would dream of the kind of power that he now has.”

But Preston can also be sharp-tongued and impolitic. Critics say his management style can be imperious, his behavior at times downright flaky. Even friends acknowledge that he’s a “character.” Others are less charitable.

“He sees himself as a big-picture guy,” says one observer. “But he seems to be unable to control his mouth. And he goes off in all kinds of directions. He loses people as he traipses along.”

Preston relishes the role of truth-teller. “Let’s look at the quandary of the hospitals,” he says. “They need more and more money every year. But that’s their responsibility, too. It’s not my responsibility just to come up with the money for whatever they happen to think they need to charge us. At the end of the day, this money comes from the taxpay-

ers. I don’t have a printing press in the basement.”

Indeed, Preston is known to take the opportunity of advocates and vendors coming to his office to acquaint them with uncomfortable realities. As a result, visitors sometimes leave with the feeling they’ve been “lectured to,” if not shouted at, according to one person who suffered through such an encounter.

The lecturing isn’t always in private. Speaking at a Commonwealth Forum last year, Preston declared that some nonprofit human service providers “don’t keep their books very well” and “need to start getting responsible in terms of business.” That comment prompted a letter to *CommonWealth* (Correspondence, Winter ’03) from Michael Weekes, president and CEO of the Massachusetts Council of Human Service Providers, charging that “the state system for purchasing human services uses its monopoly powers to make it very difficult for providers to operate as businesses.” Weekes concluded, “Reducing complex issues to glib remarks creates stereotypes and unfortunate prejudices.”

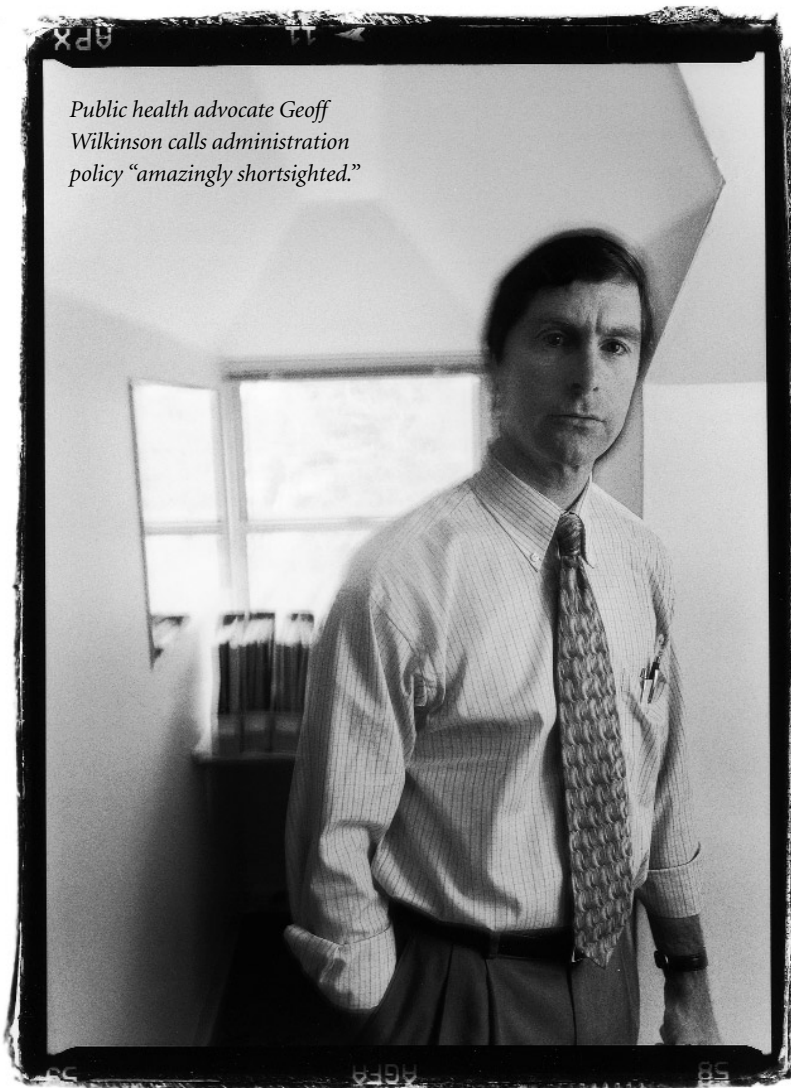
That dustup seems to have blown over. Preston got off to a “rocky start” with providers, Weekes acknowledges, “but to his credit, he’s worked hard at improving the relationships and engaging the provider community in a reform discussion, in which we both have an interest in seeing [service providers] become more effective and provide better quality.”

Even friends say he’s a ‘character.’

Then there are the stories, which circulate widely within an advocacy community that Preston sometimes pleases but more often disappoints, if not infuriates. Some roll their eyes over an e-mail he sent to agency heads last fall in an attempt to buck up morale: “Years ago, my uncle was marketing director for a major beer company. At a family gathering, he lamented how he would fare when he stood before Saint Peter. What would he say he did for his fellow man? Sold a lot of beer? Not one of us will have this problem. Our vocations are honorable and difficult, far more difficult than those who get far more credit.”

Others tell of Preston’s rambling, 30-page analysis of health care, a draft that circulated so widely it could have been listed on Amazon.com. In its first five pages, Preston referenced Baum, Carroll, and de Tocqueville as he described a public with great expectations of government (the Great and

Public health advocate Geoff Wilkinson calls administration policy "amazingly shortsighted."



Powerful Oz), a health care system out of control (the Red Queen, running just to stay in place), and the problem-solving potential of "professional and practice communities" (the voluntary "associations" extolled in *Democracy in America*). Buried within are some intriguing ideas about the role of medical professionals in stemming the problems that lead to higher health care costs. But it's not easy to follow.

In conversation, too, Preston often makes analogies to movies and books, perhaps in an attempt not to seem like such a wonk. But it may also reflect one of his old sidelines, writing book reviews for the *Christian Science Monitor*. And the habit is not without charm.

"He'd make a fabulous university professor," says Matt Fishman of Partners HealthCare, who served under HHS secretary Johnston. "He's the first human services secretary of my acquaintance who quotes de Tocqueville and *Alice in Wonderland*."

In terms of what people say about him, Preston doesn't mind taking the bad with the good, as long as the back and forth stays within bounds. "Part of this is a game," he says of his occasionally testy relationship with providers and

activists. "I expect advocates to advocate. Even when times are good, they say, 'I need more money.' That's what they do. What I don't like is when our motives are impugned. Challenging our values is not fair game."

REARRANGING THE DECK CHAIRS

At mid-morning, wearing a heavy coat and one of those Irish tweed hats Daniel Patrick Moynihan used to favor, Preston makes his way across Boston's City Hall Plaza to a windowless room in the Department of Public Health. A group of programmers and administrators from various agencies have gathered here to view, along with Preston, a demonstration of the "Virtual Gateway," a new system that will allow clients to fill out a single online application for 10 different services, including WIC, Food Stamps, transitional assistance (otherwise known as welfare), and child care assistance. The system was developed by Louis Gutierrez, one of the top health care information technology experts in the region, and about 40 programmers and designers, who have been working on the project for a year.

Virtual access is a pivotal piece of the reorganization of the Health and Human Services secretariat now underway. Most people who need state help are clients of more than one agency, but until now, they have had to travel to several different offices to apply for

services; in the worst-case situation, they've gotten social workers from each, but services from none. Under the new automated system, which will be launched at two pilot locations in July, it will be easier for intake personnel at agencies, hospitals, and shelters to match people with the services they are eligible for.

State Sen. Susan Tucker, an Andover Democrat who chairs the Health and Human Services Committee, says her committee has been pushing for the "no wrong door" approach to providing services for years, but she gives Preston credit for getting it done.

"It's a totally different climate from years ago, when agencies were fighting each other instead of looking for common solutions for the families," says Tucker. "There's a different attitude at the top. Whether or not clients have seen that is subject for debate, but if the leadership and vision stays on course, it will make a tremendous difference."

"What he's accomplished is extraordinary," says Romney. "This reorganization has been fought since the early days of the Weld administration. We got it done and Ron is making it work, and opening up options we'd never have otherwise."

The irony is that it's not at all clear how many of those services will be available. Ease of application means more clients for an already overloaded system. Meanwhile, Steve Collins, executive director of the Massachusetts Human Services Coalition, says the only visible impact of the reorganization so far is the closing of 36 offices around the state.

WRITING A SCRIP

"Do you remember the movie *M*A*S*H*?" asks Preston, back at the conference table in his office. "What was the part that the doctors there enjoyed the most?"

The martinis back in the tent at the end of the day?

"The camaraderie!" he replies. "This kind of work is a lot like *M*A*S*H*. Think about it."

Camaraderie is important to Preston, and he doesn't see enough of it in the medical community, let alone government. When he became concerned about the financial and social impact of overprescribing psychotropic drugs such as Ritalin to young children, Preston's department launched the Targeted Child Psychiatric Service, a pilot project with Dr. Ronald Steingard of the University of Massachusetts Medical School in Worcester, who is one of the few experts on pediatric pharmacology in the state. The program now provides consultation to more than 70 primary care doctors,

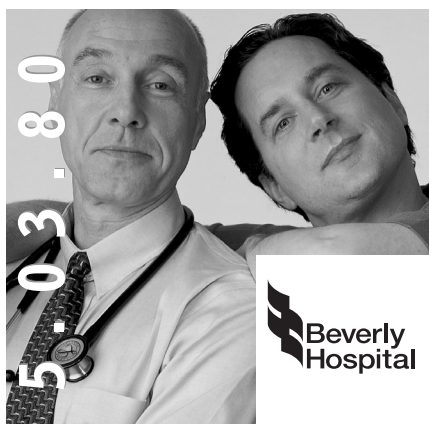
and Preston is hoping to get financial support from insurers to help keep such medication to a minimum.

"So instead of a rulebook, you have the professional community working with evidence-based data," says Preston. "A doctor wants to talk to another doctor."

This is the kind of thing Preston loves: neatly wrapped problem-solving that actually makes a difference in people's lives. Even from a big-picture perspective, it is a thing of beauty: no laws or mandates, not even much money spent, just collaboration and collegiality—and results.

What's not so clear is whether Preston can attain universal health care coverage the same way. The federal government couldn't do it a decade ago, and no individual state has done it either. At a hearing before the Legislature's Health Care Committee in March, Preston admitted as much, telling impatient lawmakers that there was probably not enough money within the health care system to pay for such a plan.

Charles Baker, one of those being consulted in Preston's policy-development process, says there are "three big questions they're wrestling with. Are there any mandates associated with this and, if so, what are they? Everyone has to buy auto insurance. Should everyone have to have health insurance? Do you require everyone to have coverage? Next,



The day Dr. Baz brightened the outlook of the hospital, not to mention that of his patients.

A Family Practitioner who also sits on the Board of Trustees, Gregory Bazylewicz, M.D., has been with Beverly Hospital some 24 years now, forming trusting, long-term relationships with so many of his patients along the way. In fact today, most of them just call him Dr. Baz, probably because it's a whole lot easier to spell. And while he not only works here every day – leading Beverly Hospital into the future – he also lives in the community. Because it's comforting to know that your doctor is always going to be here for you. For your family. For a lifetime.

