

Letters to the Editor

Mental Health Reform

To The Editor:

Congratulations on your September/October, 2003 issue focusing on Mental Health Reform, a masterpiece of diplomacy. Unfortunately it left out input from, or representation of programs which have been closed, staff who have been discharged or have left and patients who have been informed they will no longer be provided services. Reform is needed, but we need to reform the current implementation. We need to reform the reform.

Doctors Swartz and Morrissey refer to the “mental health care system” as having lagged behind the rest of the nation. In fact the initial development of what was to become the mental health system was a model for the nation in the early 1970s but has remained a “nonsystem”. In his book, *People, Patients and Politics*, Clark Cahow, reviewing the history of North Carolina mental hospitals from 1848 to 1960, cites the need to “comprehend the complex interplay in the roles of the Governor, the Commissioner [now the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS)], the Legislature and the medical centers.” Further he states “future leaders must remain aware of the continual necessity to sell the concept of this relationship to the ever-changing political community.” Unfortunately, Mental Health has suffered from a lack of leadership from the Governor’s office, administration, the Legislature and the medical centers, since the reorganization of state government at the tail end of Governor Bob Scott’s tenure.

The current implementation of “Reform” is in the process of creating a new bureaucracy in the form of Local Management Entities which will not provide direct services. Moreover it has made divestiture and privatization primary goals, supplanting quality direct patient care and invites corruption in place of what at times may have been misguided efforts to provide services in a few area programs. Doctor Visingardi’s article is brief and cryptic, and refers to “managers of public policy,” “divesting public service,” as activities operant in moving forward. He closes with a question: “Have we positively contributed



to the lives of people with disabilities and their families?” The answer to that at present is not only NO, but we have contributed negatively. His propensity to issuing multipage memoranda, stifling employee input, and issuing invitations to state-level meetings take the place of a process of interaction with the people to be served and serving.

Representative Insko reminds us that the Auditor’s report related to two major issues, a lack of accountability among the local area authorities and the state’s excessive reliance on our state institutions. Both, in fact, are failings of state-level leadership. If the benign neglect of the past continues, the only thing that will come of these efforts will be increased chaos. Perhaps in our more urban areas where political, professional and consumer and public leadership is substantial, what is good will be salvaged. Mr. Campbell (State Auditor) clearly identifies problems of “no funding to create programs” and the fact that “mental health programs had been underfunded for years.” He emphasizes “the local structure for providing services must be in place this time as we shift care back to the community.” However, reform implementation proceeds without funds and alternative services in place. Ms. Flamino provides clarity regarding the separateness of the non-system of mental health, homelessness and criminal justice, a dynamic sure to continue to obscure the true needs.

Dr. Bridges, the long-term optimist, neglects to say that the program of Vance, Granville, Warren and Franklin Counties where he served for over 20 years has been dismantled and the staff discharged without adequate alternative services, only one example of program closures. “A Parent’s Tale” provides ample

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substance and argument for the fact that state/local funded and operated services will always be necessary and the unfortunate likelihood is that those individuals affected by mental illness, developmental disabilities and substance abuse will continue to be the lowest priority of leadership. In view of this it seems that parsimony when it comes to the elaboration of bureaucracy and preservation of current staff and services must assume primary roles.

Finally, it is no coincidence that the golden years of the early 1960s to the mid-1970s saw the Division of MH/DD/SAS led by a number of highly respected licensed medical doctors. The deterioration of the nonsystem occurred parallel to the systematic removal of physician positions. The current reform has been without a physician at the state level until recently, when, after relenting to pressures from the NC Medical Society and NC Psychiatric Association along with that of consumers, one position has been advertised. Consistent with this policy to abolish medical doctors from leadership in programs which are medical, the entire Division continues without a physician director which the General Statutes still called for the last time I looked.

— Nicholas E. Stratas, MD
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The Cost of Prescription Drugs

To The Editor:

I have been reading your latest issue (Vol. 64, No. 6), which is a nice job. I liked the Ingram, Hooker Odom, and Millstein pieces in particular. I disliked Marks, whose European perspective shines through as smug superiority; I don't recall any acknowledgment of the Europe-as-free-rider hypothesis.

The Oberlander piece oversimplifies some things. For example, I don't quite accept the parallel between the original enactment of Medicare and the new drug benefit. To be sure, Congress in 1965 did appease the medical/hospital monopoly and leave costs for future attention. The new bill, however, instead of leaving the



cost issue completely unaddressed, tries to provide some competitive alternatives to price controls on drugs. Original Medicare left the BCBS models in place, and made no provision for competition, which entered the picture only with the HMO Act, the antitrust initiative, and the Reagan administration's attempt to bring HMOs into the program. The new law certainly will hasten the coming train wreck, because there is nowhere near enough money to pay for the entire entitlement package for all who will be entitled to it. Inviting a crisis may not be a bad idea, however, since no one wants to reform Medicare until they have no option. Oberlander may be right that the Democrats will eventually impose drug price controls (he might at least have acknowledged that there's a downside to squeezing industry profits), but it's more likely that the crisis will be of such a magnitude that the whole entitlement philosophy will finally have to be rethought, with a shift to defined contributions—the obvious solution.

In general, the problems with drugs, especially the high cost of promoting them and their inefficient use, lies in the professional paradigm, which says that doctors should make all the choices (perhaps with some input from non-cost-conscious patients) and that health plans should be limited to pleading from the sidelines. Most all of our problems lie ultimately, of course, in a payment system in which health plans are barred from acting as purchasing agents and must be simply payers (at negotiated prices, perhaps) for whatever professionals deem necessary to protect our health.

— Clark Havighurst, JD
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