J Contemp Psychother
DOI 10.1007/s10879-008-9097-x

ORIGINAL PAPER

We are not a Healthcare Business: Our Inadvertent Vow of Poverty

Nicholas A. Cummings · Janet L. Cummings · William O'Donohue

© Springer Science+Business Media, LLC 2008

Abstract Psychology has been fractionated from mainstream healthcare delivery and this schism has resulted in huge costs to psychologists and our intended customers. Psychology has also been naïve economically. The authors suggest three revolutions: (1) for clinical psychology to be better integrated into the healthcare delivery system; (2) for psychologists to better understand healthcare economics and business; and (3) for psychologists to become more entrepreneurial, i.e., see needs in healthcare (such as those of the elderly, obesity, improved access and value through ehealth) and systematically fill these. We note high quality businesses help many individuals (customers, family members, employees) not typically recognized by anti-business psychologists.

Keywords Mental health · Psychotherapy · Healthcare business · Managed care

By 1980 psychology had become the premier psychotherapy profession in America. Our last state had enacted psychology licensure (Missouri in 1979), and psychiatry had decided to "remedicalize," abandoning psychotherapy to psychologists as it became an essentially prescribing and hospitalizing profession. Social work was still struggling to obtain statutory recognition, and masters level counselors and marital/family therapists were just beginning the arduous path toward establishing their respective professions. Popular polls asking women to list their most desirable husband year after year revealed psychologists to be the number one choice. The media were unceasingly favorable toward us, and story after story heralded that psychology was about to solve many of society's problems. We were riding high. Then 15 years later, or circa 1995, psychology began a precipitous decline that still continues. What happened? What did we do wrong? We suggest an analysis of these questions will reveal that a revolution needs to take place: clinical psychology needs to move to take its rightful place as a healthcare business with all the strategic, training, attitudinal, and practice changes that this implies.

N. A. Cummings · J. L. Cummings
Reno and the Cummings Foundation for Behavioral Health, University of Nevada, Reno, USA

W. O'Donohue (✉)
Department of Psychology, University of Nevada, Reno 89557, USA
e-mail: wto@unr.edu

A Brief Retrospective

After decades of struggle to establish its new profession, psychology was understandably enjoying having come of age. But while it was basking in its arrival as the nation's premier psychotherapy profession, healthcare was beginning to industrialize, ushering in changes that would have been unthinkable a few years earlier. The enactment by the Congress in 1985 of diagnosis related groups (DRGs) in medicine and surgery was the first effective salvo in this industrialization. The second was by the Supreme Court which established that healthcare was subject to the anti-trust laws, and the restrictions on the corporate practice of medicine were thrown out. The inability of the government to establish DRGs for mental health led to the complacency that mental health was impervious to industrialization. Not so, said the senior author of this paper, who heeded the harbingers as he began to warn the profession of the sea

changes just ahead (Cummings 1985; Cummings and Fernandez 1985; Cummings 1986).

The term "managed care," and more specifically, "managed behavioral care" had not yet been coined, so Cummings (1986) referred to what was about to occur as the giant corporations sweeping over our profession like a swarm of locusts. Unless psychology owned the industrialization of behavioral care, it would own us. He announced (Cummings 1986) that he was establishing American Biodyne as a model to be emulated. He would cap its enrollment to 500,000 covered lives, and he invited psychologists to come and spend as much time as necessary to enable them to go out and form 50 such companies. In this way psychology, not the locusts, would own the new wave of industrialization.

The American Psychological Association (APA) was immediately not only skeptical, but oppositional. Particularly vocal were Bryant Welch, the first head of the newly created APA Practice Directorate, and Rogers Wright, the executive director of the Association for the Advancement of Psychology (AAP). Where would Nick Cummings ever obtain half a million enrollees for such an unworkable scheme? Laughably, he was accused of having added grandiosity to his paranoia. Even after managed care, as it came to be called, was entrenched, the APA's official position was it was a passing fad (Cantor 1993; Wright 1992). For 3 years Cummings kept his promise, but when no one came to learn other than corporations, he took his foot off the brake and enrollment skyrocketed to 20 million in the succeeding 5 years. Several copy-cat companies were formed, but none other than American Biodyne were psychology-driven, even to the point where medical directors reported to psychologist clinical directors. Now in his seventies, and tiring of working 90 hour weeks while being constantly attacked by his own profession as well as that of psychiatry, Cummings took American Biodyne public and left the company in 1994. Two years later a survey of practicing psychologists revealed they were frustrated by managed care, but they had fallen prey to assurances by the APA and planned to "hang tough" until managed care collapsed (Saeman 1996). Psychology had missed the opportunity to own managed behavioral care.

