THE DEMOGRAPHIC REVOLUTION OF HEALTHCARE
Proceedings of the 14th Annual Managed Healthcare Symposium

Support by an unrestricted educational grant from AstraZeneca
The Aging Generation
Will Be Like No Other Before It

Thank you for your interest in our 14th annual Managed Healthcare Symposium, the Demographic Revolution of Healthcare. As America ages, the delivery of healthcare will change dramatically. The implications are far reaching, and we have already begun to feel the effects. At the November symposium in Scottsdale, Ariz., which was accredited for continuing education by the University of Arizona Colleges of Medicine and Pharmacy, several of the foremost experts in the country were brought together to speak, to debate, and to discuss the important issues arising from this demographic shift and their impact on the business of healthcare.

In this special continuing education supplement to MANAGED CARE, you will have the opportunity to read what leading experts say about emerging demographic issues. Ken Dychtwald, PhD, defined the empowered aging healthcare consumer and characterized this group’s lifestyle, generational mindset, and expectations. His eye-opening presentation crystallized the momentum the “age wave” is gaining, and set the stage for the exchange of information and ideas during the symposium. J. Lyle Bootman, PhD, then addressed the need for providers and patients to collaborate to ensure the value of drug therapy, while recommending that payers remove barriers that impede quality improvement and focus on best practices and outcomes. Once the issues were identified, a panel of experts tackled a complex case study that illustrated how present and pending healthcare legislation and aging issues will affect payers, providers, and patients. The group identified potential solutions to the challenges we all face.

AstraZeneca, a pharmaceutical leader, is committed to bringing you valuable educational programs that provide insights and innovative solutions to assist you in formulating strategies to meet corporate goals. We hope some of the ideas presented in this supplement will be useful to you in your daily responsibilities.
The Demographic Revolution of Healthcare
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About this publication
This MANAGED CARE continuing education supplement is based on information presented at the “Demographic Revolution of Healthcare,” a symposium in Scottsdale, Ariz., Nov. 8–11, 2001, and attended by health plan medical and pharmacy directors, pharmacy benefit manager executives, physicians, pharmacists, employers, and representatives of the pharmaceutical industry.

The opinions expressed herein are those of the symposium faculty, and do not necessarily reflect the views of AstraZeneca, the University of Arizona Colleges of Medicine and Pharmacy, or the publisher, editor, or editorial board of MANAGED CARE.

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This supplement is supported by an unrestricted educational grant from AstraZeneca.
During her one-year hitch at a South Pole scientific-research station, Jerri Nielsen, MD, discovered a lump in her breast. For four months, she could not be evacuated because of harsh weather conditions. Communicating with U.S. medical professionals via e-mail until she could be flown out of Antarctica, Nielsen performed self-biopsies and, after her colleagues transmitted cell images to an American physician, she began chemotherapy.

As Nielsen relates in her book, *Ice Bound*, and in this presentation, an important aspect of medicine is the fact that medical professionals need and learn from each other.

For a long time, I felt lost in the conglomeration of big medicine. I was a cog in a machine, wondering how meaningful I was. “As a physician, can I practice medicine by myself?” I thought. “Can I survive without specialists and without a nurse?”

I thought I was born too late. I wanted to be a doctor who went across the Sierra Nevada in a wagon train. I wanted to test my own skills on the frontier. I wanted to be Dr. Quinn, Medicine Woman! I didn’t care if Antarctica was a one-way ticket to nowhere; I wanted to go where no man had ever gone before.

I learned, though, that you never want a one-way ticket to nowhere — in this case, to be a physician without other physicians, ancillary support, and all of the people
who make American medicine the very best anyone has known. Without those people, I could not have survived. In the end, modern medicine came to me; thus, I was not by myself.

Admiral Richard Byrd said of the South Pole, “The pole is nothing. It is the journey that matters.” I learned that it was the journey inside of me that mattered. It had nothing to do with getting there, but with staying, understanding the place, and surviving. And coming to peace with the things that you cannot change.

What I came to understand after I got back home was that Antarctica is not the last frontier. The frontier is in man’s mind.

At the pole, the most important thing you can have in life is a skill. You don’t have to be good at it, but knowing what you can do and that you can do it — or at least that you can learn it — is the trick to survival.

There is a sense in the United States that unless you can be the very best, you shouldn’t even try: *If you’re short and fat, you shouldn’t learn to dance because you will never be on Broadway.* What happened to the concept of being good enough at many things? That’s what enriches life, that’s what develops a person’s career, and that’s what makes a community happen. The ballerina who’s short and fat might end up running the local area’s arts program.

If you have any chance to learn something, take it. If you have a chance to be under someone who knows a lot and you know nothing, throw yourself into it, because someday you’ll be happy that you’re knowledgeable about it.

I remember, as a young doctor, having to learn medicine from a very old, old, old man. And it wasn’t easy, because I was a young, young, young girl. I learned many things about how medicine was practiced in the 1940s, which I thought were useless. When I was at the South Pole, it turned out, I was glad to have learned those things.

**Needing each other**

One of the things you soon realize at the South Pole is that you’re never alone. You have no privacy there. The dome we lived in was built by the Navy to house 17 people; we were 41. When you heard someone turn over in bed, you thought, “I know who that is because I know how he turns over in bed.” When you heard someone unzip his pants, you thought, “That’s Johnny, because I know how he unzips his pants. Now he is going to walk over to the…” and you know exactly where he’s going, because there is nothing else to think about.

So, soon, you learn that the only thing you really own is what’s inside your mind. That’s always been true, but life at the pole makes it more obvious.

On the way to Antarctica, I had rich fantasies, imagining myself in different situations and thinking, “I’m an Antarctic explorer.” I knew I was really just an emergency physician from Ohio, but I was still impressed with myself — until I saw my hospital in Antarctica. In my hospital, the floor was ice that was two miles thick.

Many of the people I was with are called polies. Most polies are people who have been in the Peace Corps, military children, missionaries’ children, or simply are global wanderers. Many of them live for a year at the pole then travel to the Third World until their money is gone, then they return to the South Pole.

There also are people called bipolars. Bipolars live in the Southern Hemisphere during its summer, then go to the Northern Hemisphere for its summer and work at a national park in Greenland. They go back and forth — it’s an endless summer.

Polies believe that everyone is necessary. They don’t see color or country boundaries. A lot of people ask me, “Why aren’t there two doctors at the South Pole?” But what
good is a doctor there, anyway? If you fell from a roof, maybe I could help you. But without a medical system, a nurse, an intensive care unit, an X-ray machine that works, and a tech who knows how to take X-rays, my chances aren’t very good.

But try to live at the pole without your power plant mechanic who makes the heat, or without the machine operator who runs the equipment that makes your water. We need everybody’s skills. One person’s education does not make him more useful to society than other people. But together, we are capable of mind-boggling things. I can only do emergency medicine, and I can’t do that by myself.

Less obvious is the fact that we need each other’s personalities.

I remember a man there who had a type-A personality. As we were talking about disaster planning, he said, “Don’t worry, if the dome burns, we’re going to walk out. Just follow me, I know the way to go.” I’m glad he’s with us, I thought.

And then there was a lady who was very quiet and unassuming and seemed to have no opinion on anything. I thought, “There are 41 people to survive here for a year and we get her?”

But in the dark, no way out, no privacy, no baths, nothing to think about except the other people for a year, the type A turned into a wild animal in a cage, pacing and making all the other animals anxious. The unassuming woman emerged as a leader. She taught us charity, patience, clarity of thought, and the ability to give credit to people who need it or they will go crazy. At the pole, we took everyone’s strength and used it for the good of the group. We protected the group from people’s weaknesses.

I once dated a person who alphabetized his steak sauce. But if you don’t have somebody like that — somebody who does the filing and keeps things in order — you will not be able to find your things when it’s dark and 100 degrees below zero. So you need that person, too. You need everybody.

In life, the first thing that matters is food. After food, a person needs shelter. Next, you need people. You need each other, you need the group. We are pack animals.

In a hospital, when a physician writes “foot” on an order sheet, an X-ray of the foot is taken by someone who knows how. It is developed and given to someone else to read. Someone types that up and it comes back to you on a piece of paper that says “negative.” As circuitous as this seems, being able to rely on each person with a role to play in the system is a wonderful thing that should not be made light of.

What made me comfortable living in Antarctica was the concept that I had knowledge of each person. I understood the system.

Going with the flow

In my hospital at the South Pole, the equipment was all on one side of the room. It wouldn’t start out that way. I’d place the gurney in the center and the lamps in the center over the gurney. But all the buildings at the South Pole shift because the ice is constantly moving, so everything is going downhill.

I used to have rigid ideas about medicine; as professionals, don’t we all? I actually believed that if I was going to repair a complex laceration of a face, that I needed a good light! At the pole, I made myself miserable; I took that lamp, stood at the head of the bed, wrapped my leg around the lamp and then tried to repair the laceration.

Well, about the time I would get the lamp under control, the Mayo stand with all my instruments on it would take off and crash into a wall. That’s when I had a
real problem: I was scrubbed, with nobody to help me and retrieve the Mayo stand. Remember, I wanted to be alone.

So one day, I gave up. I took my equipment and put it where I wanted it, and I went to eat. When I came back, wherever it was, was where it was going to be. That’s what you learn at the pole. That’s what we all have to learn as we go through an uncertain time. If you can get to that point — where you can say, “That’s the way things are,” everything works out. So I started operating against the wall. It worked fine. The lamp went nowhere. It was against the wall, too.

When I was at the pole, I thought, “I am dealing with extraordinary people. They can work through any kind of problem. I feel safe here, because I am around people with different skills and they will let me survive.”

But when I returned home, I realized that they weren’t extraordinary people. They were ordinary people in an extraordinary place. They did nothing that anyone else wouldn’t do in the same situation, because we all are capable of phenomenal strength and resiliency. We also possess amazing problem-solving skills. These people weren’t special. They were just people. I was just a regular girl from Ohio. Walt was a welder from Maryland. I taught him to operate — and he did just fine.

