

Bringing Sanity into Mental Health Care: Why We Need National Health Insurance

This forum was held in New York City on May 24, 2005. Below are edited remarks of the speakers.

Peter Steinglass, MD

The keys to the current situation of mental health care in the US are understanding (1) why the inclusion of mental health as a component of any comprehensive health care system is so important and (2) what the onset of managed care has meant for our profession.

When I graduated from medical school in 1965, 20% of my graduating class went into psychiatry. Now, nationally the figure is more like 3-4%. This is just one example of the changing fortunes of mental health and the way it is perceived within our health care system. Steadily declining expenditures for the treatment of mental health problems are another.

Yet a psychiatric disorder is by far the most likely reason a patient shows up in a primary care physician's office. Studies have found that as many as 70% of all primary care visits are driven by psychological factors. This is hardly surprising, given the prevalence rates of psychiatric disorders in the US population: 14.6% of adults suffer from an anxiety disorder at some point in their lives, 13.3% experience alcohol abuse or dependence disorders, and 8.3% suffer from mood disorders, according to the NIMH Epidemiologic Catchment Area study. In other words, one cannot be a physician in the U.S. and avoid seeing mental health disorders virtually every day.

At the same time, the way mental health is currently handled makes it very hard to address adequately the needs of our patients and families. A large body of studies has convincingly demonstrated that including a psychological component within overall health care treatment can lead to significant cost savings in medical services. The reduction in expenditures from successfully addressing smoking, substance abuse, depression, and eating disorders are just some of the examples here. Nevertheless, mental health treatment remains under-funded and marginalized in our health care system.

Insurance companies have long viewed mental

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Marianne Jackson, PhD

As a psychologist advocating for universal health coverage, I have long thought it important to bring mental health professionals into this struggle. If we want them to join the fight for universal health care, we need to understand the issues facing their field. This is particularly important when it comes to private practitioners of psychotherapy. Typically, these are psychologists or social workers doing psychotherapy in their own offices. They generally choose to work in private practice because of the autonomy, flexibility of working conditions, and the chance to earn more than in the public sector. Private practice was for a long time seen as a safe haven, where clinicians could do their work unhampered by the bureaucratic control typical of public institutions. However, in recent years, as a majority of their patients come to treatment with insurance, working in private practice has become increasingly burdensome.

A key issue for private practice is parity in insurance coverage with medical treatment. In the 1990s, when insurance companies carved out behavioral treatment and put it under the control of separate managed care companies, insurance payments for psychotherapy were drastically reduced through higher co-pays and deductibles and caps on yearly payouts for treatment. Both practitioners and patients have suffered. Practitioners who take insurance are making less money, and many are leaving the field. In some locales, patients cannot find a clinician, or they experience long waits. Many with insurance cannot afford the out-of-pocket fees, so that many who need long-term therapy must forego it.

The sheer complexity of dealing with different managed care companies and differing insurance contracts makes it an almost impossible system to work in. Insurance companies create a high level of external control over treatment through requiring written reports on symptoms and patient progress before payment will be authorized. The results are a

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health issues with suspicion. Part of it is our approach to diagnosis (every few years we adopt a different DSM system); part of it is that mental health treatment guidelines have been difficult to pin down. Because of these factors, and the ensuing challenge to mental health funding under managed care, the idea emerged in the 1990s of separating out mental health and assigning it to a group of people who would administer and carry out mental health practice. To implement these “carve-outs,” separate managed care companies, called Managed Behavioral Health Organizations (MBHOs), were created with the primary purpose of controlling costs.

As MBHOs have increasingly dominated the way mental health benefits are provided—currently as many as 180 million individuals are covered by such plans—the restrictions imposed on providers plus the resulting challenges to patient confidentiality have caused many mental health professionals to opt out of participation in any insurance plans. (Parenthetically, a variety of studies and audit reports suggest that there have been serious quality problems in these carve-out systems.)

Thus, although in the 1980s many mental health professionals seemed to favor the concept of carve-outs as a way of guaranteeing support for mental health benefits, by the end of the 1990s the mood had totally changed. One clear example: a 2002 statement by the American Psychiatric Association declared that “separation of the funding and delivery of psychiatric and/or substance abuse services as carve-outs from general medical services is detrimental to providing high quality comprehensive care. The carve-out mechanism leads to stigmatization of psychiatric patients and marginalization of psychiatric treatment.”

The take-home message from such a statement is clear—what we need is a fully integrated system of medical care in which mental health services are treated no differently than other medical care. One question, then, is whether there is any realistic chance of doing that within the current funding environment, or whether we must first move to a universal health care system to accomplish it. The

kind of system PNHP advocates, in which physicians remain private practitioners, patients can select their doctors, and coverage includes both medical and mental health services, would clearly satisfy the goal of integrated care.

PNHP-NY Metro FORUM REPORT

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heavy burden of paperwork and phone calls for practitioners and a loss of privacy for patients.

These “clinical reviews” are seen by clinicians as an interference with their professional autonomy and a form of harassment designed to discourage clinicians and patients from continuing with needed treatment. It is clear to most clinicians that these managed care giants are simply a drain on the financial resources of mental health and provide no needed service. However they are not convinced that this burdensome bureaucracy would disappear under the public financing system we favor.

Private practitioners are deeply concerned about their professional autonomy in the face of these control tactics. A particular threat to clinical autonomy is the growing demand for “evidence-based practice,” an idea which they feel is exploited by managed care firms to justify reducing payouts, particularly for long-term therapy. Private practice clinicians are also concerned about threats to patient privacy coming from the federal government. The Department of Health and Human Services (HHS) altered the HIPAA rules to take away patients’ control over their medical records. The fact that this threat to medical privacy is coming from HHS reinforces the belief among many clinicians that “you can’t trust the government”—a key factor in their resistance to the idea of a publicly-financed health system. Also, some private practitioners identify with small business and with a free market ideology. Even though most psychotherapists may be politically liberal, when it comes to their professional work, some have libertarian attitudes or are just plain apolitical.

Forum Conclusion

Many mental health providers are highly suspicious of single-payer plans like that advocated by PNHP. Thus one of the areas where we really need work is in convincing mental health practitioners that the kind of practice arrangement they now have, including private practice, will remain viable under such a system. We need to address their issues: overcoming stigma, economic parity, decent working conditions, and professional autonomy. We must show that a single payer system would not only benefit most Americans, but would be a system in which psychotherapists would be able successfully to do their professional work.

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