Why no One Came

That a large 100,000-member organization like the APA, which is well staffed and funded and sponsors a plethora of ostensibly well-informed study committees and task forces could make such a far-reaching and egregious (to its members) error is curious. That is, it is curious until one delves into the belief system of psychologists. There are two pervasive beliefs, or near universal biases, both of which are highly counterproductive to the success of the delivery of psychological services: (1) the practice of psychology is not part of healthcare, and further (2) it is not a business.

Psychology Practice is not Healthcare

In the 60 years the senior author has been a psychotherapist, as well as all of our collective experiences as psychotherapists, the worst accusation that could be leveled at a colleague, or in critiquing a therapeutic approach, was for someone to exclaim disdainfully, "That's the medical model!" Recoiling, the accused would back-pedal to reestablish acceptable credentials that reflected the psychosocial, behavioral, or humanistic models, declaring loudly that psychology is not healthcare. Psychology has failed, however, to establish an economic base to sustain itself, so it paradoxically insists that psychotherapy be reimbursed by the health system. In so doing it plays the dubious double-game that mental health is separate and different from the general healthcare industry, a stance that isolates us even more.

As will be seen below, this dichotomy has led not only to our under-funding, but to a stepchild status in the health system. There is a plethora of examples how such a narrowing of identity has harmed other successful industries. The railroads were the most successful industry of the 19th century, but their insistence they were in the railroad industry and not the transportation industry resulted in their being usurped by trucking and air cargo, both endeavors railroads could have once owned. The telegraph industry, the miracle of the same century, failed to define itself beyond the telegraph to the rightful focus as the communications industry. As a result it rejected the then newly invented telephone and subsequently withered. It is fascinating that at that time telegraph lines had already crisscrossed the continent, and it would have taken only a minor adjustment to adapt them to the telephone. Other examples are numerous, for many companies failed to identify with the broader, impending focus. In more recent history, IBM failed to see it was in the communication industry rather than in mainframe manufacture, concluding the American people would never accept the scaled down "cyber-machine" in their homes, thus letting Steve Jobs of Apple and Michael Dell introduce and dominate the early desktop computer industry. Similarly Xerox, which dominated the copier industry for years remained myopic, allowing a number of upstarts to redefine the copier as a communication device by adding faxes, scanners, telephones and even computers. The railroads eventually recovered by adding container cargo and piggy-back, IBM and Xerox adapted and recovered by emulating their new competition, but none of these industries were able to

regain their preeminence. On the other hand, Western Union and Postal Telegraph have never recovered, and they remain outmoded "messengers" through which one can wire money to a distant recipient. The telephone, however, has become cellular, has joined with the internet, and is enormous.

Facing the same medical dominance that has incensed psychology, the professions that established themselves after medicine have redefined what used to be called "medical care" into "healthcare," and have carved a successful place in the system of healthcare. One does not hear the outmoded term "medical model" as the ostensible enemy among dentists, nurses, optometrists, osteopaths, pharmacists, and podiatrists, all of whom enjoy autonomy, growth, and continuing success in *healthcare*. Only among psychologists (and to a lesser extent among social workers and other so-called mental health practitioners) is healthcare equated solely with medicine (Dranove 2000).

We are not a Business

With the industrialization of healthcare, business courses have become a routine part of the curriculum in medical, dental, nursing and all other healthcare schools, but not in psychology. Additionally, the healthcare national organizations sponsor and strongly promote continuing education business courses for their members already in practice, but not in psychology. As a consequence, all health professions are expanding into new practice horizons and delivery systems, but psychology remains mired in its traditional 50-min hour in its private offices, shrinking in income as Medicare, Medicaid and managed care continue to ratchet down their already ridiculously low reimbursement fees. Your plumber and auto mechanic charge more per hour.

It is true that Medicaid and Medicare are also reducing fees in medicine and the other healthcare professions, but these have expanded their services, and it is the frequency of these services (termed procedures), not the time the practitioners spend, that increase their incomes. But psychotherapy has mired itself in one main service, the 50-min hour, which managed care has limited in both frequency and number of sessions. As much as 90% of psychotherapy is dispensed in the 50-min hour model, remanding the psychotherapist to an ever-decreasing practice income. We have voluntarily boxed ourselves in.