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are there penalties for not being covered? Should employers be assessed for free care, since employers who do provide it are also paying for those who don't? That's an equity issue. Then there's the question of what's the right level of basic benefits?"

The other big issue is the use of the state's "uncompensated care pool" to fund the program. The pool, which is funded by hospitals and employers, paid \$565 million in health care costs for uninsured patients last year. But nobody likes it. Hospitals that pay into the fund, mostly those in the suburbs, say they end up subsidizing the urban hospitals, specifically Boston Medical Center and Cambridge Hospital, which serve most of the state's uninsured population. And no one thinks the pool, which already faces a \$200 million shortfall, will be enough to fund full coverage of all the uninsured.

Preston doesn't say so, but another movie title comes to mind: *Something's Gotta Give*. Every answer he comes up with is going to make someone unhappy. Moving uninsured patients from the hospital setting to community health centers, which he has mentioned as a priority, could be a cost saver, but not all clinics are capable of providing services, such as mammography, that require specialized, and costly, equipment. And although Romney has promised to double their state funding, from \$28 million to \$56 million, those who run the centers say they're already stretched thin by past budget cuts. Meanwhile, many providers complain about the possible disruption of doctor-patient relationships and the lack of choice, along with the feeling that they've been cut out of the debate.

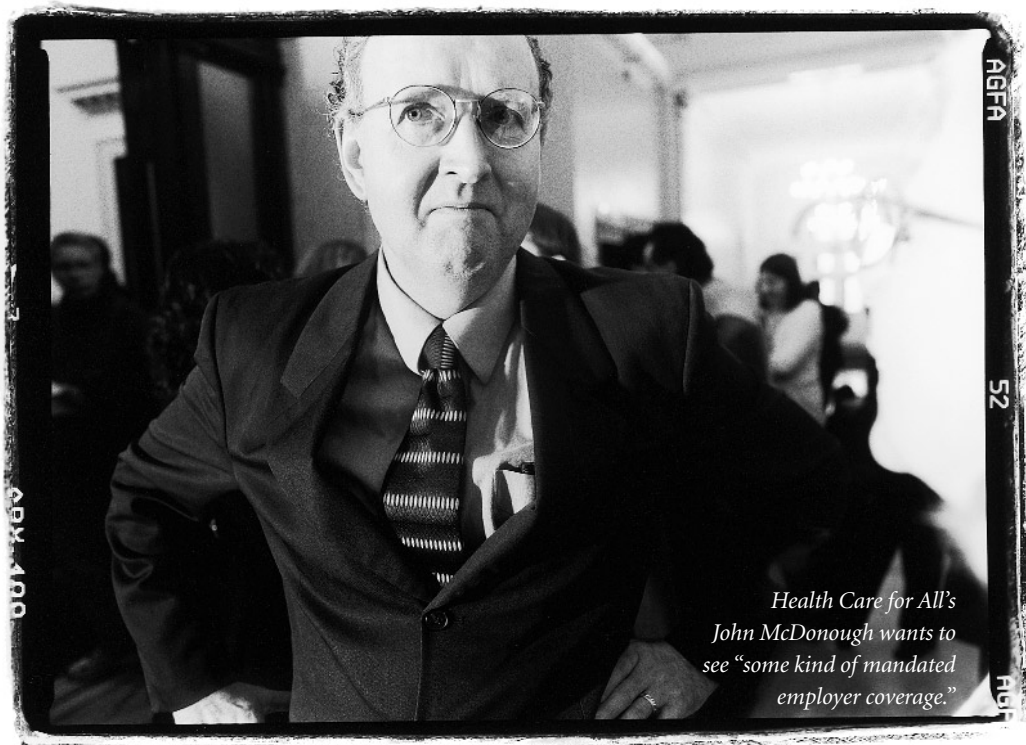
"It's a big shift," says Matt Fishman, of Partners HealthCare. "It's very different from everyone having choices. To make that proposal is to say that our values have changed. But I'm not sure we got to have that discussion."

If providing universal care seems impossible, however, so does maintaining the status quo, says Gov. Romney. "The uninsured are a financial burden to the rest of the state, and they're receiving insufficient care for themselves," he says.

"We need to solve the problem, not only to express compassion, but to help the state's finances. It's an effort that's difficult, but not impossible."

Whatever he comes up with, Preston needs to get on with it. At the March hearing, legislators voiced frustration at the administration's failure to move health care reform forward faster. The Health Care for Massachusetts Campaign is pushing for a state constitutional amendment to require affordable insurance for everyone. And John McDonough says Health Care for All is working on its own reform agenda, which it expects to file as a bill next year. In a perfect world, McDonough would like to see a single-payer system, he says, but he knows that's not going to happen. So he and other advocates propose expanding eligibility standards for public health programs like Medicaid.

"We'd also like some kind of mandated employer coverage for everyone who's working, which would deal with the lion's share of those who were above 200 percent of the poverty level," McDonough says. "Then the uninsured population would be so small, it would be quite manageable."



But employer mandates—and tax increases—are not likely to play well in Ron Preston's world. So he and his staff will be crunching numbers and working the models until they find something that will.

"I like the line from the movie *Gandhi*, when Gandhi says, 'What we can do we will try to do,'" says Ron Preston. "You know, government is the art of the possible. We're doing the best we can." ■

Understanding Medicaid

Is MassHealth state government's
problem child—or its workhorse?

BY DAVID S. KASSEL

When Christine St. Pierre was diagnosed a few years ago with diabetes, her doctor suggested it was time to give up living on her own. After all, she had already had a stroke and a heart bypass operation. But she refused.

"I wouldn't go into a nursing home," says St. Pierre. But she wasn't doing well at home, either. She became depressed, venturing out of her senior housing apartment in Peabody only on weekends to go shopping. When she returned home, all she would do is watch TV and feel miserable. "Everything was bothering me," she says. "I was on my deathbed."

Then a social worker told St. Pierre's daughter, Linda, about PACE, or Program of All-Inclusive Care for the Elderly. It wasn't a nursing home. In fact, it was an alternative to one. It would give Linda's mother a place to go during the day, a place where she could socialize but also have her blood sugar monitored and receive other medical care as needed.

"I'll never leave this place," the 84-year-old St. Pierre says happily as she sits in the day center in downtown Lynn, which is operated by the Elder Service Plan of the North Shore. (The nonprofit organization also runs two other day centers in Lynn and one in Beverly, all funded through the



A drop-in senior center in Lynn saved Christine St. Pierre from a nursing home—and saved the state a lot of money.

PACE program.) St. Pierre moved to an apartment in Lynn to be closer to the center, which she visits five days a week. She says it gives her a reason to get up in the morning. “This program has helped me very, very much,” she says.

Like all participants, St. Pierre receives services based on a care plan developed by a team of specialists, including a doctor, a nurse practitioner, social workers, rehabilitation specialists, and nutritionists. The program’s clinicians say St. Pierre has no need for a nursing home now. And the care she receives through PACE costs the state about half as much as it would if she were in a nursing home.

St. Pierre is part of a cutting-edge experiment in health care delivery not only in Massachusetts, but nationwide. The outcome of this experiment is eagerly awaited by a wide range of players in Massachusetts’s publicly funded health care system: physicians, health care administrators, advocates for the poor, and members of the Romney administration. The governor has proposed investing \$140 million in taxpayer money on an expanded version of PACE, called

Senior Care Options, in the coming fiscal year. Senior Care Options promises to provide alternatives to nursing home care that are not only more palatable to elders like St. Pierre but also less costly to the state, which pays for nursing home care through Medicaid.

With long-term care accounting for an estimated 25 percent of total Medicaid expenditures, the state is increasingly desperate for ways to control costs. In Massachusetts and elsewhere, Medicaid is the largest and fastest-growing part of government, threatening to swamp state budgets across the country. Some officials, including Secretary of Administration and Finance Eric Kriss, say that unless Medicaid spending is reined in, there may one day be little left in the state budget to fund anything else.

If this alarmist message sounds familiar, it may be because Medicaid was first dubbed a “budget buster” back in 1990. The term was coined by former state senator Patricia McGovern, when she was chairman of the Senate Committee on Ways and Means. At the time, Massachusetts was in the

PHOTOGRAPHS BY MARK OSTOW

midst of a major budget crisis similar in proportion to the one that began in fiscal 2002 and is not yet over.

Between these budget crises, however, it seemed that the Medicaid spending beast had been tamed. Not only that, Medicaid, because its costs are partly defrayed by the federal government, became the favored financing vehicle for an array of government services to the needy and disabled. Indeed, in the '90s, Medicaid became the workhorse of the state's publicly funded health care system. Now the program has turned back into a raging bull, overgrown and out of control.

Or has it? Medicaid may be the single biggest program run by the state, but half of its expenditures are covered by the federal government, which makes every service the state can shift into Medicaid something of a bargain. Overall, in fact, more state dollars are shelled out on education than on Medicaid. And if the rise in spending is the problem, some say that Medicaid is not to blame; health care costs are rising across the board.

"Medicaid is the tail, not the dog," says John McDonough, executive director of Health Care for All, a grass-roots health advocacy group, and former House chairman of the Legislature's health care committee. "When medical spending goes up, Medicaid spending goes up. When medical spending goes down, Medicaid goes down."

WHAT IS MEDICAID?

Medicaid is a joint state and federal program administered in Massachusetts by the Office of Medicaid within the Executive Office of Health and Human Services. Known here as MassHealth, Medicaid pays for nursing home, hospital, and other medical services for more than 913,000 men, women, and children in Massachusetts. Recipients include low-income women and children, the disabled, the long-term unemployed, and the elderly. While most individuals and families covered by Medicaid have incomes close to the federal poverty level, not all MassHealth recipients are poor. Disabled adults are eligible for coverage no matter their financial circumstances. And nursing home residents can qualify for Medicaid coverage by "spending down" most of their assets or by transferring them to other individuals at least three years ahead of time, or placing them in an asset trust at least five years ahead of time.

Medicaid was established in 1965, the same year as Medicare, but the two programs are very different. Medicare provides health coverage for all people over age 65 and some younger people with permanent disabilities, while Medicaid covers "vulnerable populations" of all ages. Medicare covers only medical expenses, including, in the future, prescription-

drug costs under a controversial new law passed last year, but Medicaid pays for a wide range of medical and "medically related" services, including long-term care, that Medicare does not cover. Finally, Medicare is paid for and administered by the federal government, whereas Medicaid is state administered, with the feds providing partial reimbursement. Wealthier states, like Massachusetts, get 50 percent of the costs back on most Medicaid expenditures, while poorer

Medicaid is once again a raging bull.

states, like Mississippi, can get up to 75 percent covered by the feds.

Although states run their own Medicaid programs, the federal government sets the rules—or at least the parameters. According to the Massachusetts Health Policy Forum, a consortium of health care scholars based at the Heller School for Social Policy and Management at Brandeis University, the feds require, among other things, that the states provide Medicaid coverage to children under age 6 in families with incomes below 133 percent of the federal poverty level; to pregnant women in families with incomes below 133 percent of the poverty level; and to children between 6 and 17 in families with incomes below the poverty level. States must also provide Medicaid coverage to elderly, blind, and disabled individuals who are eligible for Supplemental Security Income (SSI) and to certain low-income Medicare beneficiaries. In addition, states have the option of providing coverage for up to 30 other services.