It has been documented that a person loses 13 percent of his memory for each year spent at the South Pole because of sensory deprivation. I did lose 13 percent — or more — of my memory. But my problem-solving ability went sky high.

**Cancer, like drowning**

I speak to a number of cancer groups, and I tell them that having cancer is a wonderful thing because it teaches you what’s important in life. It enriched my life beyond anything I could ever have come up with myself. It is part of me as much as one of my bad moods. It’s something that gives my life color and texture. I don’t want a life of quiet desperation. I want to live.

I liken cancer to drowning. When you first start to drown, you think, “I’m going to drown!” Then you fight and claw and try to take your lifeguard and drown him, too. If it’s some other problem, you try to take down your friends and family.

But if you are lucky, you realize that the river is stronger than you are, and no matter how great a swimmer you are, it doesn’t matter because you can’t control it. You learn to achieve a state of peace and let the river take you with it, because eventually the water will flip you out. When it does, you’ll be alive or dead. It doesn’t matter, because it isn’t whether, how, or when you die. It’s only, did you ever really live?

If you can get to that place, you don’t worry about anything that will happen.

I see life as an amusement park. Every person gets one admission ticket and chooses her ride. I chose the roller coaster. On the roller coaster, you start by going up: Click, click, click, click. As you rise, you can see the whole park. You can make plans. But you have to be quick, because soon you’re going down, down, down, you bash your head a few times, you come back up — and the ride’s over.

Some people take the merry-go-round. On the merry-go-round, you go around and around and around. Not much happens, but the music is pretty. It’s very predictable — up and down. The good part is, every time you go around, your family and friends are there, waving to you.

It doesn’t matter which ride you choose. You can always get off and go to another ride. You don’t have to stay where you are only because that’s where you are. If you have studied all your life to get where you are, only to put in 20 years, wake one morning, and you discover you hate it, then do something else. Get on another ride.
Continuing Education Section

Continuing education is offered to physicians and pharmacists who read pages 7 through 27 of this publication, complete the self-test on page 28, and fill out the appropriate evaluation form on either page 29 or 30.

Course description

This activity is designed to educate healthcare professionals about emerging healthcare issues and demographic trends. The narratives in this section are excerpted from presentations at the “Demographic Revolution of Healthcare,” a symposium in Scottsdale, Ariz., Nov. 8–11, 2001. The symposium speakers and panel members discussed the impact that the aging population, healthcare technology, health policy, and personal choice have on payers, providers, and patients.

Educational needs assessment

Healthcare professionals at the senior management level seek information about current and emerging healthcare issues, changing demographics, and advances in medical and information technology. It is important that professionals understand how this information will shape the delivery and cost of healthcare and the development of national health policy, as these will influence the strategic directions of, and care provided by, their organizations. The symposium agenda was developed on the basis of previous evaluations and faculty perceptions of significant trends or issues.

Target audience

Managed health care professionals, including medical directors, chief medical officers, pharmacy directors, and other senior managers in managed health care organizations.

Educational objectives

After reading this, the participant should be able to:
- Recognize how demographic changes will affect healthcare and have an impact on pharmacy utilization.
- Define political, social, and economic factors that will steer the evolution of health care.
- Identify predetermined elements and recognize critical uncertainties so as to position healthcare organizations for success in a changing health system.
- Articulate how drug-related problems raise the cost of healthcare.
- Describe the original premise of managed care, how and why its role evolved over time, and the challenges the managed care industry faces as a result.
- Illustrate why direct-to-consumer advertising has become an important vehicle for educating today’s increasingly informed health care consumer.

Medical accreditation

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the University of Arizona College of Medicine at the Arizona Health Sciences Center and of Medi-Media USA. The University of Arizona College of Medicine at the Arizona Health Sciences Center is accredited by ACCME to provide continuing medical education for physicians.

The University of Arizona College of Medicine at the Arizona Health Sciences Center designates this education activity for 4 hours in category 1 credit toward the AMA Physician’s Recognition Award. Each physician should claim only those hours of credit spent in the educational activity.

Approval for category 1 credit by the University of Arizona College of Medicine should not be construed as endorsement of any product.

Release date: March 2002, for a period of one (1) year.

Pharmacy accreditation

The University of Arizona College of Pharmacy is approved by the American Council on Pharmaceutical Education as a provider of continuing pharmaceutical education. This program is approved for 3 contact hours (0.3 CEU). Credit will be awarded upon completion of registration form, successful completion of assessment questions (70 percent or better), and completion of program evaluation. If a score of 70 percent or better is not achieved, no credit will be awarded and the registrant will be notified.

ACPE program number: 003-999-02-097-H04.

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Conflict-of-interest policy in continuing education and disclosures of significant relationships

In compliance with this policy, this activity’s faculty has disclosed financial interests, arrangements, and/or affiliations with corporate organizations offering financial support or educational grants for continuing education activities, as well as organizations with direct interests in the subject matter. The following faculty members declare that they have no financial interest, arrangement, or affiliation that would constitute a conflict of interest concerning this CE activity: J. Lyle Bootman, PhD; Donna Boswell; Ken Dychtwald, PhD; Dave Garets; Art Ulene, MD.

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The author of 10 books on health and aging issues, Ken Dychtwald, PhD, has studied demographic trends for 28 years. The baby boom generation, says the founder and CEO of Age Wave, has transformed every stage of life it has entered — never has it been bound to the social dictates of previous generations — and so it will be when it reaches old age. This will have dramatic effects on the emphasis of medical research and the delivery of healthcare.

We are in the midst of a longevity revolution. Two thirds of all the people who ever lived past 65 are alive today. At the same time, fertility rates are declining (Census Bureau 2001a). These trends’ parallel occurrence is unprecedented and will have profound implications on health, disease incidence, and societal expectations about care.

For thousands of years, most people didn’t age; they died. At the start of the 20th century, the average American could expect to live 47 years. By the end of the 20th century, because of remarkable breakthroughs in public health, medications, sanitation, and nutrition, life expectancy had risen to 77 (Figure 1, NCHS 1999).

In the 1800s, couples didn’t have to think about what they would do in retirement. Because many people died young from acute infectious diseases, relatively few people lived long enough to enjoy retirement — let alone struggle with arthritis, osteoporosis, hypercholesterolemia, or Alzheimer’s disease. This is one of the most interesting ironies of medicine: Its effectiveness has swelled the number of people who live with chronic illness. To a large extent, we are not prepared for this shift.
An important consideration for any healthcare executive or practitioner is where business growth will come from. It won’t be from youth. It will be from maturity.

If I had been running a hospital or an insurance group in the 1950s, I would have paid a lot of attention to children, because that’s where the growth was (Census Bureau 2000). In the 1960s, the growth was among teenagers and young adults — a predictable shift in the population bulge that continued with each successive decade (Figure 2).

Jump ahead to 2000 and beyond. Figure 3 illustrates how demographics will change between 2000 and 2020 (Census Bureau 2000). The greater-than-50-percent growth rate of the 55-and-older population will mean that the demands on the pharmaceutical industry, medical technology, insurers, physicians, nursing homes, and assisted living are going to multiply.

The healthcare system hasn’t really had to deal with this group. The number-one reason baby boomers went to the doctor last year was because one of their children had an ear infection. This generation hasn’t yet gotten sick.

Get ready. If you think this generation is going to wait two hours for an appointment; if you think it’s going to accept only one point of view; if you think it’s not going to want its healthcare customized, you’re misunderstanding this generation.

Implications of change

Many people think that acting your age means winding it down, ceasing to be who you were, or — to put it another way — growing old gracefully. Contrarians, on the other hand, think people should grow old rebelliously, because society has established notions about what you can and cannot be because of your age. Today, we see more and more 70-year-old marathon runners, 90-year-old entrepreneurs, and 82-year-olds who get remarried. These people are not acting their age.

The 20th century was a century of youth. The 21st century will be ruled by the new old.

Why do we see ads for antiaging creams and herbs that will shrink your prostate gland? It has to do with the baby boom of 1946 to 1964, which fueled today’s enormous growth in the number of people with wrinkling skin and enlarged prostates. During that span, 10,000 children were born each day on average, 4 million a year, 76 million in all.

We weren’t prepared for the baby boom. We didn’t have any pediatricians — none — it was not considered a valid subspecialty. We see that same debate today about the need for geriatricians. Back then, we didn’t have enough hospitals, physicians, diapers, baby food, or bedrooms.

This baby boom is now rising into an age wave. This year, the boomers will be between ages 38 and 56. The generation of rebellious youth is now into its 50s. Thanks to this group’s
differences from earlier generations — its high level of education, its powerful women, its quirky character, its willingness to try new things — it transforms each stage of life through which it migrates (Dychtwald 1999). Baby boomers will not be 60 or 70 the way their elders were 60 or 70.

If this generation tends to change things as it goes, how will its expectations show up in your practices and customer bases?

With respect to how the age wave is transforming the workforce and demands on the nature of employer-sponsored benefits, boomers compose a generation of educated women, a large percentage of whom pursue careers and manage kids. American society has never experienced that. Further, in 1980, the American work force was much younger (Figure 4); by 2000, nearly half of workers were middle-aged (BLS 1999).

Life is short. Traditionally, we have responded by organizing the assignments of our lives in linear fashion: We learn, we work, we rest, and we die. But what if you knew that you might live another 10 or 20 years? Would you be in a hurry to get to be old, only so you could be old for another 20 years? I have yet to meet one person who has said to me, “I like the idea of increased longevity, because I want to be old for a long time.” What people say is, “If I’m going to live longer, I could be a late bloomer.” Or, “I’d like to be young longer.”

What people really want is to be no age at all. They just want to go about their lives, doing what they dream about doing without being told they can’t just because they’ve reached a certain age.