Psychology has demonstrated a pervasive anti-business bias that reflects a belief that psychology is a compassionate profession, and a person cannot be successful in business and still remain compassionate. By default the practice of psychology has become almost an eleemosynary endeavor that perpetuates itself by attracting students who share our anti-business bias, thus remanding the practice of psychology to remain a compassionate and underpaid profession. One recent graduate confided that she could not make her student loan payments as her overhead exceeded her practice income and she was going farther into the hole. When it was suggested she needed some business and marketing courses, she haughtily replied she did not become a psychologist to make money. When asked if she became a psychologist to lose money, she became speechless and sullen.

The "poster child" of all professional organizations for helping its members out of the hole is the American Dental Association (ADA). Twenty years ago dentistry was a dying profession. Flouridation of the water supply had so reduced caries (tooth cavities), the mainstay of dentistry, that most dentists were retiring early and students were not entering the field. The ADA sprung into action, instituted business and marketing courses in dental schools, and embarked on a national reeducation campaign for its members. As a result dentistry has expanded into new services that are lucrative because the public wants them and is willing to pay for them, and the profession is revitalized to the extent that many dentists are enjoying incomes higher than those of primary care physicians. In contrast, our APA has been impotent, unable to lead psychology practice out of its doldrums.

Our Rightful Place as a Healthcare Profession

The list of paradoxes currently plaguing psychology and used to justify the contention that we are not a healthcare profession is long and perplexing. Only a few of the more blatant ones are enumerated here (from Cummings and O'Donohue 2008).

- We are not a healthcare profession, but we should be reimbursed by health insurance for our (non-healthcare) services.
- We treat "clients," not "patients" (this switch occurred in the 1970s), but we should be paid by healthcare systems, both governmental and private, that are set up to take care of patients.
- Physicians, nurses, dentists, podiatrists, optometrists, osteopaths, naturopaths, chiropractors, pharmacists, and veterinarians have patients, while lawyers and psychologists have clients.
- We deliver "mental *health* services," but we are not a healthcare profession.
- Medicine is guilty of mind–body dualism, but we will not integrate into primary care so we can finally declare that Rene Descartes is dead.
- We do have an oxymoronic group of colleagues that call themselves health psychologists that help physicians with diseases and really do not do psychotherapy.

- Real psychotherapy involves self-actualization, with such things as marital counseling, mindfulness, and rebirthing far more fun than such mundane interventions as helping diabetics comply with their medical regimens or, helping somatizers resolve the causes of their high medical utilization.

These paradoxes have produced some nonsensical beliefs by the psychologists who are willing to go to the extreme to prove we are not a health profession and that we do not treat disease.

- Schizophrenia is not a brain condition, but the result of poor life choices (William Glasser), schizophrenogenic parents, especially mothers (Gregory Bateson, Leo Kanner), or the result of widespread poverty and oppression (George Albee).
- Alcoholism is not a disease. Tissue or neurological changes are absent, genetic or other predispositions do not exist, and a chronic inebriate can be rendered a social drinker by cognitive therapy (Linda Sobell).
- There is no medication that is helpful in mental and emotional conditions since there is no disease pathology involved (George Albee, Fred Baughman, William Glasser).

It is no wonder, then, that very few psychotherapists treat schizophrenia, severe addictions, or chronic mental conditions. Rather, they continue overwhelmingly to treat what Paul Ellwood 40 years ago called the "worried well" of the health system. This is why the requirement of medical necessity by insurers strikes terror in the hearts of psychotherapists, who insist that the health system pay for treatment that does not address illness in patients who are not sick. The preferred justification for psychotherapy is some variant of self-actualization, a term that masquerades under many names, but which for 60 years has not been satisfactorily defined.

An Awakening

Since the beginning of the 21st century there has been a renewed interest in the integration of behavioral care into primary care, with behavioral care providers (BCPs) co-located and working side-by-side with primary care physicians (PCPs). Surprisingly, such a system was first proposed and half a century ago by Balint (1957) whose prescient insights were largely ignored. He saw physicians becoming more like psychologists, and psychologists more like physicians. Following the pioneering publication by the authors (Cummings et al. 1997), several textbooks have now been written describing the training, practice and research of what is termed "integrated behavioral/primary care" (Cummings et al. 2001; O'Donohue et al. 2005; O'Donohue et al. 2006; Robinson and Reiter 2007). Such co-location, surprisingly, was proffered more than half a century ago by Balint (1957). During this period extensive health systems (e.g., U.S. Air Force, Kaiser Permanente Health System, the Cherokee Health System, and a number of V.A. hospitals, military treatment facilities, and TriCare programs) now have behavioral care providers, mostly psychologists, co-located in the primary care setting. However, there are only a few clinical psychology doctoral programs (e.g., Forest Institute of Professional Psychology, University of Nevada, Reno, Argosy, Hawaii, and the School of Professional Psychology at Wright State University) have instituted graduate programs to train BCPs. Consequently, facilities that have instituted such integrated services have had to rely on in-service training.