Mandatory benefits for all Medicaid enrollees include inpatient and outpatient hospital treatment, visits to physicians, visits to rural health clinics and federally qualified health centers, medical and surgical dental services, nurse-midwife services, and some prenatal care. Optional services include prescription drugs, individual case management sessions, and preventive and rehabilitative services. Massachusetts has long had one of the more generous Medicaid programs in the country, although several other high-income states, such as California and Minnesota, have provided even more comprehensive benefits. At the beginning of 2002, Massachusetts covered 25 of the 30 optional benefits, according to the Health Policy Forum. However, the state eliminated several of these benefits later that year.

This menu of mandatory and optional services helped turn Medicaid into a health care catch-all. Ron Preston, state secretary of health and human services and a former federal administrator, says this phenomenon dates back to the 1980s, when Congress responded to the Reagan administration's attempts to reduce discretionary spending by expanding entitlements like Medicaid.

"[They] turned Medicaid into the broadest coverage that exists anywhere in the world," Preston asserts. "Even countries that have universal health care don't have coverage like this." It includes not only nursing homes, but also long-term care in other forms, as well as various social and support services, including those provided by many state agencies. "There are very few places in the health and human services agencies where you won't find Medicaid someplace." In the coming fiscal year, Preston says, Medicaid

governorship. Bullen became head of Medicaid under Charles Baker, the undersecretary for health who became secretary of health and human services (and, subsequently, secretary of administration and finance), and together the two set out to bring the Medicaid program to heel.

Bullen, who is now chief operating officer at Harvard Pilgrim Health Care (where he works, once again, for Baker, who is CEO), says he and Baker decided Medicaid should "start to exercise its purchasing leverage." Previously, Medicaid had been a "passive" payer, he says, reimbursing providers for health care bills after the fact—and on their terms. Consistent with the effort then underway to deregulate the hospital payment system, Medicaid, like private insurers, was given the authority to enter into contracts with hospitals and other providers to set payment rates. Among other initiatives, Baker and Bullen also changed the method for paying

nursing homes to reflect the level of care needed for each resident. And they moved "aggressively," Bullen says, to leverage federal Medicare funding for Medicaid programs that mostly served the elderly. For example, they encouraged the nursing home industry to create "Medicare units" within nursing homes, primarily for patients who were recently discharged from hospitals but still needed medical care. They instituted policies to make sure nursing homes could bill Medicare for certain nursing home services, with Medicaid picking up the tab only for what Medicare wouldn't



As state Medicaid chief, Bruce Bullen reformed the program to "exercise its purchasing leverage."

will make up roughly 70 percent of the state's health and human services budget—or \$8 billion out of \$11 billion in spending.

TAMING THE BEAST

The roots of today's MassHealth massiveness can also be found in the state's earlier "budget buster" days. Shortly before McGovern coined the phrase in 1990, Bruce Bullen left his job as her committee's budget director to join the administration of William Weld, who had just won the

cover. More controversially, they also introduced managed care to Medicaid, drawing the ire of advocates for the poor, but also bringing the program more into line with private health-insurance practices.

While working to hold down cost increases in services traditionally covered by Medicaid, they also did everything they could to shift programs that had previously been funded fully by the state into Medicaid, in order to gain federal reimbursement. For example, a movement to close down antiquated state mental hospitals led to increased use

of acute-care psychiatric facilities, where services could be billed to Medicaid.

Many of these initiatives worked to control Medicaid costs and improve care at the same time, Bullen says. For instance, as a result of a new system providing higher payments for frail residents, nursing homes began competing for “higher acuity,” or higher need, patients, a move that, over a 10-year period, shifted healthier individuals to lower-cost home care, assisted living, and community programs. Millions of new federal Medicaid dollars flowed into state coffers to help pay for the programs. In 1998, according to Bullen, he and Baker obtained a waiver from the federal government to funnel Medicare, as well as Medicaid, dollars to programs like the Romney administration’s proposed Senior Care Options program, which will fund preventive health care and home-based services as alternatives to nursing homes.

Other initiatives were more controversial. The Weld administration’s effort to privatize public health hospitals and state facilities for the mentally ill and mentally retarded caused a political uproar, and the Legislature put on the brakes in the form of the Pacheco Law. In addition, the pursuit of Medicare funds for nursing home and other programs by Massachusetts and other states alarmed the feds, who cracked down on the practice.

Still, Medicaid costs did plateau, with the former budget buster remaining a fairly constant portion of the state budget—about 20 percent—from the mid-1990s to 2000. But John McDonough says it’s not entirely clear who should get the credit. “The truth is, Medicaid was brought under control in all 50 states” at that time, reflecting a period of moderate health care inflation overall, he says. Baker and Bullen “deserve credit for a lot of stuff they did,” says McDonough, who for a time sat on the Harvard Pilgrim board of directors. “But I’m not sure they can really claim, ‘We conquered Medicaid spending.’ If they really did do that, then I say, ‘Bruce, come on back and do it again, because we sure as hell need you right now.’”

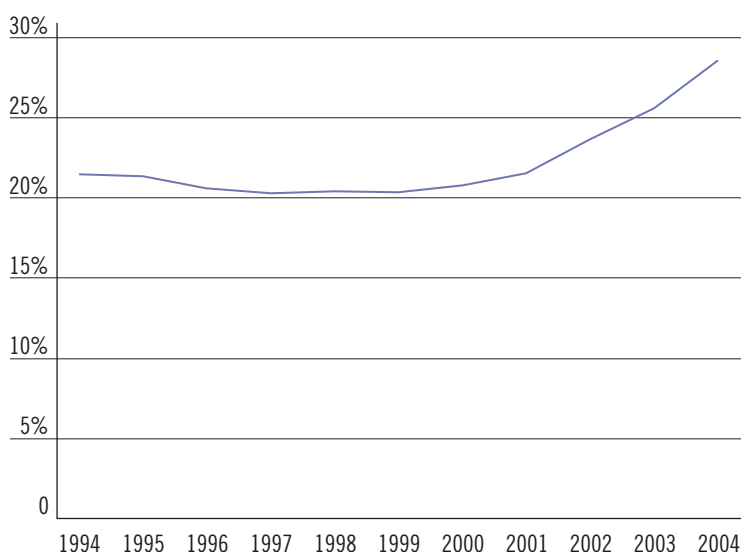
MEDICAID FOR ALL?

By 2001, Medicaid costs were once again on a sharp incline, gobbling up an expanding share of an increasingly strained state budget. This year, MassHealth is projected to eat up 28 percent of state spending, and it could edge toward 30 percent of the budget next year. (And that’s without counting Medicaid funds—\$1.3 billion next year—spent through other agencies, such as the Department of Mental Health, but not included in the proposed \$6.7 billion MassHealth

appropriation.) Some critics blame this return to budget-buster status on the major MassHealth expansions of the 1990s, particularly those intended to reduce the number of uninsured or underinsured state residents.

This expanded coverage—and many of the managed-care initiatives of the mid ’90s—became possible because the Weld administration received federal waivers, in accordance with a policy giving the states greater flexibility. One such waiver allowed the state to expand Medicaid

MASSHEALTH AS PERCENTAGE OF THE STATE BUDGET



SOURCE: MASSACHUSETTS TAXPAYERS FOUNDATION

coverage for underinsured low-income families, children, and individuals in 1996.

In 1998, the federal State Children’s Health Insurance Program brought even more people under the Medicaid tent. Under SCHIP, families making as much as 200 percent of the federal poverty level could get coverage for children ages 1 to 5, up from the old eligibility level of 133 percent. Coverage was also expanded for pregnant women and the disabled, and extended to persons with HIV and the long-term unemployed.

As a result of these expansions, MassHealth enrollment rose by more than 300,000 people between 1997 and 2002, according to an analysis prepared for the Massachusetts Health Policy Forum. At the same time, the number of uninsured residents in Massachusetts declined from just under 700,000 in 1996 to about 365,000 in 2000.

The new eligibility rules helped to give Massachusetts one of the smallest populations lacking health insurance in the country, but it also helped to make MassHealth “the BMW of entitlements,” according to state Rep. Harriett Stanley, a Democrat from Merrimac. Last year, when she was House chairman of the Health Care Committee, Stanley

wrote a paper titled *Re-engineering Medicaid*, which won the annual “Better Government Competition” sponsored by the Pioneer Institute for Public Policy Research. Stanley charged that MassHealth “has grown far beyond its original purpose as a safety net for those residents with no other health care options.” She urged that Medicaid move toward a “Ford” model, with “fewer options and more premiums and co-payments.”

Defenders of the MassHealth expansions claim that the 300,000 recipients added to the program since 1996 were covered at no additional cost to the state’s General Fund. According to Health Care for All, funding came from a 25-cent tobacco tax passed in 1996, transfers from the state’s Uncompensated Care Pool (which is funded partly by hospitals and insurers and partly by the state), and existing money in the Emergency Aid to the Elderly, Disabled, and Children cash assistance program. New federal money to support medical care for special education students, the mentally retarded, and other populations also helped to defray the cost of new MassHealth members.

But Stanley argued in her paper that “some of the financial underpinning” of the expansion “didn’t work as planned.” She noted that Uncompensated Care Pool costs continued to rise, putting further strains on hospitals; that

cigarette taxes didn’t contribute sufficient revenues to offset increased costs; and that a number of managed care initiatives didn’t reduce costs sufficiently. Contrary to Health Care for All’s analysis, Stanley maintained that “the state’s health care providers and General Fund have been supporting the MassHealth expansions of the mid-1990s.”

Former Medicaid chief Bullen says that, in understanding Medicaid’s cost explosion, the expansions of the past decade are a red herring. “It’s surprising to me that sober analysts look at the problem and conclude that the MassHealth expansion is the reason that Medicaid has turned into a budget buster,” he says. He points out that the populations served by the expansion have, by and large, been less costly to the program than the two major groups that have always been covered by Medicaid—the elderly and the disabled.

Indeed, the Health Policy Forum analysis notes that the MassHealth recipients added since 1996 accounted for only one-third of the increase in Medicaid spending between fiscal 1997 and 2002. Long-term and acute care for the disabled and elderly accounted for most of the increase. While the two groups comprise only 32 percent of MassHealth members, they use 71 percent of the spending for MassHealth services. In fiscal 2001, MassHealth spent an average



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of \$2,022 for each member of a family enrolled in the program and \$3,460 for each long-term unemployed adult eligible for assistance. That compares with \$8,723 for each non-elderly disabled adult and \$17,515 for each elderly enrollee.

A DOLLAR SHORT

Whether or not the growth of MassHealth from roughly 670,000 to nearly 1 million Massachusetts residents turned the program back into a budget buster, it did heighten a longstanding complaint of health care providers—including hospitals, nursing homes, and community health centers—that when it comes to paying its bills, Medicaid is a cheat. Matt Fishman, director of community benefits programs at Partners HealthCare System, contends that MassHealth currently pays hospitals in Massachusetts less than 70 cents on the dollar of their costs. The hospitals in the Partners system overall are being paid about 55 cents on the dollar, he says, while teaching hospitals are receiving as little as 50 cents.

