Insured Psychiatric Care

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PROVISION of psychiatric care, particularly for ambulatory persons in the low-income and middle-income groups, is high on the list of unsolved health service needs facing this Nation. Courageous experiments with insurance for mental illness, however, have suggested that it may be possible to widen distribution of psychiatric services. Notably, the Central Institute of Psychogenic Illness of the Health Insurance Fund of West Berlin offers valuable experience in this unfamiliar field.

In a national atmosphere where the potentialities of science are dramatized by radio, television, movies, and newspapers, a popular demand for efficacious psychiatric care is urgent. But there are a myraid of problems that need to be resolved before this demand can be satisfied.

The consumer, for example, often finds it difficult to determine for himself or his family what constitutes an appropriate psychiatric referral. And the consumer is not alone in this dilemma. The psychiatrist's colleagues in other specialties of medicine, social work, law, education, housing, and industry often refer to him the recalcitrant, uncooperative person whom all have given up as too difficult to deal with in the normal course of events.

In other words, the range of problems considered appropriate for psychiatric referral can be as broad as life itself (*1*). Moreover, the pressures generated by individuals who feel the need of care, by professional colleagues, or by community services acting on their own behalf are such that an extraordinary amount of psychiatric time is diverted and not necessarily well used.

The first step then is to define what is meant by psychiatric need. Within the context of these remarks, I shall limit the use of the phrase "psychiatric need" to designate psychiatric illness. This confines the definition to those manifestations of illness that seriously interfere with normal and usual functioning of adults and children in the activities of daily living. It excludes many kinds of expressions of deviant behavior as well as the wide variety of measures designed to make people happier.

If we accept these limitations, the next step is to relate the nature of the psychiatric problem to the kind of treatment needed. The present failure to clarify this relationship has resulted in an enormous waste of psychiatric time, and has added to the frustration and confusion of the consumer who does not know where to turn or what kind of psychiatric service he should seek. The waste is also a consequence of our present lack of organized psychiatric services on a community basis. A more clearly designed community plan will have to be fashioned to conserve resources of treatment as well as to expedite referrals. Insurance protection will not miraculously wipe out this grave problem. But any systematic screening method that will help consumers clarify and assess their need, and bring them more directly toward the kind of psychiatric treatment required, is bound to have a profound effect upon the practice of psychiatry and contribute to its productive use.

New York's Plan

In this connection, it seems pertinent to refer to experience in the Health Insurance Plan of Greater New York. Since its establishment 12

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years ago, the plan has worked with a wide range of psychiatric and emotional disorders requiring treatment, and has had to struggle to match needs with scarce treatment services available at fees possible for most subscribers.

The Health Insurance Plan provides psychiatric consultative and diagnostic services. It is a prepayment insurance organization, community sponsored, with medical care provided by 32 separate medical groups. Each medical group has at least one psychiatrist. Referral to community resources may be had through social services within the plan.

Psychiatric consultation is available on referral by the family physician or by other specialists so that the patient can receive consultation without delay. This means that the subscriber has the benefit, without financial barrier, of early detection and diagnosis of a psychiatric condition. An added advantage is that the physicians in the medical groups have known their patients over a period of years and, therefore, often have pertinent information on their general health and family situations.

These are distinct gains. But since the plan does not, as yet, include psychiatric treatment as a benefit, HIP is chronically pressed to find psychiatric treatment services for those diagnosed as needing such care.

It is my impression that the experiences of HIP in seeking psychiatric care for subscribers confirms the general community experience. The HIP population includes a representative cross section of a metropolitan community: school teachers, policemen, sanitation workers, governmental employees of all levels, writers, clerks, movie projectionists, machinists, and business executives among others. On an income basis, we find that approximately 90 percent of the subscribers report their earnings as less than $5,000 annually if single, and $7,500 annually if heads of families. This leaves 10 percent reporting their earnings as beyond these rates.