In an innovative attempt to move beyond the controversy, Barlow (2004) proposed that evidence-based interventions that are applicable to healthcare be termed "psychological treatments," while all else would retain the appellation "psychotherapy" and its practice would continue in the usual manner. Only the first would be eligible for reimbursement by the healthcare system, however, while the latter would have to be paid out-of-pocket or the practitioners would have to find an alternative means of payment. As might be expected, this only increased level of contentiousness. While psychology dallies, the emerging industry has forged its own vocabulary, substituting for Barlow's psychological treatments such terms as "behavioral care" and "behavioral interventions." This reflects that although currently most BCPs are psychologists, they can also be drawn from specifically trained psychiatric nurse practitioners, social workers, counselors and other therapists.

Where are our Patients?

Our patients are in the healthcare system, as psychological problems are first presented to a physician to whom all care is usually entrusted. It is estimated that PCPs are treating up to 80% of their patients who present psychological problems, making the primary care setting the de facto mental health system of the United States.

Decades ago it was discovered that 60% of visits to primary care were by patients who either had no physical illness but were somaticizing stress and emotional issues, or their physical illness was being exacerbated by psychological problems (Follette and Cummings 1967). Additionally, it was found that brief psychotherapy would reduce substantially the over-utilization of medical care that was burdening the system (Cummings and Follette 1968).Within a decade these findings were replicated in a score of other studies (Jones and Vischi 1979), and PCPs began routinely referring these somatizers to psychotherapy. All this has

now changed, as PCPs have learned to prescribe the newer psychotropic medications and referrals to psychotherapy have drastically fallen. These front-line physicians found considerable resistance existed toward such a referral, and all too often the patient responded with anger and resentment. Even those who on the surface accepted the referral, less than 10% ever entered into psychotherapy. On the other hand medication was readily accepted even though in many instances it resulted in no demonstrable change in the patient's somatizing behavior (Cummings 2006). A stark example of the decline in referrals for psychotherapy is found in the free-fall of referrals following psychiatric hospitalization. In 1990 nearly 95% of patients released from psychiatric hospitals were referred for outpatient psychotherapy. By 2000 the number had precipitously fallen to 10%, as discharged patients were given medication instead (Carnahan 2002). While psychology remains aloof from the healthcare system, often practicing in private offices far from medical settings, primary care physicians who used to refer patients for counseling are now prescribing and managing with the new psychotropic medications instead of arguing with reluctant patients who might otherwise benefit from psychotherapy.

There is a profound need to reevaluate our non-healthcare stance, perhaps even to revising our graduate training, and to reeducate psychologists as well as the general public that behavioral care is an integral and indispensable part of treatment. The alternative is continued decline as we are rendered near obsolete by the biomedical revolution.

Overcoming our Economic Illiteracy

Among practicing psychologists there is widespread misunderstanding of the economic forces that impinge on practice, suppress current incomes, and that will shape the future of healthcare delivery, either positively or negatively. Many practitioners suffer from an anti-business bias that blinds them to pertinent information that would be helpful to both them and their patients (O'Donohue et al. 2002). They complain they are seeing more patients for less money, and the managed care companies pay less an hour for psychotherapy than plumbers are paid for their work. Taking into account the wide educational disparity between doctoral psychologists and plumbers, they despair that society is treating them unfairly. It is not a matter of fairness, for there are economic principles that explain why plumbers are relatively well paid, whereas psychologists are underpaid. These principles remain a mystery to most psychologists. To put it sadly and bluntly, most psychologists are economic illiterates (Cummings 2006). In the lament, "All I want is an income commensurate with the years it took to obtain my doctorate," the complainer is oblivious to the fact that labor, along with goods and services, is subject to the laws of supply and demand. A simple illustration is appropriate.