Administration officials don't disagree that providers are underpaid. Speaking to the Greater Boston Chamber of Commerce in February, Gov. Romney himself acknowledged, "like all states, [Massachusetts has been] under-reimbursing providers for their full cost of treating Medicaid patients." By how much is another matter. "No one other than the hospitals knows what their 'costs' are and every hospital seems to have its own method for determining those 'costs,'" says Executive Office of Health and Human Services spokesman Richard Powers in a written statement. "Only the hospitals themselves know how creative their accounting is."

In any case, the shortchanging is not over. The governor has proposed \$152 million in "savings initiatives" that include cuts in MassHealth payments to acute hospitals and nursing homes, pharmacy providers, rehabilitation hospitals, and durable medical equipment vendors. But providers say such cutbacks don't "save" anything; they simply shift costs to the providers themselves—and, where providers are able to pass them along, to other payers, such as private health insurers and the employers who pay the premiums. The Massachusetts Hospital Association contends that "the administration's 2005 budget will impact hospitals negatively by approximately \$500 million, which comes on top of years of consistently inadequate payment levels." In addition, the Massachusetts Extended Care Federation projects that nursing homes might have to cut their work-



Rep. Harriett Stanley (right) wants Medicaid to be a "Ford," not a "BMW."

force by as many as 3,800 jobs across the state if the Legislature were to let the administration's budget proposals stand.

Still, given the fiscal circumstances, Health and Human Services Secretary Preston maintains that MassHealth has made out pretty well in the state budget, avoiding cutbacks in the current fiscal year that once looked inevitable. "We worked really hard, and the governor worked really hard, so that that didn't occur," he says. "All of our major entitlements are standing. Is there distress in the system? Well, sure...[but if this] were elsewhere in the government, we'd be throwing parties."

BUDGET BOOMERANG

Over the past two years, nobody's been throwing parties over MassHealth. Under the pressure of cost growth and revenue decline during the recent recession, Medicaid has been on a budget (and benefits) roller coaster. In January 2002, then-Gov. Jane Swift eliminated most dental benefits under

MassHealth for nearly 600,000 adults. In October of that year, she used her executive powers to eliminate several optional benefits for adult recipients—including dentures, prosthetics, orthodontic braces, chiropractic therapy, and eyeglasses. The estimated savings were \$22 million, or \$11 million in state costs after federal reimbursement.

In 2003, the Legislature voted to eliminate benefits under the MassHealth Basic program, which served 50,000 low-income, unemployed adults with high health needs. Last August, the Legislature also cut about 10,000 legal immigrants from MassHealth, although coverage was restored later that year to roughly 2,700 of those recipients.

The Romney administration, which had come into office criticizing the coverage rollbacks imposed by Swift, his predecessor, created a new program, called MassHealth Essential, to restore coverage for the long-term unemployed, although the income limits were more restrictive than under the original MassHealth Basic program. MassHealth Essential also capped enrollment at 36,000 people. As of January, about half that number were re-enrolled under MassHealth Essential, according to Victoria Pulos, an attorney with the Massachusetts Law Reform Institute.

‘People should pay a little something.’

But this partial reopening of the MassHealth umbrella came at a price. The administration imposed premiums for the first time on some of the lowest-income MassHealth recipients, ranging up to \$15 a month for families making less than 150 percent of the federal poverty level. The administration set up an appeal process in cases of hardship, but it also initiated a termination procedure that would drop beneficiaries from the Medicaid rolls for nonpayment of premiums. Pulos says the Law Reform Institute is concerned about reports that MassHealth had issued, or was about to issue, more than 2,000 termination notices to recipients who were more than 60 days overdue on their premium payments. But the administration is concerned about anyone taking a free ride on health care.

“The governor believes that health care is not free, and that unless you’re dealing with somebody that is really, totally, completely disabled, most of the people on MassHealth should pay a little something toward their care,” says

Preston. “There’s an awful lot of middle-class and working-class families out there that don’t get any of these state benefits and who are going through contortions with their personal budgets in order to be able to insure their children and themselves.”

Health care providers and advocates for the poor insist that program cuts and attempts to shift MassHealth costs to recipients are bound to be self-defeating, from a fiscal as well as health care point of view. Bullen, the former Medicaid director in the Weld and Cellucci administrations, agrees.

“I’m not a big proponent of cutting services or eligibility,” he says. “I think [MassHealth programs] should be administered tightly. But I wouldn’t cut them, because the more low-income people you get into the Medicaid system—the people who will be looking to the state for health care—the better it is for the state because you get as much federal help as you can... If we cut MassHealth without thinking, we will throw away a lot of potential federal money.”

Health Care for All insisted in a November 2002 report that the projected savings from MassHealth cuts would be

short-term at best because “the needs that [the MassHealth programs] serve won’t go away. Instead the result will be sicker people who require more expensive care in hospital emergency departments or nursing homes.” Not to mention a swelling of the ranks of Massachusetts residents without health insurance. McDonough, of Health Care for All, notes that at the same time MassHealth enrollment dropped

from 1 million to 913,000 the number of uninsured was on the rise, from 365,000 to 500,000.

ROOM FOR IMPROVEMENT

It’s difficult to find any unbridled optimism about the future of MassHealth. The concerns voiced by Eric Kriss and Harriett Stanley are shared by most analysts, even those who argue against scaling back services and eligibility. And there are ominous new signs coming from Washington, where, McDonough notes, the Bush administration is pushing to change Medicaid into a block grant program, which would get the federal government off the hook when Medicaid costs rise—and leave states holding the bag.

And the federal Medicare program won’t be much help either. Right now, Medicaid covers many of the costs of caring for poor elders that Medicare doesn’t pay for, including nursing homes and prescription drugs. Even the \$500 billion Medicare prescription-drug benefit may do

more harm than good to MassHealth, according to Nancy Turnbull, executive director of the Massachusetts Medicaid Policy Institute. She says the new program requires states to make payments to the federal government out of their savings from the federal drug benefit, based on a formula she says penalizes states that have been effective in moderating prescription drug cost growth.

Still, there is reason for hope in the Medicaid prognosis. In the short run, there is federal Medicaid money sitting in state coffers, unused, from Washington's state-budget relief package from last year. Powers, the Health and Human Services spokesman, confirms that the state placed \$228.3 million in supplemental federal Medicaid funds into an escrow account. Of that amount, \$55 million is being used this fiscal year to supplement the Uncompensated Care Pool, which pays for hospital and community health center care for low-income uninsured and underinsured people. That leaves \$173 million available to avoid further cuts in MassHealth. But it is unclear whether the administration intends to use that money for MassHealth or to simply put the money into the General Fund.

In the Legislature, there are signs of interest in restoring provider rate cuts. The House budget would increase the state's reimbursement to hospitals for providing care to uninsured patients by \$65 million, up to \$495 million. It would also level-fund MassHealth Essential at \$110 million and offer \$5 incentives to MassHealth patients who use community health centers for their primary care.

Looking further ahead, there is a range of ideas to rein in Medicaid costs without jeopardizing care or eligibility. Two Romney administration initiatives have drawn praise from providers and consumer advocates alike: the Senior Care Options program and an effort to control drug costs by using cheaper generic alternatives.

Similar to the PACE program that benefits Christine St. Pierre, the Senior Care Options Program would require that teams of specialists prepare care plans for seniors with the intent of providing alternatives to nursing homes. The PACE program serves just 1,500 seniors throughout the state, but Senior Care Options would ultimately serve more than 100,000 people. It would not be restricted to seniors with severe medical problems but would be available to healthier individuals as well.

The prescription drug initiative involves a "preferred list" of thousands of reasonably priced or generic drugs, which doctors are encouraged to prescribe. A doctor who wishes to prescribe a drug not on the list must get approval from MassHealth. The program has already been credited with

reducing the growth of MassHealth drug expenditures from 20 percent a year to just 5 percent in fiscal 2004.

The Romney administration is also considering initiatives to manage the care of high-cost MassHealth recipients, including "disease management" programs that identify populations that are at risk for nursing home or hospital admission. The goal is to avoid medical complications that could lead to unnecessarily expensive treatment. This kind of cost-saving initiative—one that saves money by helping vulnerable people stay healthier—is something even those who are fighting cuts in MassHealth can sign on to.

"The stereotype of managed care is that it is a way of withholding services from people," says McDonough. "But the reality of these new tools is, you identify high-cost cases and you get low-tech, low-cost interventions for behavioral change and self-management," McDonough

All agree on some ways to rein in cost.

says. As examples, he cites the development of treatment plans that require people to stop smoking, to start exercising and dieting, and to get mental health counseling. "Those services enable people to start to get control of themselves and change the behavior which is putting them significantly at risk for expensive hospitalizations."

But in this, Massachusetts is playing catch-up. In February, MassHealth officials attended a seminar organized by Partners HealthCare and the Massachusetts Medicaid Policy Institute to hear Florida officials describe their disease management programs. After the presentation, McDonough, who also attended the seminar, asked some Massachusetts officials present what they had done in the area; one, he says, told him they had "taken some baby steps in that direction."

Preston admits that, "considering the expertise that exists in Massachusetts," MassHealth is not on the forefront of reform in care management. "We are not anywhere near as advanced as some of the other states in the country in doing some of these things," he says. Until that changes, expect the saga of Medicaid, with its ups and downs, to continue. ■

David S. Kassel is a freelance writer in Harvard.

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*"We are the ones advocating
for our patients," says Mass.
General's Barbara Levin.*



and Demands

WHAT WILL IT TAKE TO SOLVE THE NURSING SHORTAGE?

BY JEFFREY KLINEMAN

Sitting on a Brighton hilltop like a fortress against disease, the beige brick edifice of St. Elizabeth's Hospital stands out against the gray March sky. The driveway, which carves a path up to the emergency room and where one might expect to hear the blare of ambulance sirens, is clear and quiet, but motorists heading down Cambridge Street toward the Charles River break the silence by honking their horns in support of the nurses gathered in demonstration at the foot of the hill.

As always, wages and benefits are at issue, but the chief source of labor unrest is another matter—one that doesn't go away even when a settlement is signed here a few weeks later. Nurses at St. Elizabeth's, and elsewhere, say that the quality of their work life is suffering, and the health of their patients is in danger. In Massachusetts hospitals, they say, on too many hospital floors, too many patients are looked after by too few nurses.

"I'll tell you straight out: If you get sick, I fear for your life," says Rita McMillan, a fiftysomething nurse in St. Elizabeth's neonatal unit. "There aren't enough of us to go around."

On this particular labor grievance, the bosses concur—with the diagnosis, if not the cure.

Hospital executives agree that nurses are in short supply. But they say the problem is not just the number of nurses they hire; it is the number of nurses available to be hired. They say that nursing is a profession on the ropes, at a time when the need for nurses—in Massachusetts and across the country—is on the rise.

"The real crunch is in the next five years," says Robert Shafner, director of the Center for Health Professions at Worcester State College. "We will have a number of nurses who will reach retirement age, and when you look at the ones who are coming in, there aren't enough to replace those who are leaving."