Recognizing that the bulk of the HIP population falls into the low- and middle-income groups (actually not too different from our national distribution), it follows that the psychiatric fees they can afford to pay are limited, unless they go into debt or change their living pattern. Some of these consumers may have the double handicap of limited funds and a discouraging diagnosis.

In many communities it is clear that among the adults and children most urgently needing care today are the extremely ill who are not yet in State hospitals or are not eligible. These are the individuals for whom ambulatory or day care is most difficult to obtain. Many clinics, agencies, and private psychiatrists find them difficult to manage and too unrewarding to be accepted for treatment.

Besides patients with extreme or chronic mental illness there are others for whom care is particularly difficult to obtain: individuals who require immediate treatment in order to meet crises; those who with intensive treatment could avoid hospitalization; and those whose conditions can be diagnosed adequately only through a comprehensive study employing interdisciplinary collaboration.

There are others whose psychiatric needs are interwoven with serious medical difficulties. Within this category are those with amputations, allergies, ulcers, and heart conditions who need integrated treatment. Among these, and others, we find persons whose ability to function in work, education, and family life is so seriously impaired that they require psychiatric treatment to attain a self-maintaining level of living.

Disadvantages in not providing psychiatric treatment as part of a comprehensive medical care plan are recognized by most organizations providing such care. In HIP, the psychiatrists themselves have urged that as soon as it is feasible psychiatric treatment should become a part of the plan.

In addition to the clinical need to provide treatment service, especially for those needing short-term ambulatory care, there are additional values from a mental health point of view that deserve mention.

Excluding psychiatric treatment from any plan may well reinforce in a patient the feeling of being a special problem, of being different, or of having a stigma. At the same time, it is not unlikely that physicians in other specialties would be affected in their attitudes toward psychiatric treatment. Exclusion strengthens any sense of difference the physician might harbor between psychiatric need and other medical

needs, setting psychiatric treatment apart as not an essential ingredient of medical care. From a practical point of view, lack of such service cannot help but increase the irritation and frustration of physicians treating subscribers who are not getting the psychiatric care they need. As in private practice, these patients often become high utilizers of medical services.

Broad Financial Aspects

We should now look at the broader population to get a fuller understanding of the financial aspects of the problem. Let us consider the fact that 1 family out of 6 in the Nation has an income of $7,000 (*2*). If we are considering those who can really afford to buy psychiatric care on a private basis, we should have to restrict the population to those having a family income of $10,000 per year. This represents 1 family in 14.

The inability of most of the population to pay for psychiatric care on a private basis becomes even clearer when we study the net income and cost figures. The crucial fact is that only 10 percent of the population at the present time is in a financial position to buy private psychiatric care. In other words, some 90 percent of the population must either look to philanthropic or governmental sources for treatment or delay treatment, go without treatment, or build up excessive debts.

A report prepared by the Community Council of Greater New York (*3*) analyzes the amount of money available, beyond basic living costs for employed persons and heads of families, to purchase psychiatric care. This study reveals that a family of four with an annual income between $7,000 and $8,000 and living modestly in a metropolitan community would have only $7 or $8 a week for psychiatric treatment fees over a period of 50 weeks during the year. A family of four with an income of $10,000 might conceivably have not much more than $20 a week for psychiatric fees.

We can assume that the inability of many medical care programs to include psychiatric service is due to the high cost of this service and its scarcity. However, with the trend in this field moving from hospital care to community care, we see a change having important bearing on our discussion. With the consumer's increased knowledge about psychotherapy, optimistic reports of shorter treatment periods, and more emphasis on early casefinding in hospitals, group practice, and health centers, we can expect that more people with psychiatric illness will come for treatment and at an earlier time in the illness. This is particularly true for the insured consumer. A nationwide family survey, conducted by the Health Information Foundation, revealed that insured families, regardless of income, are more likely to use services available to them than uninsured families in the same groups (*4*).