If people feel that they’re “finishing up” before they die, then they won’t particularly care about their vitality, sexuality, or mobility. But the more people who dream of a new career, who date at age 70, who are 90 and who want to go camping with their grandchildren, then the more people who will come to the healthcare system and say, “Please return my health to a youthful level. Please remove the obstacles to the life I want to live.”

When men pass away, their wives — these new modern women — go through a period of bereavement that lasts about 18 months. Then they pick themselves up, gather with friends, take trips around the world, volunteer at the church, and reinvent themselves. They are not widows. They call themselves solos. Widows were of another generation.

When retirement was first conceived in the 1930s, life expectancy was 63. Retirement was thought to be something that would last a year or two. One of the most profound changes in adult life is the shift from being fully employed to being not employed. People go from having no time to having an abundance of disposable time. Many people who previously had only a few minutes to see theirs doctor suddenly turn it into a hobby.

How do we deal with patients who have an enormous amount of free time? How do we manage our practices so that they’re not draining our time with their questions? Do we have their questions answered by nurses or health educators? Or maybe in a Tuesday night diabetes seminar?

Rather than work every day for decades and then suddenly stop working cold turkey, 86 percent of baby boomers say they want to work in their retirement. It may be volunteer work or a new career. It may be only for

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**Figure 3** Projected change in number of Americans, by age, 2000–2020

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2000</th>
<th>2020</th>
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<tbody>
<tr>
<td>Under 14</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>15-24</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>25-34</td>
<td>7%</td>
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<td>35-44</td>
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<tr>
<td>45-54</td>
<td>38%</td>
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</tr>
<tr>
<td>55-64</td>
<td>13%</td>
<td>73%</td>
</tr>
<tr>
<td>65+</td>
<td>35%</td>
<td>54%</td>
</tr>
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</table>

SOURCE: CENSUS BUREAU 2000

**Figure 4** Workforce age distribution, U.S.

<table>
<thead>
<tr>
<th>Year</th>
<th>16-33</th>
<th>34-54</th>
<th>55+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>15%</td>
<td>50%</td>
<td>35%</td>
</tr>
<tr>
<td>2000</td>
<td>13%</td>
<td>49%</td>
<td>38%</td>
</tr>
</tbody>
</table>

SOURCE: BUREAU OF LABOR STATISTICS, 1999
12 hours a week. But going from being somebody to living a total life of leisure is, for an increasing number of people, not very satisfying.

**Poor return on investment**

While most people don’t like the thought of aging, what they really don’t like is the kind of aging they see around them: one, the idea that they are sent off to the periphery — boomers will not go along with that — and two, disease and disability.

The 10 leading causes of death for people 65 and older are listed in Table 1 (NCHS 2001). But to the boomers, the 10 leading health problems of people age 45–64 (Table 2, NCHS 1998) are equally important. These are the conditions that they struggle with every day and that are sending them to their physicians.

Arthritis tops this list, yet there are only 5,000 rheumatologists in this country, and, by and large, we don’t know what to do with people’s aches and pains. Hypertension, diabetes, hearing, and orthopedic impairments — this is a wake-up call. In the years to come, we’re going to contend increasingly with these conditions.

We have designed a healthcare system that’s extremely good at diagnosing, treating, and reimbursing for acute illness. Yet for most older people, acute events of illness are much less important than chronic degenerative long-term conditions.

The United States spends more money on health per person than any other nation (OECD 2000). In terms of longevity, we don’t produce commensurate results. Why?

We want our doctors to spend resources on us, but we do not adhere to medication regimens, we smoke, overeat, and do not exercise. We have high expectations of our healthcare system, but we don’t expect to have to do much in exchange.

Meanwhile, healthcare has become an activist issue in America. Consumers and patients believe themselves now to be the warriors. They believe you to be their allies. They think of the tools you have as weapons at your joint disposal.

Several years ago, Andy Grove, then the 37-year-old CEO of Intel, was diagnosed with prostate cancer. His physician wanted to operate. Grove said, “Why should we do that?” The doctor thought it was the right thing to do. “That’s not a good answer,” replied Grove, who then built a database of all the therapeutic pathways pertaining to different kinds of prostate cancer. He identified the pathway that was the least risky and produced the best results. He found the practitioner who did the best work in that category and retained him. That’s the future of healthcare.

Patients will want to be involved in decision making. We’re entering a new era — the era of the empowered patient who will also be impatient. How do we take charge of the availability of information to drive patients down the right path?

The only solution is to create a new version of aging that is cost-effective and is what patients want: one that helps them grow old well. It focuses on managing the chronic illnesses that will become much more prevalent as this generation ages.

**Some predictions**

Boomers are warming to the idea that a certain amount of what they might want will be paid out of pocket. The elderly have the lowest level of poverty of any age group (Census Bureau 2001b). In terms of discretionary income, the people who can afford to travel or buy luxury cars and financial products are not the 30-something darlings of Madison Avenue, but their parents and grandparents (Census Bureau 2001c).

A huge fee-for-service side of healthcare will open up, because boomers have always felt that if you want a better ski house or a fancier hairdo, you pay for it. Imagine the idea that you will be able to buy longevity, that there will be classes of medical...
care: In coach, everybody gets the basics; in business class, I get premium service; and in first class, if I can pay $20,000 or $100,000 a year, I can buy youth. It is coming.

What do people want? They want to live longer and to be healthy as they mature. These people don’t want to be carved up or have their bodies doused with chemical toxins. This group wants healthcare that doesn’t hurt. They want it both ways.

My predictions for what new technologies will be in demand?

First: Drugs that diminish the delta between how I want to look and feel, and how I actually look and feel will be most highly sought. Second: Drugs that maintain my performance, the way I live, also will be popular.

Third: Increasingly, people are thinking, “Why wait until I have a condition to do something? Why not take a prophylactic drug now?” If there’s a drug that can prevent disease, you will see this generation pursue it. The genomic revolution will be profound in its ability to match appropriate pharmaceuticals with an individual’s genomic character and in its ability to turn off diseases.

Fourth: Watch hormone therapies. There are now 100,000 Americans who inject themselves daily with antiaging hormones.

Fifth: New tools of medicine will be in great demand. We’re not far from being able to clone individual organs. Instead of passing away because of organ failure, we could transplant our own biologically matched organ. Is that going to happen this year? No. Is it going to happen in the next 10 or 15 years? Yes.

At the end of the day, people are going to ask, “What could I be at 70?” People are beginning to imagine that a 70-year-old can be fit, sexy, and powerful. That’s a big demand on healthcare.

We’re in the most amazing moment of human evolution. We’re living longer, thanks to modern medicine. An enormous quirky generation that transforms every stage of life is moving into its 50s and toward its 60s and 70s, which will place pressure on a healthcare system that will be expected to keep people youthful, vital, and attractive. All of this as chronic disease becomes pandemic.

We will have to develop services and skills to manage the needs of an aging population, while at the same time monitor the use of, and figure out how to finance, amazing new technologies that are starting to appear from all corners. There’s never been a more phenomenal time to be in medicine and to prepare our practices and the healthcare system for that future.

References

All too often, the silo mentality that dominates healthcare financing forces decision making based on numerator information, or what we spend for healthcare, with little consideration for the denominator: outcomes.

The demographic revolution will magnify the issue of safety in medicine. J. Lyle Bootman, PhD, dean and professor of Pharmacy, Medicine, and Public Health at the University of Arizona Health Sciences Center College of Pharmacy, is a world-renowned expert on pharmacoeconomics whose research has focused attention on the economic outcomes of drug-related problems.

I’ve been fortunate to travel to about 80 countries over the last half decade, talking with ministers of health and finance. I have yet to meet one who believes he is spending too little for healthcare. The common belief is that the cost side is out of control, but few policy makers understand the relationships between cost, quality, and access.

It’s my commitment to understand those relationships, particularly between cost and quality relative to pharmaceuticals. In many peoples’ minds, this is a silo — what we spend for drugs stands apart from what we spend for physician care, for instance.

We are too quick to make decisions based on a lack of understanding that these silos are intricately related. Spending more — raising the level of grain in one silo — may actually lower the level, the cost, in other silos.

Several changes in healthcare delivery over the years have complicated these relationships. One fundamental difference is the corporatization of healthcare.

When I went to pharmacy school, I was an independent community pharmacy...
My physician colleagues in medical school would say, “I’m going to hang my shingle across from the hospital, start my own clinic, and have a successful career.”

We have moved from that type of 1920s-through-1950s cottage industry to an environment in which most healthcare workers are employees of corporations that provide healthcare, many of which do so for profit — which is not necessarily a bad word, but for-profit healthcare is far more prevalent now than in yesteryear.

Another dimension of corporatization is that the major purchasers now are large employers — auto manufacturers, oil companies, finance companies, and others.

Two other changes in healthcare have affected, or will affect, the cost-quality-access triangle. One is technology, the impact of which we are just beginning to predict. It will be beyond our imaginations, not only in terms of pharmaceuticals and new agents derived from genetic research, but also in types of equipment, computers, and software that will allow us to monitor and prevent disease and to engage the consumer. The other change is outcomes, where I believe we are turning a corner. Many of the ministers of finance who bring me to their countries desire to move away from the cost paradigm and make decisions of cost versus outcomes. We need to define what outcomes we hope to achieve, whether they are clinical, hospitalization expense, absenteeism, or indirect costs to the workplace, to name a few.

**Return on investment**

We direct more of our gross domestic product to healthcare than do most countries. The question is, what do we get for it? Do we get a better infant mortality rate in the United States than in Japan? No. Infant mortality, though, is not the only indicator of quality. All too often, we make policy decisions relative to this type of “numerator” information — what we spend for healthcare, what we spend for pharmaceutical products — with little knowledge about the denominator, the outcomes.