"It's always hard to forecast labor markets," adds David Smith, chief data analyst for the Massachusetts Hospital Association. But that doesn't stop him from making this one: "Come 2010, 2012, 2015, we're going to see dramatic reductions of the number of nurses in the workforce unless we do something dramatic, and do it soon."

Massachusetts has one of the highest numbers of registered nurses, relative to population, in the country. Yet, in 2002, 9.9 percent of budgeted nursing positions were vacant, a level of job openings not

PHOTOGRAPHS BY MARK OSTOW

seen since 1988 and up from a low of 2 percent in 1996. Last year, the RN vacancy rate dipped slightly, to 8 percent, the first decline in seven years. But that was widely seen as a passing phenomenon—a poor economy forcing older nurses back to work—and one that, in an industry where the average worker is nearly 50 years old, will soon be offset by a wave of retirements. The reality, say those on both sides of the picket lines, is that Massachusetts, like the rest of the nation, is in the midst of a nursing shortage. And with the first members of the baby boom generation approaching 60, the need for nurses will soon be greater than ever.

In Massachusetts, a vital nurse workforce is doubly important: important not only for care but also because of the health care industry's prominent place in the state's economy. Any loss of confidence in its internationally renowned hospitals could be as painful to the state as a medical error could be to a patient.

"There might be more nurses per 100,000 people here, but we will still experience the shortage due to the intensity of the health care system in Massachusetts," says Sharon Gale, president of the Massachusetts Organization of Nurse

"High vacancy and turnover rates among direct care workers are generating a downward spiral within the state's health care labor force—creating an instability that threatens the quality and availability of health care services for thousands of people who are ill, elderly, or living with disabilities."

For the past 18 months, health care has been, far and away, the field with the largest number of job vacancies in the state, according to a series of reports by the state's Division of Employment and Training (which is now known as the Division of Career Services and Division of Unemployment Assistance), which analyzes the state's hiring trends every six months. In the latest survey, there were more than 15,000 health care-related vacancies—the majority for practitioners such as registered nurses and licensed practical nurses, radiological technicians, and physical therapists, but also for nurses' aides, orderlies, and attendants.

The demand for doctors (both for general practice and for specialties such as anesthesiology), x-ray technicians, pharmacists, and all manner of home health care aides has also shot up over the past several years, according to a study conducted by the Milken Institute and the New England

AS THE POPULATION AGES, EVEN MORE CAREGIVERS WILL BE NEEDED.

Executives. "There's a robust system here, there are a lot of health care institutions throughout the state, and Boston is the mecca of health care delivery. We can't lose that."

Compounding the supply problem, a lot of nurses aren't happy. They believe the only way they will be happy is if there is a legal limit on the number of patients they each are required to care for. Though it may be a legislative blunt instrument, many nurses say that it would guarantee good care for patients and good working conditions for them. But this proposal has hospital administrators squawking—and wondering where they would find the nurses to manage the smaller caseloads.

HELP WANTED

Health care is big business in Massachusetts, and it needs a lot of hired help. The industry employs 400,000 people overall. As the population ages and demand for medical care rises, even more caregivers will be needed. But no one knows where they will come from. Even today, nursing isn't the only health care occupation that doesn't have enough bodies to fill its ranks.

As far back as 2000, a report prepared for the Massachusetts Health Policy Forum warned that the health care industry was in the midst of an "unprecedented" labor crisis:

Healthcare Institute, and no one knows where those needed employees will come from, either. Massachusetts is a national leader in medical training, but between 1997 and 2003 more than half of its medical residents and more than two-thirds of its fellows (post-graduate doctors who get further training before going into practice) left the state after completing their training. The state also lost half its anesthesiologists between 1999 and 2001.

But in any hospital, nurses constitute the largest group of employees and deliver most of the patient care. In the health care chain, nurses are the key link.

"We, as nurses, are the ones who are advocating for our patients," says Barbara Levin, an orthopedics nurse at Massachusetts General Hospital. "We can make recommendations and communicate to them what the recommendations for their recovery have been. We're teaching them, and they're teaching us."

Nationally, the health care industry is expected to be short more than 800,000 nurses out of 2.8 million needed by the year 2020, according to a study conducted in 2002 by the US Department of Health and Human Services. In Massachusetts, the shortage is projected to be more than 25,000 of the 86,000 needed—or 29 percent, similar to the rest of the nation.



Sen. Richard Moore: Demand is high in hospitals, but home care is also suffering.

biotechnology company. In addition, the long-term trend of broader career options for women drove down nursing-school enrollments.

"My teacher said to me, when I was a girl, 'Well, dear, do you want to be a teacher or a nurse?'" says Linda Wells, chief nurse at Emerson Hospital in Concord. "Things have obviously changed, and a lot of the options out there have less stress, fewer hours, and better pay. So, as nurses, we're competing with all of these other professional opportunities out there for women."

As a result, the nursing shortage has now spread from hospitals to some of the very industries nurses fled to. Visiting-nurse agencies, for example, told *The Boston Globe* in December that they had been turning away hundreds of patients per month due to lack of staff.

"The demand is there in the hospitals, and it's probably the most acute," says state Sen. Richard Moore, an Uxbridge Democrat who is co-chairman of the Legislature's Health Care Committee. "But there's need across the board. We need more school nurses, more visiting nurses for those in their homes, and more for nursing homes and assisted-living facilities."

This is not the first time nurses have been in short supply. "There have been cyclical nursing shortages that have been documented over a number of decades," says the MHA's Smith. "I came here 16 years ago, and things looked a lot like they do today. We had nurse vacancy rates running around 10 percent, the economy was overheated, and there were problems with ambulance diversions [due to understaffing at emergency rooms]. But within two or three years, the bottom fell out of the economy, and nurse vacancy rates were at 2 or 3 percent."

The shortage may not fix itself this time around, however, especially in hospitals. In part, that's because nurses, and prospective nurses, have other options today. According to a study conducted by Peter Buerhaus, a Vanderbilt University School of Nursing professor, registered-nurse employment in non-hospital settings grew throughout the late '90s. Nurses found they could avoid the stresses of hospital life—and especially the night and evening shifts that are the soft spot in nursing retention—by working for a visiting-nurse agency, a nursing home, or a pharmaceutical or

OUT OF PROPORTION

The hospital industry has particular problems drawing nurses to its doors, some of its own making. In the decade of restructuring and consolidation that followed hospital deregulation in 1992 ("Romancing the market," *CW*, Winter 2002), nurses bore the brunt of the adjustment to an era of competition and managed care.

"In the '90s there was much more pressure on hospitals to cut costs and become efficient," says Dana Beth Weinberg, author of *Code Green: Money-Driven Hospitals and the Dismantling of Nursing*, which used Boston's Beth Israel Deaconess Hospital as a case study. "One chief way was to cut the labor force, and primarily they cut nurses. At the same time they did that, they trimmed the length of stay [for patients]."

For nurses, that meant sicker patients to care for. "Even if your caseload stays the same, you've lopped off the time of stay in which they don't need as much care and monitoring," says Weinberg. "So you have the sickest, neediest patients in the hospital, and there aren't as many people to



Jackie Long-Goding of Northern Essex Community College: The shortage of bodies is spreading to nursing school faculties.

take care of them.” The decision to cut staffing levels also cost hospitals “advanced practice” (that is, more-experienced) nurses, who spent less time with patients but were skilled at imparting specialized knowledge to new hires.

“In the 1990s, because those nurses weren’t considered to be providing direct care, they were told, ‘You’re gone. You’re eliminated,’ or they went back to the bedside,” says Julie Shindul-Rothschild, head of community and psychiatric nursing at the Boston College School of Nursing. “Now, some hospitals are hiring those advanced practice nurses back, but the patient loads and the acuity level are such that they don’t have the time to provide the mentoring.”

Some hospital executives admit they have fences to mend with the nursing profession. “Things have gone awry when administrators and doctors have tried to treat nurses like pieceworkers in a factory,” says Paul Levy, chief executive of Beth Israel. “This place did for a while, and that’s what we had to undo.”

Beth Israel was a shambles as recently as three years ago, the byproduct of a tumultuous merger with New England Deaconess, according to Weinberg. But under Levy, the hospital has tried to make amends by taking nursing concerns to the top, with strong chief nurses serving at the executive level. Patient acuity and nurse staffing levels are closely monitored, and nurses are encouraged to come up with their own schedules. Massachusetts General Hospital takes a similar approach.

“If a nursing floor says we need more people, we respond to that,” says Levy. “Part of what we try to do is called shared governance, where nursing staff are meeting with governors on a regular basis and saying, ‘This is what we need.’ My job as CEO is to make sure there’s a good shared process across the hospital.”

The Massachusetts Nurses Association, the union that represents 25 percent of nurses in this state, takes a different tack. The MNA is pushing a bill to write “safe staffing” levels into law. It is one of several such initiatives in states across the country, and similar to a law recently passed in California. The union and its supporters claim that two-thirds of Massachusetts nurses who left patient bed-sides for other opportunities would consider coming back if they could be assured of reasonable staffing levels.

In the latest version of the MNA proposal, nurses would care for no more than six patients at any point during their shift; in more acute nursing specialties, the ratio would be 1-to-3 or even less. The proposal also includes strong monitoring systems, including a toll-free hotline that patients or families could call to report inadequate staffing and fines for hospital violations, which would be posted publicly.

First proposing a similar measure in 1994, the MNA has long argued that unreasonable patient loads threaten quality of care, but the union’s case was bolstered by a 2002 study. Linda Aiken, a nursing professor at the University of Pennsylvania, found that the likelihood of a patient dying

within 30 days of surgery increased by 7 percent when their nurses had more than four charges.

“When we first filed the bill, we knew staffing was at the root of the problem, but there was a lack of data,” says MNA executive director Julie Pinkham. “But now we have mountains of research. Inappropriate nurse staffing will either lead to increased length of stays or it will literally kill a patient.”

The MNA bill seems to be gaining momentum on

UNDERSTAFFING CAN ‘LITERALLY KILL A PATIENT.’

Beacon Hill, where the union claims the support of more than 100 lawmakers. But critics charge that the “safe-staffing” push is as much about job security as patient security, with ratios remaining constant even for the night shift, when most patients are asleep.

Hospital administrators say they can use less-skilled

LPNs (licensed practical nurses) to handle some tasks, and that the proposed legislation also does not take into account the mix of experienced and inexperienced nurses on a given shift. Moreover, they say that in California, mandated staffing ratios have left hospitals squeezed economically and paralyzed medically, forced to turn patients away from emergency rooms because they don’t have the staff required under the law.

“Obviously, we need more nurses and we need more time for those nurses to take care of patients,” says Dr. Donald Moorman, vice president for surgery at Beth Israel Deaconess. “But we can’t leave those patients unable to get care because of ambulance diversions.”

It’s one thing to mandate staffing levels; it’s another to come up with the staff to maintain them, says Sen. Moore, who scoffs at the claims of legislative support for the MNA bill. “People sponsor it because it’s like motherhood and apple pie,” he says. “Nurses are great, but making the thing work is a different story.”

FACULTY SHORTAGE

Moore has his own bill, one designed to increase the supply of nurses in the Commonwealth. “You can’t create positions for people who aren’t there,” he says. “You need to prepare



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the field before you can reap the harvest.”