There seems to be little doubt that the demand by consumers for psychiatric care is rolling up around us. We see, for example, an increasing number of organizations sponsored by citizens springing up in all parts of the country, and each is trying to find solutions to various aspects of this problem.

The complexities involved in providing the consumer with protection through insurance are apparent, especially since we believe the standards for this care should be similar to the standards for other medical care. In other words, a psychiatric program should remove the economic deterrent to those seeking help. It should provide treatment adequate in amount, kind, and quality as early in the onset of the illness as possible. Appropriate participation by the related professions of psychology, social work, and therapeutic education should be an integral part of the plan. Its design needs to take into account the fears, anxieties, and resistance of patients who are seeking, accepting, and utilizing this kind of care.

West Berlin's Plan

The Health Insurance Fund of West Berlin, with its Central Institute for Psychogenic Illness, has been able to meet a wide variety of psychiatric needs, including psychotherapy. From first-hand information gained during a visit to Germany in the summer of 1956 and from the 1953 and 1954 annual reports of the program, I can give the following description.

One of the reports states that the basic premise underlying the program is that a great deal of illness "is not primarily organic but is emotional or mental in nature. The Health Insur-

ance Administration therefore organized the Institute for Psychogenic Illness . . . so that insured persons could receive psychotherapeutic treatment."

The health insurance program, which covers some 750,000 people, operates through a series of polyclinics, or health centers, located in various districts of the city. Psychiatrists in these polyclinics may themselves treat patients with psychiatric problems, using any of several psychiatric methods, including shock therapy or sleep therapy. For psychotherapy, however, they refer patients to the Central Institute for Psychogenic Illness.

The psychotherapeutic services are given only to ambulatory patients who are able to remain in the community. In addition to patients referred by the polyclinics, the institute cooperates with mental hospitals in the region by accepting for followup some patients after they are discharged.

The Health Insurance Fund provides for 150 to 200 treatment-hours for each patient, but the institute tries to get results in 100 hours. Both individual and group therapy are provided. Patients receiving individual treatment are seen 2 or 3 times a week over a period of a year or a year and a half.

Patients referred to the institute are given at reception a preliminary examination lasting 1 to 2 hours. Later they receive a complete physical examination including extensive neurological examination. About 2 weeks after that, the patient returns for the institute's decision as to whether he is accepted. Two psychiatrists and an internist review the findings, decide whether the patient is treatable, and outline the general plan for treatment if the patient is accepted. A diagnosis is established.

The institute sees from 120 to 150 new adult patients and from 50 to 60 new children a month. Of these, according to the institute's criteria, one-third are not treatable, one-third have a good prognosis, and the final one-third are in a borderline category. Those considered unsuitable for treatment are referred back to the polyclinic or to some other service for supportive psychiatric or social care. The one-third with a good prognosis are generally accepted, and the one-third that are considered borderline are studied more carefully to determine whether or not they can be helped. The institute staff apparently tries to accept the borderline group if there is any possibility of response to treatment.

The waiting period between acceptance and beginning of treatment is usually about 3 months.

The comprehensive character of its diagnostic and screening service seems an important factor in the successful operation of the program. Many believe the institute's ability to maintain stable and effective service lies in the team studies that precede the decisions for accepting a patient. Another significant factor in the institute's program is the seeming effectiveness of its time-limited psychotherapy.

In general, the institute accepts most neuroses, especially compulsive, obsessive, and agoraphobic. They do not accept schizophrenic patients.

Reports on psychotherapy are submitted to the director of the institute after the first 50 hours of treatment and when treatment is completed. If a patient has not improved sufficiently at the end of 150 hours of psychotherapy to discontinue treatment, the psychotherapist must justify an extension.

There are no psychologists with the clinic, and no psychological testing is done. Part-time group psychologists work in group therapy. There are no social workers at the institute, but the staff may call on social work service from outside agencies.

Persons treated by the institute through 1953 numbered 5,114. Investigation of 1,389 dismissed cases showed the following results: cured, 538 (39 percent); improved, 401 (28 percent); unchanged, 275 (20 percent); results not yet determined, 175 (13 percent).