The Case of the Mortar Carrying Bricklayer and the Plight of Psychology

A former patient who had recently moved into the community from another state was not able to get a job in his skill as a bricklayer, and in desperation accepted a minimum wage laborer's job carrying the mortar up the scaffolding to the bricklayers. He complained that even though he was working as a hod-carrier, he should be paid bricklayer's scale because he was a journeyman bricklayer. One day in a fit of pique he fell off the scaffolding, and now recovering from two broken bones, insisted he should be paid bricklayer's workers compensation scale, not that of a laborer. As I listened he reminded me of so many of our colleagues who are doing the same work as master's level psychotherapists, but want to be paid a higher doctoral pay scale. However, economic principles, not fairness, determine remuneration (from Cummings 2007). Consider the following:

- A perusal of state rosters of licensed psychotherapists or counselors reveals that the number of master's level practitioners (social workers, psychiatric nurse practitioners, marriage and family therapists, counselors) far outnumber the psychologists licensed to practice.
- Similarly, the managed care networks are populated largely by master's level providers, establishing the scale on the lower level, not at the doctoral level.
- The precipitously declining numbers of referrals for psychotherapy creates a glut of practitioners that further suppresses compensation.
- The absence of entrepreneurial and business training that is now found in all healthcare professions other than our own has prevented our profession from innovating new practice opportunities like those found flourishing in expanded dentistry, nursing that now dominates emergent care, and physicians that have refined the marketing and delivery of cosmetic and concierge medicine and surgery.
- Finally, our failure to establish ourselves as an integral and necessary part of healthcare has contributed to our being replaced by the biomedical revolution.

The Failure of Parity

The enactment of parity (i.e, rendering third party reimbursement for behavioral health care to be equivalent to reimbursement for physical healthcare) in 44 states as well as in the federal government constitutes perhaps the most

successful legislative effort in the history of mental health. The sad fact remains that expenditures in mental health care are less now than they were before parity, as the percentage of the national healthcare budget that goes to mental health has shrunk from 7% to less than 5% (Carnahan 2002). The managed care companies, as well as the government, simply instituted more draconian hurdles for mental health than for physical health. The well-intentioned "every-willing-provider" laws that mandate acceptance into managed care networks of every qualified applicant that their own negative effect. They merely created a larger practitioner pool vying for the diminishing number of referrals.

Had we been more economically savvy we would have anticipated that legislation is almost invariably trumped by economics. The often attempted rent control legislation is one painful example. Intended to aid the struggling renter, it only increased the shortages of available housing as landlords abandoned properties in rent-controlled districts and the building of new affordable housing sharply diminished (Sowell 2003).

Characteristics of a Business

- In spite of psychologists' contention that psychotherapy practice is not a business, but rather a "helping profession," it demonstrates all the attributes of a business.
- The practitioner offers a marketable service that the consumer wants.
- Seeking and receiving the service places the patient in the role of customer.
- The provider is licensed to dispense that service and is taxed on the income.
- The service is provided at the practitioner's office, which constitutes his or her business location, and the customer (patient) willingly comes to this office.
- In providing the service the practitioner must generate a revenue stream that will offset overhead (the cost of doing business.). Generating a sufficient patient load is called marketing, even though the techniques differ from the marketing of most commodities.
- Income above and beyond overhead, taxes, and other expenses constitutes the margin of profit.
- Unless the psychologist is determined to engage in an eleemosynary endeavor, the inability to attract customers (clients), to collect payment for services, or to meet expenses constitutes a business failure, even though professional parlance would prefer to call it unsuccessful practice.

In summary, the sooner a practitioner accepts that practice is business and sets about learning business principles and methods, the more likely is that psychologist to succeed. Psychotherapy acumen is a must, but it has to be augmented with a firm knowledge of business methods. We have seen too many excellent psychotherapists struggling without knowing why their practices are not generating sufficient income to sustain a livelihood.

Lessons from both the Biodyne Model and Integrated Behavioral/Primary Care

Both American Biodyne and the integrated behavioral/primary care models of practice are unabashedly in the healthcare business, and the results are startling when compared with traditional psychological care. In contrast to traditional referrals in which only 10% enter psychotherapy, when the PCP has only to walk the patient down the hall to the BCP's, 85–90% of patients in this so-called hallway handoff enter behavioral treatment. This is a ninefold increase in referrals (O'Donohue et al. 2006). Additionally, the method leverages the physicians' time, releasing the PCP to attend to more profitable procedures for which she or he is trained.