Moore’s plan calls for a \$30 million trust fund to repay student loans for nursing-school graduates; it would also encourage mentoring programs within hospitals and fund recruitment drives. The staffing-ratio issue would be addressed by a “best practices” review of nurse staffing plans. Moore says it may also be possible to improve nursing care by shifting non-patient-care tasks to other hospital staff.

“Maybe there’s a better mix of people in terms of clerical support,” he says. “We need to look at how nurses are spending their time. It could mean a whole new way of training nurses [and] incorporating more technology, and it could mean we need to look at the whole job of patient care.”

But Moore’s recruitment-and-retention approach, which has the support of both the Massachusetts Hospital Association and the Massachusetts Organization of Nurse Executives, draws attention to another problem standing in the way of solving the nursing shortage: opportunities to gain nursing degrees.


According to the American Association of Colleges of Nursing, 583 students who qualified for admission were turned away from Massachusetts baccalaureate nursing programs last year due to lack of faculty or clinical facilities—and that’s counting the numbers from only 12 of the 15

programs in the state. Across the country, some 16,000 prospective nurses were rejected, primarily because of a lack of instructors and clinical space, according to the AACN.

In Massachusetts, the problem has been exacerbated by a wave of early retirements, encouraged as a solution to state budget woes, which caused a large number of nursing instructors to put up their feet prematurely. Applications to state nursing programs have gone up over the past two years, but because training capacity is shrinking rather than expanding, there hasn’t been a flood of new graduates: The Massachusetts Board of Registration for Nursing reports that 1,751 RNs graduated from nursing programs last year, a number that has steadily decreased from 2,371 in 1998. While admissions and enrollments have finally climbed back up to the levels they reached in 1998, experts maintain that their programs are at maximum capacity.

“We just don’t have enough faculty to take all of the people who would go into a nursing program,” says Shafner. “I just spoke up in New Hampshire, and they told me the situation was the same. There are waiting lists that are two, three, four years long at schools of nursing.”

Meanwhile, the state’s community colleges, which offer non-baccalaureate RN programs, are facing the same problem. In 2002, Northern Essex Community College lost seven



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of its 10 nursing faculty members to early retirement, though one instructor was brought back after four Merrimack Valley hospitals got together to assume the position's \$60,000 salary. Despite this attrition, NECC has expanded nursing enrollment in response to increased demand, but it will soon run into shortages in other health-related departments, according to Jackie Long-Goding, associate dean for health professions.

"If a nursing student can't get anatomy and physiology, they can't complete the program," says Long-Goding. "I really don't know how long we can do it. Clearly, the critical need will move from nursing to other areas that contribute to the education of a competent nurse."

Moore's bill calls for several nursing faculty initiatives, including allowing instructors who took early retirement to be re-hired without jeopardizing their benefits—an option reserved for critical professions. But at a time when hospitals and other health care providers are bidding up the salaries of nurses and nursing supervisors out of desperation, the difficulty of hiring and retaining nursing instructors extends to private nursing schools as well.

"Why do you think we have too few faculty?" asks Lea Johnson, assistant dean of the Northeastern University School of Nursing. "They can get paid \$60,000 here, or they can work as nurse managers and make over \$100,000 a year."

MONEY TALKS

Of course, that is the classic solution to a supply problem: bid up the price. Some say that could be the answer to the nursing shortage as well. One study, by Joanne Spetz of the Center for California Workforce Studies and Ruth Given of Deloitte Consulting, indicates that higher wages might draw young nurses into the profession as efficiently as they have brought some older nurses back into the fold.

But Pinkham, of the MNA, says keeping them there is another matter. "If you don't fix the conditions, you're not going to keep the people who go in," says Pinkham. Recruitment efforts solutions "are a great thing," she adds. "But if

you recruit that college grad and get them into the system, and they still have eight patients when they should have four, they're going to leave."

For their part, hospitals have learned, through the current shortage, the price they pay when these key caregivers



The MNA's Julie Pinkham: New nurses won't stay if conditions don't improve.

vote with their feet. Replacing experienced nurses costs as much as a year's salary in recruitment, hiring bonuses, and fill-in time paid to an agency or per-diem nurse. For this very reason, however, some hospital officials worry that the financial enticements designed to draw in younger recruits—good pay, getting their educations paid for—might make nursing attractive for the wrong reasons.

"My concern is that as we have all these supply initiatives, we have to be sure we're meeting people's expectations as far as what the patients need them to do," says Dr. Moorman. "There's potential to have a situation where people have been drawn into the profession, and they're still not ready to hold someone's head while they're vomiting."

Nursing may not be for everyone. But Barry Hayden, a former Franciscan brother who joined the profession 18 years ago, says hospitals had better figure out how to make their jobs more palatable before it's too late. "Look around," he says, gesturing to his colleagues outside of St. Elizabeth's, almost all of them clearly many years out of nursing school. "Look at the people here. Ask yourself how old they are." ■

Jeffrey Klineman is a freelance writer in Cambridge.

Health insurance is a constitutional matter

BY BARBARA WATERS ROOP AND JOHN D. GOODSON

It's almost a cliché: The Massachusetts health care system is in crisis. Every stakeholder is unhappy. It is not a crisis of technology—new drugs, machines, and methods abound, so that, at its best, medical treatment here is at the cutting edge. It is a crisis of affordability and finance. A new wave of medical inflation is sending shockwaves through the system, exposing it for the Rube Goldberg device it is. The recession compounds the crisis.

Whenever inflation ripples through our gerry-built system, the ranks of the uninsured grow—by 65,000 for every 10 percent jump in employee premium costs, according to the Division of Health Care Finance and Policy. All purchasers of health care, public and private, seek protection from rising prices by cutting coverage and shifting costs to others.

State and federal programs cap access and cut reimbursement rates. Employers raise contribution rates, cut benefits, or drop coverage. Individuals drop coverage, betting that the cost of getting sick will be lower than the cost of insurance; losing often spells financial catastrophe.

Providers often take the first hit from cost shifting, confronting lower reimbursement rates and increased demand for uncompensated care. They try to shift costs back to insurers, who then pass them on to employers and taxpayers, fueling the next round of premium hikes and the next rise in uninsurance. Those with the least bargaining power—low and middle-income working families priced out of the private health-insurance market but earning too much for public coverage—suffer the most.

Today's recession only aggravates the cycle of rising prices, cost shifting, and growing uninsurance. All the players who can cut back and shift costs do so. The Legislature struggles each year to control state spending and balance the competing demands of stakeholders seeking new funding or programs or ways to cut costs or increase reimbursements. But with about 600,000 uninsured in Massachusetts—644,000 according to the latest US Census data—uninsurance has become a structural problem threatening the health and financial security of Bay Staters; the Commonwealth's ability to provide key services, like education; business profitability and competitiveness; and the stability of the health care industry, which provides the high quality care we demand and drives economic growth.

The Committee for Health Care for Massachusetts—a

coalition of doctors, nurses, patient and health care advocates and community leaders—came together to find a way make sure the Commonwealth addresses this problem head on. Our proposal is straightforward—amend the state Constitution to make our elected officials responsible for guaranteeing every Massachusetts resident access to affordable health insurance. If ratified by the voters, this amendment will mandate action but leave it to our elected officials to design a system that best meets the needs of the Commonwealth—its people, businesses, and health care providers.

Why a constitutional amendment? The lessons of recent history are clear. A similar constitutional guarantee gave the people a valuable tool to leverage fundamental education and financing reforms in the 1990s—reforms designed by the Legislature with stakeholder input. The mandate the Commonwealth's founders put in our constitution was essential to forcing those changes.

By contrast, the Commonwealth's attempt in the 1980s to achieve universal health coverage by legislative means was deeply disappointing. Our elected officials, with stakeholder input, designed and enacted an equitably financed system of coverage for everyone. But the first recession brought repeal of the private funding component, which would have guaranteed coverage for most Massachusetts residents.

Opponents of our proposal say a constitutional amendment is not required to reform the health care system. It's true that legislative reforms are a legal option—but not a political one. One failed legislative attempt followed by almost 15 years of debate and incremental reforms—reforms that are now be in jeopardy—demonstrate this. Let us be clear: Given the history, new calls for a legislative approach are merely code words for inaction.

Why by initiative? The initiative process is a vehicle for voters to instruct their elected officials to act. Our proposal establishes a principle: that our elected officials are responsible for ensuring access to affordable health insurance for every resident. It does not impose a specific mechanism. Some would prefer that it did. But that would mean circumventing a process that only the Legislature can successfully oversee.

Reform will require cooperation between the public and private payers that finance the current system. It will require balancing the varied and often conflicting interests of the

many stakeholders in our health care system. Forging the legal nuts and bolts required to provide everyone access to affordable health insurance is a uniquely legislative function. But the principle that will guide and drive this process forward belongs in the Constitution.

The cost of affordable health insurance for everyone is a legitimate concern. That cost, if any, must, however, be compared to the costs of inaction. Inflation, inefficiency, uncompensated care, and avoidable hospitalization cost billions each year, fueling inflation and uninsurance.

No price tag can be accurate until the Legislature and stakeholders design the new system. Until then, opponents will raise, however disingenuously, the specter of outrageous costs to thwart change.

ity, cost-effective care.

It limits coverage to “medically necessary” care, as all insurers, public and private, do to control utilization and costs. It provides a mandate to do what our elected officials and private stakeholders want most—to get good value for our health care dollar. Cutting waste and inefficiency will produce more resources for direct care, which will make Massachusetts residents healthier and more productive and Massachusetts businesses more profitable.

Lawmakers are understandably wary of adopting a proposal that the Supreme Judicial Court could interpret more broadly than either the Legislature or the proponents intend. But legal precedent suggests the SJC will defer to reasonable legislative interpretation of the amendment.

Our proposal establishes a principle: that our elected officials are responsible for ensuring access to affordable health insurance for every resident.

Some estimates have already been offered, based on the misleading assumption that Massachusetts taxpayers would foot the entire bill for buying individual policies for every uninsured individual—yet many qualify for family plans, many qualify for MassHealth or SCHIP (with 50 percent federal payment), and many could pay some or all of the premium themselves.

These misleading estimates ignore the \$700 million taxpayers, hospitals, and employers currently pay for uncompensated care, which could be used to provide better and cheaper care for the uninsured. They assume we can’t cut a dime from the over \$16 billion we now spend on administration when reputable studies show that better information management can generate \$2.5 billion in savings. They deliberately overlook the \$1 billion spent each year for avoidable hospitalizations and assume that providing high quality, coordinated preventive and acute care in doctors’ offices instead of expensive, sporadic care in emergency rooms will not generate savings over time. Reputable research and practical experience contradict these assumptions.

Our proposed amendment is not a blank check—quite the contrary. It mandates an affordable system that roots out waste and inefficiency and reallocates the savings to qual-

In the *McDuffy* educational equity case, the SJC didn’t even issue its opinion that the Legislature had an obligation to act until reform legislation had been drafted. If the Legislature enacts legislation that can reasonably be said to meet the standards set out in the amendment, the SJC is likely to defer. Legislative action within a reasonable period of time following ratification will likely limit litigation to that which accompanies any new law.