In order to determine to what extent a permanent result had been achieved, special studies were made of 300 former patients whose treatment had been terminated successfully 3 or at least 2 years previously. Of these, 83.7 percent had retained the benefit of their treatment; 13.6 percent had relapsed, and the status of 2.7 percent could not be evaluated. These results were confirmed by neurologists and internists of the Central Association of Specialists, which is not connected with the Institute for Psychogenic Illness.

It is difficult to compare costs for the United States and Germany for the psychotherapeutic services, since the compensation of physicians differs considerably between the two countries. At their own rate of payment, it costs the institute an average of DM 750 per patient served per year. At the present rate of exchange, this would be about $178.50.

The full-time physicians receive monthly salaries ranging from DM 700 for the young psychiatrists to DM 1,400 (before 20 percent taxes). The payment is DM 5.00 per hour for medical therapists and DM 4.00 per hour for nonmedical therapists. Each psychiatrist sees about 7 patients twice a week and participates in screening about 16 or 17 applicants a week.

The provision of psychotherapy, though it had been included in the health insurance program for 10 years, was still a controversial issue. However, four other cities in Germany also give psychotherapy services to subscribers of their insurance plans: Munich (paid by social insurance and the university), Göttingen, Heidelberg, and Hamburg.

It is the belief of those at the institute that a great deal of knowledge has been accumulated with regard to the appropriate integration of psychotherapy within the framework of medical care. As a result, they look forward to replacing full analysis for the treatment of neurosis with psychotherapy, in certain circumstances.

For those interested in further substantiation of the results of the psychotherapy program, the Central Institute for Psychogenic Illness has published studies assessing their achievements.

Conclusion

It is my belief that the consumer's demand for psychiatric treatment will continue to increase. The problem of mental illness, now that it is in the open and acknowledged, goes to the heart of our social health. Those working in the field can, hopefully, influence the forms the solutions will take.

We cannot underestimate the complexities and difficulties that must be faced in order to achieve sound planning. At the same time, I should urge that an understanding of these problems be shared with consumers so that their efforts can supplement those of all professional and planning groups striving to meet these needs.

Summary

The experience of the Health Insurance Plan of Greater New York, which provides psychiatric consultation but not treatment, offers abundant evidence of the need for more readily available and financially feasible psychiatric services for low- and middle-income groups. From the fact that only 10 percent of the people in the United States can afford private psychiatric care, it is clear that the lower income groups face a serious problem in obtaining psychiatric help, particularly psychotherapy of long duration.

An existing insurance plan, the West Berlin Health Insurance Fund, with its Central Institute for Psychogenic Illness, has been able to provide its members full study, psychiatric treatment, and psychotherapy. Each member accepted for treatment (more than one-third of the applicants) receives 150 to 200 treatment hours over a period of 1 to 1½ years.