The United States spends 13.6 percent of its GDP for healthcare (OECD 2001). I don’t know if this is appropriate; likewise, I’m not certain what is reasonable to spend for drugs. Interestingly, in Japan, for every $1 spent on healthcare, 25 cents goes toward drugs, while health spending represents only 7.6 percent of its GDP (Figure 1). The Japanese will also live about five years longer than most of us will.

The U.S. spends about 8 cents on the healthcare dollar for pharmaceuticals, though I see that climbing dramatically in the age of genomics.

I do know that when we spend for pharmaceuticals, there is inherent value. To test this, we could conduct an experiment where all reimbursement for pharmaceuticals is eliminated. We could measure how disease would progress if we wanted...
to save 8 cents on the dollar. How this could modify our healthcare expenditure of 13.6 percent of GDP is an interesting question to ponder.

In this country, we spend about $168 billion a year on pharmaceuticals (Gebhart 2001). Slightly less than a decade ago, it was about $75 billion, meaning that in fewer than 10 years, spending has more than doubled, if $28 billion in over-the-counter and diagnostic regimens are included. This is a booming market.

As baby boomers enter the healthcare market, chronic disease will be on everyone’s mind. Table 1 depicts the number of agents in development for chronic illnesses (PhRMA 2001). Cancer is a high priority, due probably to public policy and fear.

In 1965, you might have seen 20 to 25 agents in development by the pharmaceutical industry. Today, with more than 700 agents in development — and perhaps 7,000 soon with the coming of genomics, it will become very difficult for any practitioner to keep track of all those medications and understand how to use them appropriately. The baby boomers will demand better, cost-effective products.

**Reaching optimal goals**

There has been an explosion of efforts recently to identify cost-effective drug therapies. But do we achieve optimal value? It was my hypothesis in the late ’80s that the value of most pharmaceutical agents diminishes with time.

The reason for this — and the reason we do not achieve optimal value — is simply because of what I refer to as a drug-related problem (DRP); this is defined as any event or circumstance that, actually or potentially, interferes with the achievement of an optimal outcome, such as reducing blood pressure or controlling asthma. DRPs are classified in eight areas (Table 2, Hepler and Strand, 1990). One, failure to receive drugs, includes nonadherence and failure to prescribe.

There are very fine drugs today that can improve health significantly. Statins, for instance, successfully decrease and maintain cholesterol levels. When someone is prescribed a statin, that person can expect to be on a particular agent for life. Yet there is strong evidence to suggest that most patients adhere to statin therapy 80 to 100 days.

If we pay for 80 days of therapy, do we achieve our optimal goal? Do we achieve the value inherent in that class of drugs? No.

**$1 spent, $1 lost**

So, what are the financial incentives to address these issues? The gap between what we hope to achieve versus what we actually achieve is significant. We launched a national drug-related morbidity study several years ago, and we uncovered some interesting results.

Nearly 6 in 10 patients are being treated with pharmaceuticals appropriately. But 4 in 10 encountered a DRP (Figure 2). Many simply did not adhere to therapy. Of this 40 percent, more than half resulted in treatment failures: We didn’t control the blood pressure, for instance, which brought on complications. In 11 percent of the group, we achieved our goal — we controlled the blood pressure, to continue the example — but there were complications related to medication use that led to a new medical problem (Johnson and Bootman 1995).

We followed this group and found that among those who experienced a DRP, there was an increase in hospital admissions, long-term

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**Table 1: Medicines in development for selected chronic illnesses**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number of medicines in development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>28</td>
</tr>
<tr>
<td>Asthma</td>
<td>21</td>
</tr>
<tr>
<td>Cancer</td>
<td>402</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>18</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>42</td>
</tr>
<tr>
<td>Depression</td>
<td>26</td>
</tr>
<tr>
<td>Diabetes</td>
<td>25</td>
</tr>
<tr>
<td>Hypertension</td>
<td>11</td>
</tr>
<tr>
<td>Stroke</td>
<td>18</td>
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</tbody>
</table>

Source: Pharmaceutical Industry Profile 2001

**Table 2: Classifications of drug-related problems**

- Untreated indication
- Improper drug selection
- Subtherapeutic dosage
- Failure to receive drug
- Overdose
- Adverse drug reaction
- Drug interaction
- Use without indication

Source: Hepler and Strand, 1990
care admissions, and emergency room visits. We also framed this information in terms of unnecessary medical expense (Table 3). During that year, $75 billion was spent nationally on pharmaceuticals. Our research indicated that for every $1 spent to purchase pharmaceutical products, we spent another $1 to treat people who experienced drug-related problems (Johnson and Bootman 1995).

Some of my former students have continued this type of research. They have found that, today, the cost of DRPs is about $160 billion (Ernst and Grizzle 2001). It remains close to the 1:1 ratio.

Another recent study looked at DRPs from the perspective of cost sharing. Canada increased copayments for the elderly and the poor. What it learned was that cost sharing didn’t reduce what it was intended to curb: drug consumption.

It lowered drug costs, as much as 10 to 14 percent. However, the silo of drug cost is intimately related to others, and adverse events among the elderly increased from 5.8 to 12.6 per 10,000 person months, while for the poor population, it almost doubled from 14.7 to 27.6. ER visits increased by 14.2 visits per 10,000 person months in the elderly and by 54.2 visits for the needy (Tamblyn 2001).

When forming policies about copayments, it’s important to keep in mind that such changes may cause a shift in how we spend our resources. To me, when we form policy we often forget to evaluate the impact that policy will have over time, not on the numerator but on the numerator and denominator simultaneously. That is true of clinical, economic, and humanistic quality-of-life outcomes.

Our immediate goal should be to maximize the value of drug therapy. Achieving better quality of life should be our ultimate goal.

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It’s difficult to predict with accuracy where healthcare will be in more than a couple of years, let alone in the year 2010, but knowing how to read the tea leaves can position your organization for success. David Garets, group vice president for Healthcare Industry Research and Advisory Services at Gartner Inc., presents a model that healthcare organizations can use to determine the direction of healthcare.

This exercise will present scenarios for 2010 based on a model called scenario thinking. The model is the subject of a book by Peter Schwartz, *The Art of the Long View*.

It’s painful to do this, but it’s very enlightening methodology. The first step is to develop a question you want to answer — in this case, “What will the delivery and financing of healthcare be like in 2010?” In this methodology, there are two types of drivers. One type is predetermined elements — that is, you know what the end result will be. The other is critical uncertainties, the outcomes of which you don’t have a clue. To look at the big picture, healthcare organizations must consider drivers in five distinct realms: social, technological, economic, environmental, and political.

Within this context, what are the predetermined elements? In the next 10 years, there will be an aging population with an entitlement mentality — 40 million of whom are uninsured — combined with an information explosion, an inability to control healthcare costs, a globalization of diseases, and greater governmental oversight.

Then there are the critical uncertainties, the wild cards. There’s really no way to know their outcomes: What will happen with privacy laws? Will medical quality and avoidable medical errors become front-page social issues? What will be the impact of the human genome project?
avoidable medical errors become front-page social issues? What's going to drive the adoption of standards for controlled medical vocabularies that enable the exchange and measurement of information and structured data within and among healthcare organizations? What will be the impact of the human genome project? Double-digit healthcare inflation will be unsustainable; will it result in employers relocating outside the U.S. or abandoning defined benefits in preference of vouchers? How will the industry react to the globalization of diseases, such as Mad Cow disease or smallpox? American hospitals are running into things that they've never seen.

We distilled these predetermined elements and critical uncertainties into two broad categories that, for our model, serve as two axes that cross to form a matrix. This matrix can be used to chart the direction of healthcare (Figure 1). We believe that financing and evidence-based decision making are crucial to the future of healthcare delivery. Our healthcare analysts, therefore, selected accountability for payment as the horizontal axis, and data standards and structure as the vertical axis.

As you move left on the horizontal axis, government pays a larger share of healthcare costs, and, therefore, personal accountability is diminished. The vertical axis goes from (at the bottom) no standards, or “blurry islands of data,” up to an environment of established standards for controlled medical vocabularies and structured data capture. If you don’t capture structured data, it’s difficult to establish best practices.

In Quadrant C, a single-payer system meets a lack of data standards. The payer, therefore, imposes brute-force rationing. This is where the U.K. and Canada are. Where you’ve got data standards in a single-purchaser environment, there’s still rationing, but it’s based on evidence of what works. That’s our Quadrant A.

At the other extreme of accountability for payment, citizens — enabled by vouchers or health stamps — purchase their own healthcare services. When these multiple purchasers interact with robust data, you’re in Quadrant B, where decisions are based on evidence of what works, clinical quality, and cost-and-satisfaction outcomes. Multiple purchasers meet a lack of standard data in Quadrant D, where consumers’ decision making is based less on information than on their reaction to advertising.

This exercise is not about figuring which quadrant we’ll be in, come 2010. The important thing is to determine the direction we’re moving. If you can do this, you can plan appropriately so that your organization can succeed in that environment.

In the United States, we are near the bottom right of Quadrant D. We don’t have many data standards, and we’re not anywhere near a single-payer environment.

Let’s examine some scenarios, placing ourselves in each quadrant in the year 2010 and looking back to see how we got there.

**Rational rationing**

In Quadrant A, the government is the purchaser. There is widespread sharing of robust information about costs, quality, and patient satisfaction. How did we get here?

Financial pressures, strong-armed employer negotiating, and declining reimbursements led many managed care organizations into bankruptcy. The complexity of moving enrollees into alternative plans led to chaotic mismanagement of financing and lapsed coverage. The feds intervened and put MCOs into receivership.

The human genome project spun miracle cures, but the expensive medications that came with it became the straw that broke the camel’s back for Congress, which slapped strict price controls on drug manufacturers by the end of the decade.