What the SJC isn’t likely to stand for is inaction. By writing the principle of affordable health insurance into the state Constitution, the citizens will have a powerful judicial ally.

Even opponents of this proposal concede the need for affordable health insurance for everyone. Expanding access and making the system affordable and sustainable will not be simple, but it can and must be done. This constitutional mandate will be a catalyst for getting stakeholders to the table to end the cycles of inflation, cost shifting, and uninsurance that hurt the Commonwealth’s residents and its economy. Our health and prosperity depend on prompt action, and with this amendment, we will get it. ■

Barbara Waters Roop, PhD, JD, and John D. Goodson, MD, are co-chairmen of the Committee for Health Care for Massachusetts.

An amendment won't provide a health cure

BY RICHARD C. LORD

The proponents of a state constitutional amendment to establish an individual right to comprehensive health insurance, enforceable against the Commonwealth, have clearly given a lot of thought to the problems besetting our health care system. Apparently, however, they have given no thought at all to how those problems might be solved. Instead, they offer a very dangerous political ploy.

Their proposal is political in two senses. Explicitly, it is a device to force the state Legislature to immediately reshape our health care system—risky enough, one might think. The implicit political aim is much worse: to induce voters to approve a general statement of principle without regard to its practical consequences. A constitutional amendment creating an entitlement will inevitably produce irreversible legislative and judicial results that, though to a significant extent unpredictable, are certainly not anything the public would willingly entertain.

What are these consequences? In the absence of a real plan, we can only speculate, based on a review of the three general approaches to universal coverage: incremental, individual mandate, and single payer. This sobering exercise quickly reveals just why the amendment's proponents avoid specifics so assiduously.

The incremental approach, which we are now pursuing, has worked to extend insurance coverage to specific populations, but is hardly suited to fulfilling a constitutional mandate for universal coverage. An employer mandate to provide health benefits for all employees, a key component of more extreme incremental approaches, has won initial approval in a number of states, including Massachusetts, only to be abandoned because of its negative implications for economic competitiveness and jobs. This employer requirement is in place only in Hawaii, which has no neighbors and whose economy is based on industries that cannot readily relocate to New Hampshire or Arizona—but Hawaii's uninsured rate has nevertheless remained comparable to ours. Not only has this approach been rejected here and elsewhere, where implemented it has failed to deliver.

The second approach is an individual mandate, hinted at by the proponents, which would require everyone to purchase health coverage, with state assistance if necessary. This is analogous to auto insurance—except that there would be no choice about participating; some people opt not to have cars. Also, the language of the proposed amend-

ment requires insurance providing “coverage for all medically necessary preventive, acute and chronic health care and mental health care services, prescription drugs and devices.” Individuals forced to buy health insurance would have no option other than the most high-end, comprehensive policy (Lincoln Navigators for all!) at an exorbitant cost, either to the individual or to the state, which would have to subsidize this purchase for those who can't afford it.

The third approach is a “single payer” plan, which might involve a state takeover of insurance and reimbursement or even a completely government-run health system. But the state's track record on the insurance program it already runs is nothing to brag about. The Commonwealth is currently funding its MassHealth obligations at about 70 cents on the dollar, to the great distress of hospitals and other providers. The touted administrative efficiencies of single-payer insurance amount to one-time savings approximating a single year's increase in health insurance premiums, hardly enough to finance coverage for half a million uninsured.

A more direct government takeover of health care would produce a system that is not only compulsory, but monopolistic, with much less independence for physicians and patients, and much more control vested in bureaucracy. In Canada, most private health insurance is banned, prices are controlled, and physician fees are set by government. Waiting times for referrals are high and rising, far beyond anything that would be accepted here. Tellingly, Canadians favor their system *in principle*, but are deeply dissatisfied in practice.

It is clear that any plan to achieve universal health coverage would entail radical changes to our existing health care system—especially if the promised savings are to be realized. The public has a right to some sense of what those changes would be, and what they might cost; the proponents of change have a responsibility to offer a vision, rather than calling for a leap in the dark. It simply will not do to say, “No price tag can be accurate until the Legislature and stakeholders design the new system,” and to reject all attempts at analysis. No state, no household can afford to conduct itself that way. In the absence of a real plan, the test is not “accuracy” but reasonableness—and the estimates I have seen are reasonable attempts to assign some dollar values to an intentionally slippery proposition.

Even the highest estimate, up to \$47 billion (twice the size of the entire state budget), easily meets the test of rea-

sonableness. This figure comes from an independent academic study prepared before the present proposal was advanced, and it takes account of the certainty that if Massachusetts were the only state with universal coverage, it will find itself caring not only for its current population, but for an influx of people from other states who lack insurance and need very expensive treatment. The figures that are flimsy are the ones used by the proponents to claim offsetting savings. What they are really asking the voters for is a blank check.

Who will decide what the new system is like, and what it will cost? Ultimately, the courts. The proponents, enthusiastic about legislative control, cite the constitutional case on education (*Webby, McDuffy*, now *Hancock*) as an example of judicial restraint, which it surely is not. The case has been in the courts for 26 years. The Supreme Judicial Court's 1993 decision has required the Commonwealth to expend billions of additional dollars on education, and the April ruling that children in poor districts are still short-changed educationally could force legislators—who are already struggling to balance the state budget in a difficult economy—to labor under a huge new spending mandate. Because the enterprise of public education for children is only a fraction of the size of the health care system treating

everyone, the fiscal exposure on health could be much greater.

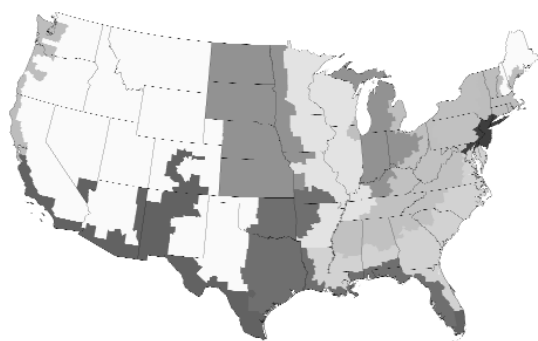
Following the failure of national health care reform a decade ago, Massachusetts and other states returned to the local, incremental approach to extending insurance coverage. The business community has supported and continues to support this strategy, which has been successful in reducing lack of coverage among our citizens. True universal coverage, however, can only be achieved on the federal level. A single state is too constrained by federal law, by resource limitations, and by competitive economics to take this plunge alone—and to do so by constitutional mandate, with no option of changing course, is to court disaster.

To apply a constitutional amendment, the bluntest of political instruments, to something as delicate as our health care system is incredibly risky. Four years ago, voters narrowly rejected a ballot question that would have swept away the existing health insurance system as a way to force legislative action. This proposal, perhaps less threatening on the surface, is, if anything, even more dangerous. It deserves to be rejected as well. ■

Richard C. Lord is president and CEO of Associated Industries of Massachusetts.

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Consuming Kids: The Hostile Takeover of Childhood

By Susan Linn

New York, New Press, 304 pages

REVIEWED BY GREGORY LAUZON

In 1984, the Reagan administration deregulated advertising on children's television, allowing networks to create programming for the purpose of selling toys to children. Within just a year, the top 10 bestselling children's toys were all based on—surprise!—television shows.

Such is the power of the media over young hearts and minds, says Susan Linn in her book *Consuming Kids: The Hostile Takeover of Childhood*. An instructor in psychiatry at Harvard Medical School, associate director of the Media Center at Judge Baker Children's Center, co-founder of the coalition Stop Commercial Exploitation of Children, and yes, a parent, Linn's message is this: The onslaught of commercial media on kids, and the disastrous consequences that ensue, are not as bad as you think; rather, they are far, far worse.

While television is the chief

marketing now identify “alpha” children—those deemed “cool” by their peers—and provide them with free product samples to show off to friends). In fact, Linn posits, advertising has so thoroughly suffused our culture that most of us—adults as well as children—scarcely notice it anymore. And that's just the way the industry wants it.

“Influencing choice while creating the illusion that our choices are not being influenced is the whole purpose of advertising,” Linn writes.

And if adults are unknowingly susceptible to advertising's hypnotic influence, one can reasonably assume that children—who, depending on their age, may not even be readily able to

be ever more creative and persistent in order to connect with them.

But Linn argues that “the industry confuses—or pretends to confuse—the trappings of sophistication with maturation.” An 8-year-old may yearn to look like a miniature teenager, and

she may be able to toss off grown-up catchphrases from television like an expert. But she's only just recently learned to read and it will be years before she is truly ready for the realities of adolescence. Either kids are somehow maturing far more quickly than ever before in history, or they are being rushed

through the only childhoods they'll ever have.

Parents may share some complicity in their kids' dash to adulthood, but they are unwilling accomplices at best. According to Linn, what really drives the trend are the imperatives of advertising. For marketing convenience, the industry tends “to group six- to eleven-year-olds together (or eight- to twelve-year-olds) as a one-size-fits-all target audience for everything from food to clothing and toys to MTV,” she writes. One need not be a child-development expert to know that there is an enormous difference—cognitively, emotionally, and physically—between a 6-year-old and an 11-year-old, or even an 8- and 9-year-old.



Kids are being rushed through the only childhoods they'll ever have.

offender, both in its ubiquity and efficiency in delivering corporate-sponsored messages, it is by no means the only bogeyman, Linn writes. Other electronic media—radio, audio CDs, computer software and videogames, and the Internet—are culpable as well, along with print advertising, billboards, clothing, and even other kids (corporations on the vanguard of what's known as viral

distinguish between reality and fantasy—are nearly defenseless. For that reason, Linn argues, advertising to them is unconscionable, unethical, and, she urges, ought to be (as it once was) illegal.

Marketing professionals will tell you such complaints are overblown. Modern kids, they say, are far more sophisticated consumers than previous generations, so marketers must

On a practical level, what this leads to is the phenomenon, by now well recognized by marketers and children's advocates alike, of kids "getting older younger," with the products migrating along with their tastes. As an example, Linn cites the runaway success of a line of highly stylized dolls called Bratz, which were introduced by a small (now much larger) toy company, MGA Entertainment, to fill the gap created when the appeal of Barbie dolls started skewing ever younger, finally reaching preschoolers.

"The Bratz hit the market as the brand that was going to bring tweens [10- to 12-year-olds] back to doll play," Linn writes. "They are hip and sexy—much sexier than Barbie... On the official Bratz website, they are posed to show off their lush butts and melon-sized breasts."

But now the Bratz are following in

Barbie's footsteps, moving their way down the age range. "The sexy little Bratz are bestsellers for five- to seven-year-olds, who are now going to be getting even older even younger," Linn reports.

The Bratz example certainly hit home with this reviewer. As an editor at *FamilyFun*, a national parenting magazine—one that is, editorially at least, intended as an antidote to consumer culture—I have written favorably about Bratz. I've stood in MGA showrooms, nodding approvingly as marketers showed me the latest Bratz products. I have given Bratz dolls to my 8-year-old niece (which she happily accepted). But after reading *Consuming Kids*, I will choose my words carefully the next time I write about these products. And my niece won't be getting another Bratz windfall, at least not for a few more years.