The Biodyne Model is based on over 20 years of evidence-based research and field demonstrations, and although freed from the 50-min hour, it actually expands psychotherapeutic services, even to addressing issues that are usually excluded by managed care because they do not qualify as medical necessity (Cummings and Cummings 2000). As a successful healthcare business model, it remains unparalleled and is still being used in a number of flourishing venues. It was originally based on capitation (the financial structure in which the providers are paid an agreed upon monthly flat fee per member per month, or pmpm), freeing the practitioners to provide any needed services rather than the ones usually covered by third party fee-for-service reimbursement. Unfortunately, most psychologists who have tried capitation failed miserably because the payment method is geared to innovation, not the delivery of relatively inefficient traditional therapy they were providing.

Entrepreneurship

Practice is becoming more difficult as the result of ever-increasing competition, professional "overcrowding," and lowered demand, and therefore innovation is required for practice to survive. The process of business innovation is called entrepreneurship and is different from entrepreneurial. The latter essentially means the management, marketing and other important ongoing aspects of an established business. On the other hand, an entrepreneur is one who creates, organizes, manages and assumes the *risk* of an *innovative* business enterprise. Note that the key

words are "risk" and innovative," and are the very attributes that are so absent in professional psychology. Steve Jobs and Bill Gates, who, respectively, founded Apple and Microsoft, are entrepreneurs.

Professional psychology is at the low ebb, and because it continues to attract students, it was named in a recent poll as one of the nation's most overrated endeavors, with an average income at the bottom of all the doctoral professions in healthcare (Nemko 2006). The next decade will decide whether professional psychology will survive, so innovation in defining itself to the public and in restructuring itself into a delivery system the public wants are crucial. In contrast to other healthcare organizations, our APA has failed to exercise leadership in training for, and encouraging innovation in how we package and deliver our services. The long outmoded 50-min hour remains sacrosanct.

In order to fill this void the Milton H. Erickson Foundation teamed with the Cummings Foundation for Behavioral Health and with considerable time and expense created a continuing education MBHA (master of behavioral health administration), all on video. The courses were all taught by renown experts and were designed for practicing psychotherapists who could fulfill each course requirement one by one and do as many as they wished, all in their spare time. These courses all on disks were offered to licensed practitioners at a cost so minimal as to be unheard of in continuing education. To date only a relative handful have taken advantage of the offer. This does not auger well for the future of psychotherapy, a profession that is desperately in need of innovation and creative change.

Entrepreneurship and Recognizing Business Opportunities in Psychology

One of the senior author's mentors Henry J. Kaiser (who built the Los Angeles aqueduct from Hoover Damn, who was a major ship builder in World War II, and together with Sidney Garfield, built the Kaiser Permanente healthcare system) said that a first step in building a successful business was to "find a need and fill it". Obviously psychologists need to find needs that are related to their expertise and interests—opportunities relating to mousetraps are of no interest. Fortunately, healthcare is currently about 15% of the GDP and increasing at a rate that is alarming (although behavioral health is only about 5% of the total healthcare dollar). Worries about these higher than the general rate of inflation increases, worries about demographic changes (the ever increasing proportion of the elderly who tend to be higher medical consumers), and worries about increases in lifestyle problems (e.g., obesity) form both important dimensions of the current healthcare crisis and the nexus of opportunities for psychologists. We can see that these are central issues in every political campaign. In crises, lie opportunities.

Psychologists missed both the first wave and the second wave defined by these crises. We have already discussed how psychologists missed the first wave—managed care. They also missed the second wave of opportunities—disease management. Disease management arose when the healthcare industry examined how it was spending most of its money and found that approximately 40% of its funds were spent on chronic diseases such as diabetes, asthma, COPD, pain, and coronary problems Cummings et al. 2005). In addition, it realized that the healthcare system was poorly organized to address these chronic conditions. The healthcare system was designed to take care of acute problems (broken bones, heart attacks) but not to address lifelong conditions that needed a lot of self management. Thus, individuals with these chronic conditions were being poorly treated and not getting their healthcare needs met. This was a huge opportunity.

Unfortunately, beginning about two decades ago, physicians, MBAs and nurses jumped in and now own the disease management industry which is hundreds of millions of dollars. Dominant companies such as Healthways employ only a handful of psychologists even though disease management deals with problems such as self control, social support, depression, treatment compliance, education and lifestyle changes—i.e., problems that are in our expertise not theirs. We missed this opportunity and we believe that psychologists and the patients of disease management both suffer because of this (Cummings et al. 2005).