At the same time, large employers threatened to go offshore if healthcare costs didn’t drop. That caused fear of massive unemployment. To Congress, the only ac-
ceptable solution was to subsidize healthcare costs, so the government then nationalized the remaining MCOs to establish a uniform delivery mechanism.

In this future, the Health Insurance Portability and Accountability Act worked. Privacy issues were assured; personal-health-record and content providers flourished.

How will we know we’re moving in this direction? You will see a release of affordable computer-based, patient-record systems. You’ll also see federal legislation that will standardize medical vocabularies. Indeed, Health and Human Services will standardize elements of the electronic medical record under existing HIPAA law this year.

Another driver: Expensive but effective treatments turn affordability into a social discriminator. That could precipitate legislation toward a more egalitarian system.

What are the implications of this scenario? This is a fixed-price model in the extreme. An emergence of structured data and input standards will require robust data warehouses, cost-accounting applications, and clinical decision-support systems. If HHS decides it needs integrated clinical and financial outcomes information for everybody, it will require a Level 3 computer-based patient record system, which provides for structured clinical documentation, an awareness of clinical context, advanced alerts and reminders, and definable pathways. We’re not there today.

**Free market**

By 2010, three drivers led us to Quadrant B: financial pressure and declining value offered by existing MCOs, increased sophistication and access to information via the Internet, and significant legislative changes in privacy and tort reform.
Patients are in the driver’s seat, enabling a shift in accountability for payment and health status to consumers, as well as the emergence of data standards.

Big purchasers still fund a portion of what used to be called the premium, but they’ve relinquished accountability for how the money is spent to special interest groups and aggregators. With clinical, financial, and patient-satisfaction information widely available, aggregators have become the buying agents for consumers. These aggregators, or collectives, are organized around political, social, and health-related issues. For example, the citizens of Celebration City could decide to have a virtual health plan. People with diabetes could form a national virtual health plan.

In this scenario, the cost of care declines because consumers have incentives to take care of themselves; smokers, for instance, will pay more than people who work out at the health club or who have lower cholesterol levels. The dream of prevention and health maintenance is realized. Care delivery organizations, meanwhile, compete on service and their ability to provide high-value specialty care, now that routine care has become a commodity. These organizations fund consumer-focused initiatives and differentiating services, such as home visits and personal health records.

How will we know we’re moving toward Quadrant B? Consumers demonstrate cost consciousness, as they will pay for what they get. They will use the Internet for contextually relative medical information, as well as for processing and storing their personal health records. Personal accountability for health will become a reality as consumers are offered incentives to alter behaviors to reduce personal expense.

You’ll see defined benefits erode, while personal purchasing increases — in other words, a move toward defined contribution. Additionally, standards for transactions and communications will be adopted. You’ll see sophisticated medical-management applications that provide a collaborative commerce platform with the aggregators.

The technological implications of this are that there will be a proliferation of computer-based patient-record systems and a need for data-mining capabilities.

In addition, we’ll need zero-latency environments. That means that when a physician is trying to make a decision based on the best evidence, she gets administrative, clinical, or financial feedback on the spot — not in five minutes or two months. You can count on one hand the healthcare organizations that can do this now.

**Irrational rationing**

Jumping from the Garden of Eden to doom, Quadrant C is characterized by a single purchaser and blurry islands of nonstandardized data. The government has extensive influence on the provision of care because there’s no way to analyze data.

Decisions are arbitrary and driven by political factors, such as lobbying and influence groups, rather than scientific analysis of information. Healthcare providers are squeezed financially, and due to the arbitrary nature of government mandates, aren’t able to do effective strategic planning. That results in an underfunded healthcare system that is not able to respond effectively to the needs of the people it serves.

How did we get here by 2010? By many of the same economic pressures that would have driven us to Quadrant A, though the difference here is that there were egregious security violations that led to passage of restrictive healthcare privacy laws, thus preventing the exchange of information for any purpose other than the direct delivery of care. In this environment, nobody can aggregate sufficient quantities of comparable data. The government has been forced to serve as the national payer without any clear way of knowing whether it’s getting real value for its payments.

How to tell whether we’re moving in this direction? You’ll see drug-price controls.
Hackers get into patient data. Healthcare-standards efforts fail. Finally, the slowing economy takes many of the dot-coms and e-healthcare companies with it.

As for the implications, there will be an emphasis on reporting systems that will satisfy government-payer requirements. Customer relationships aren’t an issue — who cares what consumers think? They get whatever they get. Development of computer-based patient records halts because there’s no funding and because there’s no competitive advantage to them. With limited data, there is limited medical management, which means little or no focus on prevention and wellness.

**Wild wild West**

Quadrant D is not much better. Here, there are individual purchasers and a limited ability to exchange information. Consumer choice is influenced by slick advertising.

How did this happen? The economy weakened but premiums continued their double-digit increases. To remain competitive, employers were forced to restructure employee-benefit plans as defined-contribution models. The government followed suit with health stamps to cap spending in Medicare and Medicaid. The ranks of the working uninsured swell with those who choose not to purchase healthcare. A tiered system of healthcare emerges based on the amount of money one is willing to spend, but because there’s limited data from which to make intelligent decisions, there’s no guarantee that spending more money will guarantee better services.

To differentiate themselves in a commodity market, healthcare organizations diverted information-technology dollars to advertising and customer relationships.

How to see this coming? You’ll see a move to flexible-benefit plans by employers regardless of the economy. There will be increased healthcare advertising, a decreased emphasis on prevention, and an increase in self-care and alternative medicines.

Beyond these implications, you’ll need only a relatively unsophisticated computerized patient record. Organizations will deploy personal health records as a marketing tool, but because there are no standards for what a record should be, there will be limited transferability of that information from one organization or provider to another. Why spend enormous amounts of money on clinical documentation and evidence-based protocols if you aren’t going to be able to exchange the information?

**Control the direction**

You have some ability to control the outcome of some critical uncertainties. There are some common themes that follow from this. First, there is a necessity to build clinical repositories and warehouses of discrete data elements that incorporate business intelligence. Payers are doing that but, for the most part, providers aren’t.

Second, invest in medical management and customer relationship-management strategies, except in Quadrant C. Again, payers are doing that, but providers aren’t. Focus on measuring clinical, financial, and patient-satisfaction outcomes.

In 2010, I think the United States will end up in Quadrant B, near the intersection of the axes, because a push for standardized data capture will force us to move up. If the economy stays soft, we could end up either in Quadrant A or Quadrant B.

If the economy takes a dive and stays there, I doubt there will be money to invest in standards, leading us to Quadrant C and brute-force rationing by 2010.

The most important metric to watch is this migration to defined-contribution plans. If unemployment goes up, it becomes a buyer’s market for employers. They can then move to defined-contribution plans to help them cap their healthcare costs.

Read the signs and pay attention to what’s happening outside of your world.
Demographic trends, consumer desires, and expensive emerging medical technologies are on a collision course. Managed care models have helped to remove most of the excesses that had characterized healthcare, and while some reduction of waste can still be achieved, it will take fresh thinking for the system to remain efficient as these trends collide. Donna Boswell, partner in the Health Group of Hogan & Hartson’s Washington office, sets the stage for a lively panel discussion by enumerating the challenges facing healthcare.

We are witnessing a crash course of developments that will affect consumers, payers, and the ability to get healthcare in America. Some of these developments relate to the technological advance of medicine, while others revolve around financing.

With the unlocking of the genetic code, we are about to see a fundamental shift that is likely to take medical care outside of institutional settings. This will add new costs and challenges for those who decide who gets access to these interventions.

Genetic interventions are going to be sexy. Part of the challenge is in helping consumers understand that only some of those will be right for them personally. That’s going to be difficult to convey. Teaching consumers about which kinds of care are appropriate for them is something for which we have no systems in place.
Most employers don’t think of health benefits as a form of healthcare financing. They view them as a way to compensate employees, which is not the same. As a result, delivery of care to employees is not quite matched with the original goal of managed care. Managed care started out under the premise that if I do a better job of prevention and early intervention — not waiting until people are critically ill — I can provide higher quality healthcare.

That requires a longer view of the individual’s health, a view the employer wants the managed care industry to take. The industry doesn’t have that luxury; the reality of employer-based healthcare is an open-enrollment season every year. The people whom one MCO has so carefully managed during the past year can switch to a different plan.

On the government side, Medicare and Medicaid were set up as entitlements. A beneficiary ultimately can compel care to be delivered to him or financed for him by appealing to the Constitution. At the same time, the government has said, “We can’t afford this. We need to squeeze some of the cost out of our entitlement, so we’ll manage care too.”

Because managed care was working to create a market for itself, it declared itself equal to this challenge. We saw MCOs buy the spin that they could be a cost-saving dynamo that would help Medicare and Medicaid out of their financial problems.

Unsettling forces in play

In its early days, the managed care industry stressed that preventive care is quality medicine — and added, as an aside, “Oh by the way, it could also save you money.” However, during the healthcare reform debate of 1993–94, HMOs were cast as the cost-containment wonders of the world.

The overselling of that image has created a rich challenge for them. Premium increases are exceeding inflation rates, largely because of the consumer’s growing appetite for expensive new medical technology. The emerging reality, from the MCO’s perspective, is that “We’ve already squeezed everything we can out of the system using existing methods. We’ve got to have a new way of approaching it.”

Consumers, meanwhile, are frustrated with what they perceive to be a cutback in services. Health plans try to manage their care, but people think they are being told, “You can’t have the care.” That’s not the same as, “We won’t pay for the care.”

That miscommunication has created a problem: The consumer sees the MCO — not the employer — as the heavy: It’s not because my employer didn’t bargain more wisely, I’d be willing to pay more to get what I want. How do I go outside my plan?

Yet if patients are to have choice and be responsible for their own care, their demands are going to become more difficult for MCOs and employers to resist. This adds costs. Defined contribution has been touted as one solution, but the models in existence so far are not working well in terms of giving employers and payers a way out of their dilemmas.

