Mental Health
– A Review of 1997
Taking It Slowly With Managed Care - Invited Address in a Workshop on Managed Care for Mental Health: International Experiences and the New Zealand Direction, Schizophrenia Fellowship National Conference, Christchurch, September 5-7, 1997

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What Is Managed Care and Why Do We Want It?
Managed care arose from a need to contain the escalating health costs of the insurance and litigation based US health system, which were rising at rates of more than 10% a year through the early 1990s. It is described as the application of market forces to health. It is an insurance based system in which health management organisations (HMOs) provide cover for illness through a range of preferred providers who discount their services partly on the basis of restricting the options for care relating to particular illness groups. The heart of the managed care system is the utilization review in which the cost-effectiveness of the options for care are analysed, resulting in the more wasteful options being eliminated.

Utilization review studies have found as much as a quarter to a third of all medical services performed are of little or no benefit to patients. Utilization reviews have also shifted the emphasis of care towards preventative approaches. While managed care initially resulted in increases to the cost of health care it began to be very effective in 1994 (only a 6.5% increase in national costs) with managed care group health care costs falling by 1.1% and remaining flat in 1995.

A recent newspaper report describes the "inexplicable" buoyancy of the US economy, with one commentator saying that the reduction in health care insurance costs was a major contributor. A majority of US citizens have their health insurance paid by their employer, and about half the US population (135 million people) is enrolled in a managed care system. The US government expects to save $250 billion through the implementation of managed care.

The Development of Managed Care Systems in New Zealand
In New Zealand the development of managed care has been based more on the British non-profit fund-holding model than the US managed care system, but looks set to evolve from the former to the latter. You start off with an independent practitioners association (IPA) - a GP practice group - and you bulk fund it for a number of services (clinics, tests, interventions, medications, referrals to other specialists, prevention and health promotion activities) based on the demographic structure (age, sex, socio-economic status, culture) of the IPA's client group and the predicted need for GP level services. If the IPA saves money on the drug bill, it can put that money into a prevention campaign such as immunisation. Alternatively, it could improve the facilities of the IPA or training of its staff. So while the principle of bulk funding IPAs is not to allow the business to skim off the profits made from cost savings, increasing the value of the assets owned by the business or paying for overseas conference holidays does make it possible for some skimming to occur.

The next stage signalled by the Minister of Health is to fund IPAs for the costs of
all health services, not just community services. IPAs would then become the purchasers of hospital services and also of community mental health services. Again the aim is to reduce costs on expensive treatments by the practice of good preventative medicine. So if the IPA did not need to purchase expensive heart operations and treatment for lung cancer because it was successful in its anti-obesity and anti-smoking campaigns, that money could be directed in other ways, including lowering the costs of health care to the clients of the IPAs. The problem is that need for very expensive treatments is not evenly spread from year to year, and there is no accurate way of predicting the likelihood of the IPA clients having a heart attack or being involved in a serious car accident. Consequently, there is quite a high level of risk in taking on the purchasing of all health services, and IPAs will need to have cover for that risk from an insurance company who will, in all likelihood, be a business partner and, in some cases, a business owner of the IPA. Insurance companies will expect to make a healthy profit on their investment.

The client of the IPA will become increasingly restricted to the IPA services and those of its preferred providers. While there may be options outside the IPA providers, particularly for high risk/cost groups like people with a mental illness, we would have to decide whether we were in or out. So by going to a particular IPA we would, in fact, be choosing our health care plan. We would find that, in addition to the basic government service, we could get additional benefits if we were prepared to pay for these ourselves.

Mental health services in New Zealand have thus far stood outside the managed care paradigm. Even the use of utilisation review in mental health services in New Zealand is in its infancy. The first steps towards a managed care system are the independent needs assessment and service coordination agencies in the southern and northern Health Funding Authority regions, particularly in the northern region where discretionary funding has been added to the service brokerage function. These services are driven in part by the need to hold down costs by shifting services to less expensive models of service provision, particularly in the case of the Northern Division of the Health Funding Authority’s Regional Coordination Service whose focus is to keep people whose accommodation needs are level 3 or greater out of acute wards.