Selling sex to ever-younger children is the, well, sexiest charge Linn makes against marketers, but it's by no means the only one. In chapter after chapter, she shows how American corporations sell kids on fast food, violence, tobacco, and alcohol. She details how advertising has crept into our public schools, mostly through Faustian bargains struck by cash-strapped administrators.

Even the unborn are not safe from consumer indoctrination. Linn talks about a book called *Oh Baby, the Places You'll Go! A Book to be Read in Utero* that "informs" the fetus about the wonderful Dr. Seuss books that await it in the world outside the womb.

Not that Linn buys it; in fact, she dismisses the entire Baby Einstein-to-Mozart Effect continuum of products as more placebo for parents than means of grooming genius in

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—*Boston Herald*, February 6, 2004

HEINZ FAMILY PHILANTHROPIES

the cradle. But even if these baby-boosters don't have their intended effects, Linn wonders about the unintended kind.

Discussing *Baby Gourmet*, a video series that introduces "little ones to beautiful fruits and vegetables," Linn allows that the tape "seems to have been created out of the best inten-

tion of puritanical, scorched-earth morality. "I love satire and, as my friends and family know, get a kick out of irreverence," writes Linn. "I even liked the extremely violent movie *Pulp Fiction*, which I thought was a funny and provocative commentary on, among other things, the mundanity of evil, but I wouldn't

'Pester power' is a perfectly acceptable tool among advertisers.

tions," and if directed at age 2 and over, would be no worse than "just one more unnecessary children's video series on the market. At best, it might be beneficial to kids." To her, however, the whole idea of media bombardment of infants is troubling. "Until we know how babies respond to television, it's irresponsible, and potentially harmful, to create video programming aimed specifically at them."

One wonders why Linn is even that charitable, especially after the chapter in which she details how marketers not only create in children a desire for products, but also, by exploiting family dynamics and kids' needs for autonomy, teach kids how to wheedle them out of their parents.

Referring to a 1998 study intended to help retailers boost sales by making kids more demanding, Linn writes, "We might hope that 'The Nag Factor' was an aberration. It's alarming to think that people would actually want to wreak havoc in families just to make a buck, but exploiting the nag factor—or 'pester power,' as it is also called in the industry—continues to be a perfectly acceptable tool from the marketers' point of view... If advertising executives have any doubts about 'pester power,' these seem to center only on whether it's effective, not whether it's ethical."

Linn's measured comments on such egregious tactics make her case that much stronger. She also asserts that she is not speaking from a posi-

tion of puritanical, scorched-earth morality.

One suspects that most children haven't, but the same couldn't be said of another of Linn's favorites. "As a show for adults, *The Simpsons* often serves up good social commentary, but that doesn't mean it's a great program for kids. The problem? Humor on *The Simpsons* is rooted in irony and satire, neither of which is readily understood by children... Until the age of about six, children are unable to understand verbal irony even when it's delivered in a markedly sarcastic tone. Irony and satire in *The Simpsons* is much more subtle than that."

Many of the points Linn makes are, or ought to be, obvious. It's easy to see why 5-year-olds should not be encouraged to act "sexy"; in the face of a childhood epidemic of obesity, toys and ads that equate fast food with fun are certainly counterproductive. Everyone can probably agree that programming and products that glorify violence are at least problematic.

But the commercialization of childhood raises subtler issues as well. Linn shows how our increasingly prepackaged culture is in itself bad for kids. "Play comes naturally to children," she writes. "They play—often without knowing they are doing so—to express themselves and to gain a sense of control over their world. But play is continually devalued and stunted by the loud voice of commerce."

Here, Exhibit A is Harry Potter. Upon publication of the first book in the series, Linn writes, "millions of children experienced the world of Harry Potter essentially in silence, the stillness broken only by the rustle of pages turning or the quiet murmur of someone reading aloud." All that came to an end with the Potter movie and merchandise blitz.

Of course, Hollywood has been turning books into movies for decades. But these days, a movie and the spin-offs it leads to fill in the gaps that used to be filled by kids' imaginations. Now, what we have are "products, products, and more products," Linn writes. "Puzzles, board games, dolls...computer games...candy, costumes, socks, shirts, boxer shorts, backpacks, calendars, duffel bags, and rolling luggage."

Thirty years ago, a child might find under the Christmas tree a nameless, stuffed doll, to which she could imbue any personality and history she liked. Today, products such as Bratz—or even the relatively wholesome American Girls dolls—come scripted with ready-made histories, personalities, and play patterns. How many children will feel compelled to imagine an ordinary household broom as Harry Potter's trusty Nimbus 2000 when the "real thing" is being hawked on television? Even Lego blocks, Linn points out—which are often regarded as an open-ended, brain-building toy—are now nearly always packaged as a kit with instructions that imply a "right" way to assemble them.

So what to do? And who to do it? The last thing Linn wants is to put the onus on parents to counteract the onslaught of consumer messages. "When it comes to mitigating the harms to children caused by advertising the easiest solution is to blame parents," writes Linn. "It's certainly what the industry

loves to do. Yet how can one family, alone, protect their children from an industry spending \$15 billion annually to manipulate them?" Linn suggests that society needs to start thinking about the problem from the bottom up: What's best for kids? "From that perspective," she writes, "the answer is simple. Let's stop marketing to children."

Linn recognizes that it will be difficult to wean corporate America from such a captive audience, but not impossible. "I can almost hear a chorus of responses...ranging in tone from despair to outrage to condescension," she acknowledges, preemptively. "It's anticapitalist! It's anti-American! What about the First Amendment? Let the industry regulate itself!"

But to her, the principles involved in protecting children from commercial exploitation override free-

market bromides, and thus have the power to win the day. "Just because marketing to children is a fact of life at this moment in time does not mean it always has to be that way," writes Linn. "At various points in our country's history, societal ills from slavery to child labor were all a fact of life. They are no longer."


In the short term, Linn does offer some strategies for parents who want to keep the marketing beast at bay, at home and in the community. First, she advises, take a close look at our own behaviors. If kids see their parents relying on material possessions for happiness, we can hardly expect them to act differently. And, not surprisingly, Linn insists that setting limits on television watching "is the single most effective thing we can do to reduce children's exposure to advertising." Outside the home, parents should actively engage their neighbors

in dialogue about media saturation, and strive to make schools a safe haven from commercialism.

Achieving significant political or legislative change, of course, will be much more difficult. Still, Linn points out that many countries have enacted effective bans on advertising to kids. Sweden, Norway, and Finland forbid marketing to kids under 12. The Canadian province of Quebec forbids it for kids under 13. And in Greece, televised toy ads are banned from 7 a.m. to 10 p.m.

"Banning marketing to children may seem to be quite radical," Linn says, "but it really isn't." She's right. In the face of the evidence collected in *Consuming Kids*, what's really radical is that we allow marketing to kids at all. ■

Gregory Lauzon is a staff writer at FamilyFun.



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The Access Project
Ad Hoc Committee to Defend Health Care
Alliance for Multicultural Integration
Baystate Medical Center
Berkshire Health Systems
Beth Israel Deaconess Medical Center
Boston Area Rape Crisis Center
Boston Health Care for the Homeless Program
Boston Institute for Psychotherapy
Boston Medical Center
Boston Public Health Commission
Boston Urban Asthma Coalition
Brandeis University/Heller School
Brigham & Women's Hospital
Brighton-Allston Mental Health Association
Brightwood Health Center
Brockton Neighborhood Health Center
The Brookline Center
Cambridge Health Alliance
Cancer Connection
Cape Cod Free Clinic in Falmouth
Caritas Carney Hospital
Caritas Good Samaritan Medical Center
Child Care Resource Center
Children's Friend and Family Services
Cushman Square Health Center
Community Action Committee of Cape Cod & Islands
Community Partners
Cooley Dickinson Hospital
Dimock Community Health Center
Dorchester House Multi-Service Center
The Duffy Health Center
Dukes County Health Council
Ecu-Health Care
Family Health Center of Worcester
The Family Van, Harvard Medical School
Fenway Community Health Center
Franklin Community Action Corporation
Free Health Care Center
Geiger Gibson Community Health Center
Gloucester High School/School-Based Health Center
Great Brook Valley Health Center
Greater Lawrence Community Action Council
Greater Lawrence Family Health Center
Greater New Bedford Community Health Center
The Guidance Center
Hallmark Health

Hampshire Community Action Commission
Health Access Collaborative of Southeast Massachusetts
Health and Education Services
Health Care For All
Health Law Advocates
HealthCare Dimensions Hospice
HealthFirst Family Care Center
Healthy Malden
Helping Our Women
Heywood Hospital
Hilltown Community Health Centers, Inc.
Holy Family Hospital and Medical Center
Holyoke Health Center
Holyoke Hospital
Home Health VNA
Island Health Plan
Jeanne Jugan Residence/Little Sisters of the Poor
Jewish Family & Children's Service
Jewish Memorial Hospital and Rehabilitation Center
Joint Committee for Children's Health Care in Everett
Jordan Hospital
Joseph M. Smith Community Health Center
Kit Clark Senior Services
Latin American Health Institute
Lawrence General Hospital
Lowell Community Health Center
Lowell General Hospital
Lynn Community Health Center
Lynn Health Task Force
Lynn Public Schools
Marlborough Hospital
Martha Eliot Health Center
Massachusetts Community Health Worker Network
Massachusetts Department of Mental Health
Massachusetts Housing and Shelter Alliance
Massachusetts Immigrant and Refugee Advocacy Coalition
Massachusetts Law Reform Institute
Massachusetts League of Community Health Centers
Massachusetts Senior Action Council
Massachusetts Society for the Prevention of Cruelty to Children
McLean Hospital
The Mercy Hospital
MetroWest Latin American Center
MGH Chelsea Health Care Center

MGH Revere Health Center
Mid-Upper Cape Community Health Center
Morton Hospital and Medical Center
Neponset Health Center
New England Medical Center
Nueva Esperanza
The Open Door Free Medical Program
Outer Cape Health Services
The Outreach Van Project
Paraprofessional Healthcare Institute
Parent/Professional Advocacy League
Partners for a Healthier Community
Planned Parenthood League of Massachusetts
Prevent Blindness Massachusetts
Quincy Medical Center
Saint Anne's Hospital
Saints Memorial Medical Center
The Samaritans of Boston
Sisters of Providence Health System
South Cove Community Health Center
South End Community Health Center
South Middlesex Legal Services
South Middlesex Opportunity Council
South Shore Mental Health
Span, Inc.
Springfield Southwest Community Health Center
St. Francis House
Stanley Street Treatment & Resource
Steppingstone
UMass Memorial Health Care
Union Hospital
United Way of Massachusetts Bay
Upham's Corner Health Center
Urban Medical Group
Vietnamese-American Civic Association
VNA & Hospice of Western New England
VNA Care Network
VNA of Cape Cod
VNA of Middlesex-East
Voice and Future Fund
Wayside Youth & Family Support Network
Whittier Street Health Center
Women of Means
Women's Educational and Industrial Union
Worcester Communities of Care
Youth Opportunities Upheld
YWCA of Lowell

The Blue Cross Blue Shield of Massachusetts Foundation is pleased to support these organizations that are dedicated to finding innovative ways to expand access to health care for low-income, uninsured, and underserved residents of Massachusetts. We applaud their creativity and commitment.