Policy makers haven’t been able to help. The federal legislative agenda, merely an exacerbation of these developments, has arisen from consumer demand: Give me a Medicare drug benefit, give me privacy, give me access to this service. State legislatures, on the other hand, say, “We can’t afford these things.” As a result, the health policy agenda became fragmented after the Clinton healthcare debate ended. Various constituencies pursued different agendas.

Providers are discontented with payment rates, especially for government programs. I recently investigated a Medicaid rate of $8 for a psychiatric visit. One wonders if the doctor could put his wisdom and training to work for that patient. The easiest way out when you’ve got $8 coming is to figure out what drug a patient needs and send him off.

This is cost shifting. Regardless of whether the drug is appropriate for that patient, the provider can’t afford to take the time to treat him. It’s easy to shift that cost to another part of the budget. This undermines the ethics and quality of our system.

Coming to the fore

The collision of priorities already is being played out in the pharmaceutical area. Increasing costs — whether because of inappropriate prescribing, consumer demand, or inflation — have forced payers into plan-design changes to control drug budgets.

Most methods in the private market are variations of what we’ve known for a long time: higher and tiered copayments; a shift of cost and responsibility to the consumer; step therapies; and formularies, some of which really attempt to manage care.

What’s troubling is that none of these tools seems to be based on clinical requirements of care or quality-of-care issues, because payers have assumed the role of being the cost-containment force.
What’s wise, for example, about requiring a higher copayment from a person with a more serious illness? If my condition requires an innovator drug, why should I have a higher copayment than someone whose disease can be treated with a generic drug? This is arbitrary cost management.

The final piece of the puzzle is long-term care, which is where demographers say the demand will be. Long-term care is expensive. So is private insurance, the cost of which could create a two-tier society in terms of who has access to services.

Long-term care is primarily institution-based. Most younger people are not in the mood to move into a nursing home, no matter how much care they need. Baby boomers like aging in place — the concept of staying where we are and having the care come to us. This is costly and problematic.

Very soon, we could see the adoption of information technology that delivers on managed care’s original selling point. To do managed care as it was proposed, one has to have longitudinal information about patients and their use of healthcare sectors.

Through the wise use of technology, we can deliver on what managed care’s original selling point. To do managed care as it was proposed, one has to have longitudinal information about patients and their use of healthcare sectors.

Through the wise use of technology, we can deliver on what managed care offered to do in the first place. Regulations, however, could stifle the promise that information technology offers.

**CASE STUDY**

A panel of experts convened to discuss the preceding issues in the context of a simulated case study. The study presented a fictitious, four-generation, middle-class family in which the great-grandmother’s failing health presents an immediate social, medical, and economic crisis. The grandparents, active and independent, live with chronic illnesses. The working-age couple consider the alternatives facing their older loved ones while trying to raise their own children. The group’s discussion highlights the competing pressures for resources every family in this situation faces.

**ART ULENE, MD:** Donna, from a consumer’s standpoint, what do you think about the situation this family faces — to spend all of great-grandma’s assets, then put her on Medicaid and let the government pay for it?

**DONNA BOSWELL:** It’s not a reasonable approach, but it’s where we are. Going on Medicaid would break the grandmother’s spirit. She worked very hard all her life not to be thought of as poor, but she doesn’t have the assets to get her through more than a year in a nursing home.

**GARY ERWIN, PharmD:** In this particular case, there is Medicare coverage for 100 days of long-term care. So the financial discussion should be about what kind of facility to use so this person might be restored to functionality. Then the decision is whether she can go into a community-based setting, as opposed to a nursing home.

**ULENE:** But some would say we shouldn’t spend resources to rehabilitate 92-year olds when, in this country, 44 million people are uninsured and we’re not immunizing children.

**JAMES M. PUSEY, MD:** With a lack of outcomes data for many of these programs, it’s a difficult discussion to have objectively. As long as decisions about where resources are put are based on shared information, society will make the right decision.

**BOSWELL:** But isn’t that the problem? We don’t have shared information and resources. The inequities cause some people to make poor choices.

**ULENE:** David, managed care has been both devil and angel — everyone looks to managed care to solve the riddle of wise resource use, and yet, you’ve got a giant bull’s-eye painted on your chest. Is managed care the solution to this problem?

**DAVID GEORGE:** There are a lot of dynamics in play here. Many large employers and health plans are shifting costs to employees at the point of service. In addition, many of the more intrusive financial sponsors are backing away from being hands-on in the delivery system as a means of controlling costs. Short term, we’ll see a lot more inflation. It’s going to be a challenge for all of us to figure
out how to get the inefficiencies out so we can pay for the good things that are coming.

**BOSWELL:** If you’re backing away from actually managing — from helping me make decisions — aren’t you in effect abdicating insurance?

**GEORGE:** Actually, I see that as an opportunity. Platforms are emerging from the pharmaceutical benefit management industry that have real-time technology, a better underlying database, and better physician and patient information. Physicians and consumers, who share the most important relationship in healthcare, need better information to make decisions, and to the extent we can make that happen, we have a chance to be more efficient.

**WILLIAM B. BUNN, MD:** It’s the employer’s role to stand in the middle of that relationship, because as the payer it’s in our best interest to maximize the return on what we spend. If we start looking at defined contribution — and I assure you that’s coming because there probably isn’t another easy answer for a lot of employers — it’s going to be key that employers teach employees how to make decisions and to take care of themselves, and to give evidence-based protocols to physicians.

**ULENE:** Gary, in the case study, the working-age couple discussed purchasing long-term coverage for themselves. Most people can’t afford that.

**ERWIN:** I’ll get candid. If you have money, seek an estate planner now. Protect your assets so you don’t have to use them all to pay for nursing home care. If you can, move to a state where there’s a program for all-inclusive care for the elderly. A few states are trying experiments that would break the dysfunctional relationship between Medicare, Medicaid, and payers. They’re putting those resources in a single pot and looking at community-based long-term care services.

As for this case study, that woman would probably go into a facility that will accept Medicaid. That’s $3,000 a month. I challenge all of you to walk into a nursing home that charges $3,000 a month and to say to yourself, “I want to put one of my relatives in here.” Not one of you will walk out and say, “This is a really nice place.”

**ULENE:** We don’t trust MCOs anymore. We can’t look for solutions from physicians, who see it as their moral responsibility to get everything they can for each patient but do not recognize that they’re stealing from the next patient and that the pot is going to run out. If we in healthcare don’t resolve these problems or at least re-educate people about expectations, then some damn politician will.

Ulene asked the panel to respond to a question from the audience about how to help people with chronic conditions learn to care for themselves so that they can stay independent, and how return on investment for that effort can be calculated.

**ERWIN:** When you get into assisted living and nursing homes, you are really talking about functional status. That becomes your primary endpoint. From a scientific perspective, the evidence in the literature about the economic benefits of treating an 85-year old with a statin drug or treating a 75-year old with an Alzheimer’s drug is...
nonexistent. What you’re left with is how to increase independence.

This requires engaging the family and using pharmaceutical products appropriately. That gets to defining appropriate use and paying for it.

**BOSWELL:** Do you think appropriate pharmaceutical use will ever take into account age, as opposed to being disease- and indication-appropriate?

**PUSEY:** In my mind, the issue is whether you want to set a baseline or want the individual to continue living at a high level of functionality. My father is an example: He’s 83 and is the oldest kidney transplant recipient in the United Kingdom. He had renal failure seven years ago. Fifteen years ago, it would have been terminal. He would have been admitted into a hospital at enormous costs, possibly for months. But he could go on dialysis at home, staying with my mother as a result of innovation and research. And then finally, he got a call saying, “Would you like a new kidney?” For me, the mission is about innovation and research and continued functionality for older people.

**ERWIN:** My answer resides in that 30-day period at the end of life in which 50 percent of all Medicare dollars are spent. If you could predict that 30-day period, you could do some good interventions. The solution to our healthcare crisis revolves around management of “When is enough?”

**PUSEY:** Yes, and of who makes that decision.

**GEORGE:** Well, the one person I don’t want making that decision is somebody in Washington. The answer comes down to some kind of medical-legal-ethical-lay-developed agreement that applies some rationality to rationing.

**ULENE:** There was an article in the *Annals of Internal Medicine* recently that defined a new entity: clinical inertia, the failure of physicians to treat patients according to appropriate indications. We have heard at this conference from several people about the role of pharmaceuticals in keeping people independent, ultimately reducing medical cost, and that there are huge numbers of people who would benefit from use of pharmaceuticals but are not getting them. We’ve got a conflict, in which a managed care organization that churns members every year may not have an incentive to spend on drugs in the short term because it’s going to lose the client long term anyway.

**BUNN:** We focus a lot on what we’re going to pay for. But the real issue is like making a product right the first time. So, whether it’s evidence-based medicine or step therapy, that’s the challenge — providing information and forcing providers to do things correctly. That’s difficult. The last time we looked at our own depression population, 85 percent weren’t following what’s in the *Physicians’ Desk Reference*.

**BOSWELL:** But look at what we’ve done. The one in the best position to take the long view is the employer, who knows the least about medicine. The MCO — which promised it would do that — has financial incentives so screwed up that it’s driven by this year’s target. We’ve made every employer in the United States look after its own employees.

**GEORGE:** The most important people in this system are the patients themselves. There is an opportunity to educate people. As for the concept of planning, aging is a predictable reality — and yet, when it happens, whose problem is it?

**ERWIN:** I spend 50 percent of my time from a population approach trying to get physicians who practice in long-term care settings to get past clinical inertia. Most physicians really do have the patient’s best interest in mind, but they’re overwhelmed. If you can get through to the physician, our experience is that in a meaningful two- to three-minute conversation, you really can change behaviors, one person at a time.

**GEORGE:** There are things we can do to help physicians better understand the choices and the implications of their decisions. That’s a worthwhile integrated strategy that we all have an interest in.