What are the new wave opportunities? There are many but we want to mention two and discuss one a bit more. The two we see are gerontology and integrated care (and these intersect in interesting ways). What is clear is that due both to medical advances and better public health, individuals are living much longer. These elderly also require unique services (e.g., caregiver support related to Alzheimer's disease, bereavement counseling, behavioral health services in assisted living, and disease management tailored to their unique needs). However, psychologists are doing very little to address these. There are only a very few programs offering any specialty in this, and only a few token gerontologists on the typical clinical faculty. Again, there are practically no psychologist lead businesses addressing these opportunities (Hartmann-Stein 1998). Entering students are interested in child psychology and only very rarely interested in the elderly. More education is needed to see the business opportunities related to providing high quality services that meet the needs of this population.

Integrated care is needed in all primary care medical clinics. The business and ethical case for integrated care is this: integrated care can make patients healthier at lower costs. We believe for payers, patients, and providers it is a win-win-win situation. It does not attempt to artificially restrict the supply of medical services (as managed care attempted to do; but rather decreases the demand for integrated care services by making patients healthier). Payers are interested in economically efficient care (if they are not, again, proportionately more dollars go to healthcare and less is left over for education, food, etc.). Integrated care is efficient as it can give the patient that care that they need (e.g., treatment for their Panic Disorder—instead of unnecessary coronary care) rather than treatment the medical system is designed to give them. For the patient, integrated care provides one stop shopping and less stigma. And for the behavioral health provider, there is both the provision of needed services in a high volume setting; as well as the possibility of reaping financial rewards due to the value proposition that he or she is providing. Studies have shown that integrated care can produce decreases in medical costs in the range of 20–40% (Cummings et al. 2003). These savings can both drive contracts be used to drive more dollars toward the profession of psychology and the creation of businesses owned and operated by psychology.

In addition, there are other business opportunities (the business that can provide high quality and effective treatment of obesity will be worth billions of dollars; ehealth and telehealth also are the waves of the future). However, again, psychologists need to think like businessmen and not like economic victims to see and develop these. And the social welfare premise of our profession does not need to be lost—we should only develop businesses that provide high quality services. Psychologists need to concentrate on maximizing benefits to the public when appraising businesses, rather than worrying if too much money is flowing into someone's pockets.

Summary and Conclusion

The senior author is often accused of having consistently predicted the future of healthcare, and particularly behavioral healthcare, for the past 50 years. At this dire time we would like to believe that somehow psychology will rally before it is too late, but we are far less sanguine. When psychology reaches the point of no return, two things will have happened: (1) the flow of practice referrals will slow to a trickle relative to the number of practitioners available, and (2) incoming students, whom the APA and academia to date have perhaps purposely shielded from the true decline in the profession, will awaken to the facts and cease to go into psychology. At that point the crisis will have hit academia, psychology departments will shrink, and finally those who have failed to train us for the future will feel the pinch.

Innovation is an adaptive process of evolution. When obsolescence sets in, the outmoded order is painfully replaced by the new and vigorous adaptation. Systems that fail to innovate die. But they are replaced by the adaptation. This always involves the interim loss of jobs, dislocation, resentment, and often panic. Such occurred when managed care replaced the health provider as the determiner of practice, and most health professions have adapted and recovered. Psychology has not, and often such a failure is succeeded by gut-wrenching collapse out of which innovation will emerge. Yes, this sounds Darwinian, and psychologists as they continue to fight adaptation do not like the idea that when all else fails a new system can only rise from the ashes of a rigid system that refused to change or to die. We do not hesitate to point out to our patients the need for change. Psychologist, it is time to heal thyself.

References

Balint, M. (1957). *The doctor, his patient, and the illness*. New York: International Universities Press.

Barlow, D. H. (2004). Psychological treatments. *The American Psychologist, 59*, 869–878. doi:10.1037/0003-066X.59.9.869.

Cantor, D. (1993, August). Will the solo independent practitioner be extinct by the year 2000? Paper presented at APA practice directorate mini-convention, American Psychological Association Annual Meetings, Toronto.

Carnahan, I. (2002). Asylum for the insane. *Forbes, 169*(2), 33–34.

Cummings, N. A. (1985, August). The new mental health care delivery system and psychology's new role. Invited awards address to the American Psychological Association Annual Meetings, Los Angeles.

Cummings, N. A. (1986). The dismantling of our health system: Strategies for the survival of psychological practice. *The American Psychologist, 41*, 426–431. doi:10.1037/0003-066X.41.4.426.