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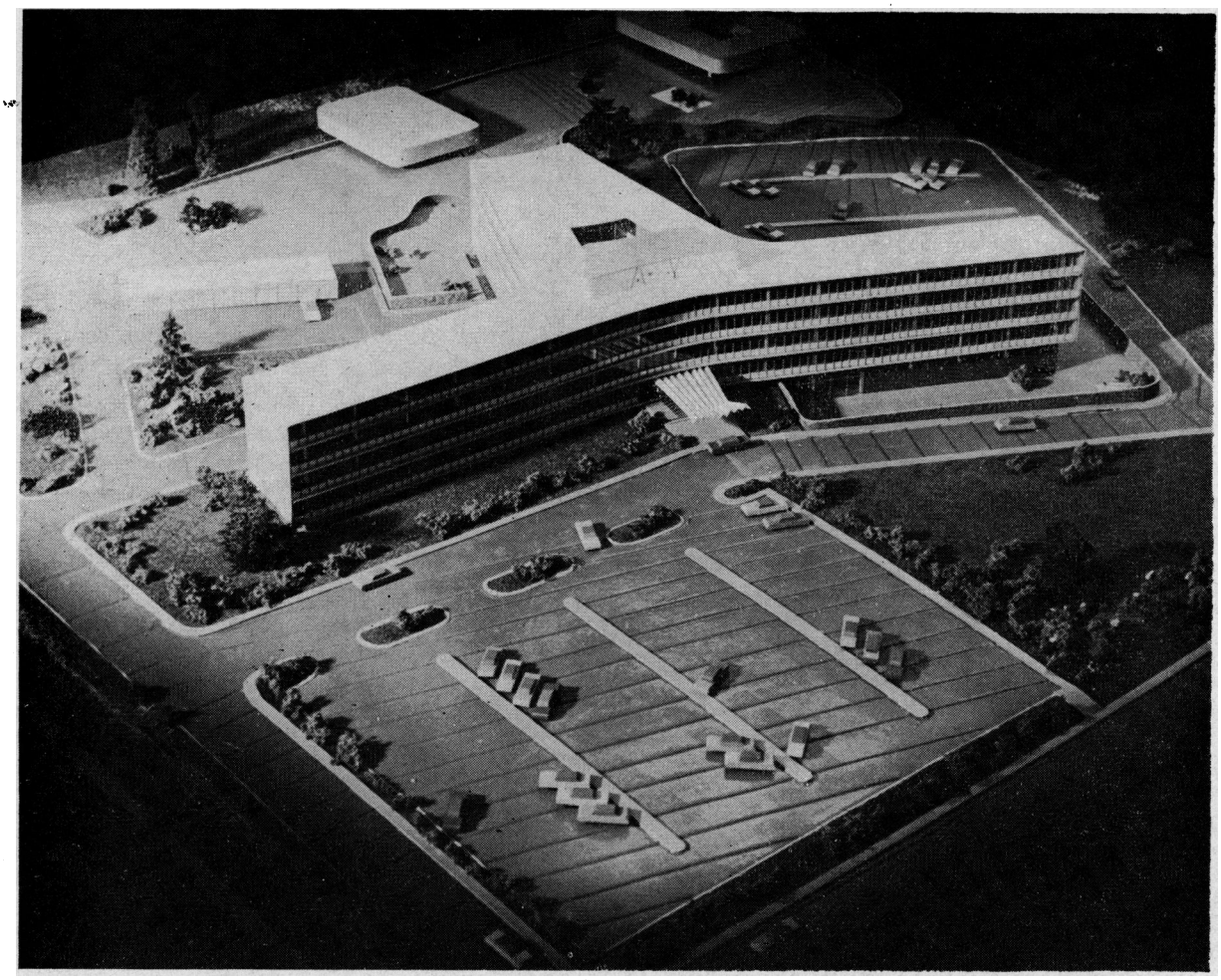

NEW INDIAN HOSPITAL

The hub of health and medical services for 81,700 Indians will be the new 200-bed Public Health Service Hospital in Gallup, N. Mex. Construction of the $2,966,300 building, a modern four-story concrete and aluminum structure, will be completed in November 1960.

As the prime referral facility for 7 peripheral hospitals and 24 health centers and field stations in an area about the size of West Virginia, the hospital will serve Indians living on or near the Navajo Reservation in Arizona, New Mexico, and Utah.

Referral care will encompass not only the specialty surgical and medical services (diagnostic workup, cardiovascular diseases and gastroenterology, orthopedics, urology, gynecology, ophthalmology, and otolaryngology) but also such specialties as neuropsychiatric and rehabilitation services which have not been available to any great extent for this Indian population.

The comprehensive outpatient department will provide complete and integrated medical care and preventive health services. The center's medical staff and consultants under contract will give specialty consultation to field personnel. The center will also serve as the training facility for the region for both hospital and field health personnel. It is anticipated that comprehensive internship and residency training will be developed in several specialties.