**ULENE:** I would suggest that you need to provide physicians with a more basic understanding of the philosophy, the underlying issues. There isn’t a physician now who would not accept the idea that resources are finite. I think physicians need to be educated as to the benefits of pharmaceuticals not just for controlling a number, such as cholesterol levels or blood pressure, but the role that some agents play in the path to independent living and reduction of disability. It’s my belief that if you educate doctors about the fundamental benefits in pharmaceutical agents, rather than why one drug is better than the other, you will see more rational, more appropriate use.

I want to thank our panel for dealing with a tough subject in a very expert way.
Adele Gulfo, vice president for AstraZeneca’s Cardiovascular Therapeutic Area, discusses the pharmaceutical industry’s perspective on direct-to-consumer advertising. Gulfo says prescription drug advertising has value for today’s consumers, who actively seek education and information about their health and about products and services that improve and maintain their health.

There are three major reasons why direct-to-consumer advertising has become an important and effective tool for patient education. First, today’s healthcare consumer is demanding. Second, we are in the midst of major changes in healthcare delivery. Finally, there is an unprecedented amount of health and medical information available publicly, thanks in part to the technology-and-information explosion.

With respect to the new healthcare consumer, baby boomers are well informed, well educated, and demanding. They have a strong desire to take control and take action when it comes to their health. This has led to a significant change in healthcare delivery: the erosion of the doctor/patient relationship. The patient has kicked the physician off the pedestal: “No doctor, I don’t think that’s right. I want another opinion. I have more information, and my data may be more accurate than yours.”

Recently, people were asked whether they depend only on their physicians for health information or seek it on their own. Sixty-five percent gather their own information, then seek a peer-to-peer dialogue with the physician (Deloitte and Touche 2001). Put another way, two thirds do not take what the physician has to say at face value.

A second change in healthcare delivery has to do with a general decline in the quality and confidence of care. Some of this may be perception, but there is reality herein. The AMA, for instance, recently found that 100 million Americans have been involved, directly or indirectly, in some sort of medical error. Consumer decline in the confidence of health care quality has led people to become proactive.

The information explosion is perhaps the biggest driver of necessity for responsible direct-to-consumer advertising. The age of the uninformed consumer is over. There are 15,000 health-information Web sites, though not all health information on the Web is accurate (Berland 2001). Half of the 52 million American adults who have searched the Web for health and medical information say what they found there influenced their healthcare decisions in some way (Pew Internet Report 2000).

Constructive DTC models

There are examples of direct-to-consumer advertising and education that I believe are beneficial in terms of their information value. They reduce stigma, they appeal to baby boomers’ mindset, and they inform — making them educational and effective.
More than 17 million Americans suffer from overactive bladder; less than 20 percent are treated for it (Milsom 2000). Many are either too embarrassed to discuss the problem or they don’t think it is worthy of bringing up with their physicians.

Through its advertising, one company takes the stigma out of overactive bladder. The ad portrays a relatively young woman to whom consumers can relate. By casting a baby boomer in a clever script, the ad effectively makes the point that there’s no reason not to talk about this medical condition, for which there are treatment options.

Hypercholesterolemia is a major cause of coronary heart disease. Overall, 100 million adult Americans have total-cholesterol levels over 200 mg/dl. About 65 million have LDL-C levels high enough to warrant intervention, including lifestyle modification. Of them, 36 million qualify for drug therapy, based on recent ATP-III guidelines, but only 8 million Americans actually receive drug therapy for their condition. Of this group, less than 30 percent are treated to their cholesterol goals (NCEP 2001).

In developing an effective advertising campaign for its statin, one company capitalizes on the mindset of the baby boomer: My cholesterol level is here. I need to get it lower. I want to do that fast, and I want to take control. It’s all about numbers. The message: I took control and I got what I needed to reduce those numbers. It feeds right into a generation that wants to take control.

A third example of effective advertising involves straightforward education about a widespread condition that may not necessarily be thought of by sufferers as a problem needing direct medical attention. Gastroesophageal Reflux Disease, or GERD, affects more than 65 million adult Americans, though only 35 million have been adequately diagnosed (Consumer Health Sciences 2001). Some 15 million are taking a product to treat their condition — often using over-the-counter remedies.

One ad for a product to treat this bridges the education gap by saying that if left untreated, GERD can lead to a more serious condition called erosive esophagitis. This informative ad begins by asking, “Do you know that acid reflux can wear away the lining of your esophagus?” It’s effective because it engages the consumer, then goes into more substantive information about the condition and treatment.

Direct-to-consumer advertising creates awareness about disease and treatment options and prompts consumers to consult their physicians and to take action. In addition, it can help many disease sufferers avoid more serious complication: GERD leads to erosive esophagitis; coronary heart disease leads to death. Appropriate and responsible communication by our industry can prevent serious illness or mortality.

As manufacturers and as an industry, it’s our responsibility to utilize effective tools to do this. Direct-to-consumer advertising has a legitimate role in today’s healthcare environment, providing information to the aggressive new healthcare consumer.

References


CONTINUING EDUCATION QUESTIONS
Demographic Revolution of Healthcare

Directions: Please tear out the combined answer sheet/assessment form on Page 29 (physicians) or 30 (pharmacists). On the answer sheet, place an X through the box of the letter corresponding with the correct response for each question. There is only one correct answer for each question.

1. The fastest-growing age group through 2020 will be:
   A. 35–44.
   B. 45–54.
   C. 55–64.
   D. 55+.

2. What percentage of healthcare expenditures in the U.S. are spent on drug treatment?
   A. 8 percent.
   B. 10 percent.
   C. 13 percent.
   D. 25 percent.

3. Which of the following exemplifies “predetermined elements” that organizations can heed in predicting healthcare’s future?
   A. The aging population.
   B. The impact of the Human Genome Project.
   C. The spread of health information on the Internet.
   D. Answers A and C.

4. Which is not a Dychtwald prediction for healthcare’s future?
   A. Demand will escalate for prescription drugs that improve the way people look and feel.
   B. A new fee-for-service side of healthcare will arise, representing a higher level of care.
   C. Baby boomers will seek coverage for old-age care.
   D. Drugs that prevent disease, such as those with genetic applications, will be popular.

5. Having allowed others to cast them as cost-saving vehicles, MCOs face which challenges?
   A. Reconciling demand with finite resources.
   B. Finding ways to fund federal coverage mandates.
   C. Proving their commitment to high-quality care.
   D. All of the above.

6. Which illness is given the highest priority from a standpoint of the number of drugs in development?
   A. Coronary heart disease.
   B. Cancer.
   C. Arthritis.
   D. Asthma.

7. Which of these exemplifies “critical uncertainties” that healthcare organizations must watch for carefully when considering strategic planning?
   A. The evolution of standards for structured data capture.
   B. Use of defined contribution.
   C. Globalization of diseases.
   D. All of the above.

8. Implications for healthcare organizations of the aging of the baby boom generation include:
   A. Demand for customized care.
   B. A desire to maintain an active lifestyle late in life.
   C. Answers A and B.
   D. A younger workforce, on the whole, than what existed 20 years ago.

9. In a 1995 study, how often did drug-related problems result in treatment failure?
   A. 7 percent of the time.
   B. 11 percent of the time.
   C. About a quarter of the time.
   D. More than half of the time.

10. The original premise of managed care was that:
    A. Exclusive provider networks would compete on cost.
    B. Prevention and early intervention would result in higher-quality care.
    C. First-dollar coverage would be attractive to enrollees.
    D. Pharmaceutical use would keep people out of institutional settings.

11. Which set of circumstances characterize an advanced free market in healthcare?
    A. Evidence-based decision making and consumer accountability for payment.
    B. Consumers pay for care; healthcare organization advertising is influential.
    C. EMRs and privacy are secure, while expensive treatments force access discrimination.
    D. Employers still offer defined benefit packages but data for purchasing decisions are raw.

12. Which is not one of the 10 leading health problems for people age 45–64?
    A. Allergies.
    B. Hemorrhoids.
    C. Arthritis.
    D. Hearing impairments.

13. For every $1 spent in the U.S. on pharmaceuticals, about how much is spent to treat drug-related problems?
    A. 40 cents.
    B. 50 cents.
    C. $1.
    D. $2.

14. Under the Gartner model, which factor can contribute to irrational rationing of care?
    A. Lack of data standards.
    B. Expensive treatments that force access discrimination.
    C. Increased popularity of alternative therapies.
    D. Primary care becomes commoditized.

15. What share of U.S. adults seeks health information and education from sources other than their own physicians?
    A. 40 percent.
    B. 50 percent.
    C. 65 percent.
    D. 80 percent.
CONTINUING EDUCATION ANSWER SHEET/CERTIFICATE REQUEST
Demographic Revolution of Healthcare

CME Credit for PHYSICIANS

Sponsored by the University of Arizona College of Medicine at the Arizona Health Sciences Center

Name _________________________________________ FIRST MI LAST
Title __________________________________________
Specialty_______________________________________
Address _______________________________________
City ___________________________________________
State ___________________________ ZIP ___________
Daytime telephone ______________________________

Physician — Maximum of 4 hours in category 1 credit. This learning module may be used for category 1 credit through March 31, 2003.

Complete answer sheet/evaluation form and mail to:

Continuing Medical Education
University of Arizona College of Medicine
PO Box 245121
Tucson, AZ 85724-5121

Alternately, you may fax this completed sheet to: (520) 626-2427.

Credit will be awarded upon successful completion of assessment questions (80 percent or better) and completion of program evaluation. If a score of 80 percent or better is not achieved, no credit will be awarded and the registrant will be notified.

Please allow up to six weeks for processing.

The cost of this activity is provided at no charge to the participant through an unrestricted educational grant by AstraZeneca.