Cummings, N. A. (2006). Psychology, the stalwart profession, faces new challenges and opportunities. *Professional Psychology, Research and Practice, 37*(6), 598–605. doi:10.1037/0735-7028.37.6.598.

Cummings, N. A. (2007). Treatment and assessment take place in an economic context always. In S. O. Lilienfeld & W. T. O'Donohue (Eds.), *17 great clinical ideas* (pp. 143–162). New York: Routledge (Taylor and Francis).

Cummings, N. A., & Cummings, J. L. (2000). *The essence of psychotherapy: Reinventing the art in the era of data*. San Diego: Academic Press.

Cummings, N. A., & Fernandez, L. (1985). Exciting new opportunities for psychologists in the market place. *In Practice, 5*, 38–42.

Cummings, N. A., & Follette, W. T. (1968). Psychiatric services and medical utilization in a prepaid health plan setting. Part 2. *Medical Care, 6*, 31–41. doi:10.1097/00005650-196801000-00003.

Cummings, N. A., & O'Donohue, W. T. (2008). *Eleven blunders that cripple psychotherapy in America: A remedial unblundering*. New York: Routledge (Taylor and Francis Group).

Cummings, N. A., Cummings, J. L., & Johnson, J. N. (Eds.). (1997). *Behavioral health in primary care: A guide for clinical integration*. Madison, CT: Psychosocial Press (International Universities Press).

Cummings, N. A., O'Donohue, W. T., & Ferguson, K. E. (Eds.). (2003). *Behavioral health as primal care: Beyond efficacy to effectiveness. Cummings Foundation for Behavioral Health: Healthcare utilization and cost series* (Vol. 6). Reno, NV: Context Press.

Cummings, N. A., O'Donohue, W. T., Hayes, S. C., & Follette, V. (Eds.). (2001). *Integrated behavioral health: Positioning mental health practice with medical/surgical practice*. San Diego: Academic Press.

Cummings, N. A., O'Donohue, W. T., & Naylor, E. V. (Eds.). (2005). *Psychological approaches to chronic disease management. Cummings Foundation for Behavioral Health: Healthcare utilization and cost series* (Vol. 8). Reno, NV: Context Press.

Dranove, D. (2000). *The economic evolution of American health care: From Marcus Welby to managed care*. Princeton: Princeton University Press.

Follette, W. T., & Cummings, N. A. (1967). Psychiatric services and medical utilization in a prepaid health plan setting. *Medical Care, 5*, 25–35. doi:10.1097/00005650-196701000-00005.

Hartmann-Stein, P. E. (1998). *Innovative behavioral healthcare for older adults: A guidebook for changing times*. San Francisco: Jossey-Bass.

Jones, K. R., & Vischi, T. R. (1979). The impact of alcohol, drug abuse, and mental health treatment on medical utilization: A review of the research literature. *Medical Care, 17*(suppl), 43–131.

Nemko, M. (2006). Overrated career: Psychologist. *U.S. News & World Report,* 51–52.

O'Donohue, W. T., Byrd, M. R., Cummings, N. A., & Henderson, D. A. (Eds.). (2005). *Behavioral integrative care: Treatments that work in the primary care setting*. New York: Brunner-Routledge (Taylor and Francis Group).

O'Donohue, W. T., Cummings, N. A., Cucciare, M. A., Runyan, C. N., & Cummings, J. L. (Eds.). (2006). *Integrated behavioral health care: A guide to effective interventi* . Amherst, NY: Humanity Books (Prometheus).

O'Donohue, W. T., Ferguson, K. E., & Cummings, N. A. (2002). Reflections on the medical cost offset effect. In N. A. Cummings, W. T. O'Donohue, & K. E. Ferguson (Eds.), *The impact of medical cost offset: Making it work you* (Vol. 5, pp. 11–28). Foundation for Behavioral Health: Healthcare Utilization and Cost Series. Reno, NV: Context Press.

Robinson, P. J., & Reiter, J. T. (2007). *Behavioral consultation and primary care: A guide to integrating services*. New York: Springer.

Saeman, H. (1996). Psychologists frustrated with managed care, economic issues, but plan to "hang tough". *National Psychologist, 5*(1), 1–2.

Sowell, T. (2003). *Applied economics*. New York: Basic Books.

Wright, R. H. (1992). Toward a political solution to psychology's dilemmas: Managing managed care. *In Practice, 12*(3), 111–113.