EXAMINATION: Place an X through the box of the letter that represents the best answer to each question on page 28. There is only ONE answer per question. Place all answers on this answer form:

A. B. C. D.

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PROGRAM EVALUATION
So that we may assess the value of this self-study program, we ask that you please fill out this evaluation form.

Overall activity rating

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Were the educational objectives met?

A great deal Not at all

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Will this activity benefit you and improve patient care?

Very much Very little

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What other topics would you like to see addressed?

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Give an example of what you will do differently in your practice as a result of participating in this activity:

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Did you detect any bias in this presentation?

Yes ____ No ____

If yes, explain:

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Comments:

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CONTINUING EDUCATION ANSWER SHEET/CERTIFICATE REQUEST
Demographic Revolution of Healthcare

CE Credit for PHARMACISTS

Sponsored by the University of Arizona College of Pharmacy
at the Arizona Health Sciences Center

Name _________________________________________

Specialty_______________________________________

Address _______________________________________

City ___________________________________________

State ___________________________ ZIP ___________

Daytime telephone ______________________________

Pharmacist — This program is approved for 3 contact hours (0.3 CEU).

ACPE program number: 003-999-02-097-H04.

Complete answer sheet/evaluation form and mail to:

Office of Continuing Education
University of Arizona College of Pharmacy
PO Box 210207
Tucson, AZ 85721-0207

Alternately, you may fax this completed sheet to
(520) 626-2023.

Credit will be awarded upon successful completion of assessment questions (70 percent or better) and completion of program evaluation. If a score of 70 percent or better is not achieved, no credit will be awarded and the registrant will be notified.

Please allow up to six weeks for processing.

The cost of this activity is provided at no charge to the participant through an unrestricted educational grant by AstraZeneca.

EXAMINATION: Place an X through the box of the letter that represents the best answer to each question on page 28. There is only ONE answer per question. Place all answers on this answer form:

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PROGRAM EVALUATION
To receive pharmacy credit, please provide all information requested below. This will assure prompt and accurate issuance of your continuing education certificate.

Please rate this program as follows:

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How long did it take you to complete this continuing education activity?

hours _____ minutes _____

Requested topics/skills to address in future programs:

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Comments: ______________________________________

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Did you detect any bias in this presentation?

Yes ___ No ___ If yes, please explain:

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________________________________________________
Love, it has been said, is the only rational act. Morrie Schwartz, a college professor, espoused this belief, giving freely of himself. When he was diagnosed with amyotrophic lateral sclerosis, he continued to share — by teaching others what it was like to die. Mitch Albom, one of Schwartz’s former students and now a nationally syndicated newspaper columnist for the Detroit Free Press, wrote the bestselling Tuesdays With Morrie to help his onetime professor teach what Schwartz called his last class, and to spread the professor’s lesson of love.

Morrie Schwartz had a wonderful way of making you feel like you were the first student he ever taught, which I think is the mark of all great teachers. I met him on the first day of class in 1975 at Brandeis University. I was a freshman in an intro to sociology class. As he began to call roll, he said, “Mitchell Albom.” And he said, “Is it Mitch or Mitchell — which do you prefer?”

I was touched that he asked. I said, “Well, my friends call me Mitch.” And Morrie said, “All right. And Mitch? I hope one day you’ll think of me as your friend.”

That began a remarkable relationship. I took every class Morrie offered. We hung around campus together, we went for walks, we ate. He was full of wonderful ideas. He said, “Don’t worry about your grades or about how much money you’re going to make. Follow your heart, give to your community, stay involved with others.”

When graduation came, I bought him a briefcase. I didn’t have any money then, so I’m sure it was the cheapest briefcase you could find. It had his initials on it.

You would have thought I was giving him a gold brick. He began to cry. He hugged
me and said, “Mitch, you’re one of the good ones. Promise you’ll stay in touch.”

I promised. And I proceeded to break that promise every day for 16 years.

I got out into the world and wrote for a newspaper. I found work on radio. My career took off. People recognize your name and give you an award and a bigger pay-check. You get a bigger house, a bigger paycheck, and one morning, you wake up and think, “This was meant to be. Success was always supposed to be mine.”

We forget who helps us experience success. We forget our teachers. I forgot mine.

During those years, Morrie did what he always had done. He didn’t aspire to be the dean. He wanted to teach a handful of kids every year, just to reach a few of them. He was involved with his community — as he told me to be.

He loved to dance. There was a place in Harvard Square where you’d pay $5 and you could dance any way you wanted with anybody you wanted. Morrie would go there in sweatpants with a towel around his neck and do the tango, the merengue, the rumba — they played rock, but that didn’t matter to him — he’d grab a coed and take over the floor. People clapped for him. They had no idea he was a learned professor; they thought he was a crazy old kook. That was him, enjoying life to its fullest.

When Morrie was in his 70s, he began to notice a change. It was subtle at first. Long walks made him tired. Then he began to stumble inexplicably. Once he went down on the dance floor and, as he told me, “Mitch, I never stumble when I dance.”

Finally, on a beautiful summer day, he sat in a neurologist’s office and the doctor gave him the bad news: ALS. He had maybe a couple of years to live.

Morrie walked outside to the same beautiful summer day that he’d left behind, and there he made a profound choice. He could be angry or he could try to find something positive in this negative hand he had been dealt. And because he had always been positive, and because he was a teacher, he decided he would teach about what it was like to die — right up to the day he died. “After all,” he figured, “everybody’s going to die. There must be something I can share that will help someone.”

**Treat me no differently**

ALS marches insidiously through the body. It eats your muscles and nerves until you have none left. Yet your mind stays perfectly intact, so you’re completely aware of what’s happening, until you can’t move an eyelash, right up to the day you die.

In Morrie’s case, it began with his legs. Even as he went from a cane to a walker to a wheelchair to a bed; even as he lost the ability to walk, to shave his own face, to brush his own teeth; even as he lost the ability to wipe his own rear end — he taught. He invited people in. He said, “Come talk to me. Learn from me. Pay no attention to this body — that’s the box I came in. I’m still here. Look at my eyes. You want to do something good for me? Don’t treat me like I’m already dead.”

He wrote down aphorisms about living with terminal illness. A friend sent them to the *Boston Globe*, which published a story about this old man who was teaching people how to die. That found its way to ABC’s *Nightline*, which featured Morrie.

A thousand miles away, I did a double take. There on my TV was a white-haired, sickly version of my professor, but it was otherwise very much Morrie, talking about what it was like to die — right up to the day he died. “After all,” he figured, “everybody’s going to die. There must be something I can share that will help someone.”

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*Tuesdays With Morrie*, which entered the New York Times bestseller list in 1997 and reached #1 the following year, is in its 30th printing. Albom used the advance from the book to pay Schwartz’s medical bills.
The first thing he said to me was: “How come you didn’t call me Coach?”

I was wrapped up in my work life back then. I was working 90 hours a week. When I arrived in Boston, I rented a car and a cell phone, and as I drove into Morrie’s neighborhood, I was talking to ESPN. Well, Morrie had asked his nurses to carry him outside. He wanted to greet me at the curb. So I came down the street, on the phone, and I saw this figure in a wheelchair about 50 yards away. I hit the brakes.

Now, the proper thing to do would be to take the cell phone, throw it out the window, and go run and give this man a hug. I’d like to say that that’s what I did.

What I actually did was drop below the dashboard and stay on the floor of the car to finish this conversation. All because at that point in my life, work came first and everything else — even a dying old man — could wait.

Learn from my mistake. People come before work.

When we went into his house, all around me were vials of pills, an oxygen machine, and nurses. The place smelled like a sick person’s home smells.

Yet Morrie never spoke about his disease or how bad it was. He talked about all the things he was learning and how he’s having a chance to continue to teach.

I was so impressed with his serenity that when I flew home that night, I thought, “I’m 37 and healthy. He’s 78 and dying. Why does he seem 10 times happier than I?”

I went back every Tuesday for the rest of Morrie’s life to try to get the answer. Morrie was able to say this matters, that doesn’t matter. You think this matters, but when you get here it’s not going to matter. How valuable would it be to have this perspective when you’re young and healthy enough to do something with it?

Giving is living

When people visited Morrie, they would come out an hour later in tears. They’d be crying about their divorces, their jobs, their lives. “I don’t know what happened,” they’d say. “I tried to comfort him, but after five minutes, he’s comforting me.”

I watched this happen so many times that I said, “I don’t get it. If anyone had earned the right to say, ‘You think you got it bad? Bring the sympathy in this direction, please!’ it would be you. Why don’t you?” He looked at me as if I’d just stepped off a spaceship. He said, “Mitch, why would I ever want to take like that? Taking only makes me feel like I’m dying. Giving makes me feel like I’m living.”

The opposite is the basis of Madison Avenue: Taking is going to make you feel alive. Take this new refrigerator, this vacation, this big-screen TV, you’ll feel better about yourself. But taking will not make you feel alive. Think of a movie where an old man is dying and his family leans in to hear his final words. Does he ever say, “Bring me the big-screen television set. I just want to touch it one more time?” In that final moment, all that matters is that the people you love are around you, and you being able to tell them that you love them. Giving is what living is about.

In life, if you are too busy taking, then all that will happen when you go is that your money will be fought over, your body will rot, and your accomplishments will mean nothing. Plan to be 100 percent dead.

But if you live your life as Morrie did — sharing yourself, making time for others — you will live on in people’s minds and hearts. If you really want to cheat death, to put your chips on immortality, then consider acts of kindness, sharing, caring, and giving. That is how you pass yourself on to other people.

In your careers, when you’re deciding how to handle something, remember what you’re doing. You’re helping people. Don’t lose sight of that. Try to remember the purpose behind what you’re doing, and follow your heart. It will not lead you astray.

“If there’s anybody you love with whom you’re feuding, let it go. Because when you get to where I am — and you will — you will care only that she is there with you and that you can tell her how much she means to you.”

— Morrie Schwartz