The Downside of Managed Care
When we move to less expensive treatment options two things happen: we are denied choice and, occasionally, we are denied treatment that we really need. The classic example is the US$40 million verdict in 1995 against Kaiser Permanente, the largest health management organisation (HMO) in the US. The family of a 6-month-old boy with a rare blood clotting disease alleged that he lost both hands and legs following a cardio-respiratory arrest during the trip to the hospital. The HMO had directed the family to a hospital 42 miles from his home, where the HMO received a 15% discount, despite the fact that the child had a 104-degree temperature.

At the same time as the managed care companies have forced this kind of penny
pinching they have been making phenomenal profits and their CEOs have been the highest paid in the US. For example, Leonard Abramson, founder and chief executive of US Healthcare, will gain a US$1 billion bonus as a result of his company's $9 billion merger with Aetna Life & Casualty Co. More as a result of the greed of managed care companies than large scale dissatisfaction with service received, there has been a flood of state and federal bills aimed at curbing the excesses of managed care companies. These cover legislation requiring:

- insurers to pay for a 48-hour minimum of inpatient care for maternity patients and their babies following delivery,
- standards for access to emergency care that would prohibit managed care plans from requiring prior authorisation for emergency care and defines what constitutes such care, and
- managed care organisations not to restrict physicians from advising patients about treatment options which may not be covered by the managed care plan.

Perhaps the strongest opposition to managed care has come from the mental health sector. Insurers have traditionally baulked at providing full mental health cover because of the long-term effects of much of mental illness, the wide range of treatment options, and the uncertainty about what works and what does not. Thirty percent of Americans experience an episode of mental illness each year, and 14% have experienced three or more episodes of major illness. However, only 40% of those experiencing mental illness receive treatment, and only 60% of those who had experienced three or more episodes of major illness had ever received treatment. Mental health services consume 15% of the health budget and clearly have the capacity to consume more. Only 64% of people with severe mental illnesses have some private health insurance, but it is often highly restricted, paying only 50% of the costs or with limits on visits to doctors, outpatient support, days in hospital, and annual and lifetime limits (eg, 190 inpatient days) on the total amount of care received. Utilization review in mental health has drawn two major conclusions:

- the evidence on psychotherapies makes no general distinction between the effectiveness of different modalities, including brief therapies and group therapies, and therefore these more cost-effective therapies should be used,
- substitution of psychiatrists and psychologists by less expensive social workers and counsellors does not lead to less effective therapy.

Because mental health is affected by a very wide range of demographic variables, the requirements by managed care companies for information about clients can seem unduly intrusive. Here is an example of the information required by a managed care company and the potential range of people who might view that information.

"I authorize you to furnish New York Life Insurance Company, its agents, affiliates and subsidiaries, or benefit plan administrators, independent claim administrators and insurance support organizations, with copies of records you may have concerning examinations, treatment, including
drug, alcohol or psychiatric treatments, if any, history, diagnoses, prescriptions, other medical information, information relating to medical expenses and any personal or employment related information which may relate to this claim.

"I understand that such information and records will be used by New York Life for the purpose of evaluating and administering claims for benefits. New York Life may release it for those purposes, or for the purpose of coordinating benefit payments under any Non-Duplication of Benefit Provision, to any of its affiliates and subsidiaries, to its representatives performing business or legal functions, to insurance support organizations, to benefit plan administrators, to independent claim administrators, to my employer, group policyholder or contractholder and their representatives, and to all other insurance institutions."

Ohrin-Greipp J & Ohrin-Greipp C, 'A Word About Managed Care', 1997, therapy687@aol.com

Not surprisingly there has been considerable professional opposition to managed care, but more importantly a broad coalition of US consumer, family and advocacy organisations met in May of last year in an effort to stem the damaging tide of poorly planned implementation of public managed care systems. Michael Faenza, President and CEO of the National Mental Health Association, doubts that managed care companies have sufficient expertise in or experience of working with persons diagnosed with serious mental illnesses or with the mental health issues of children and their families. Laurie Flynn, Executive Officer of the US National Alliance for the Mentally Ill, has said of the introduction of managed care to mental health: "Perhaps the most serious risks we face in this transition time are the continuing incentives to under-recognise, under-diagnose, and under-treat serious and persistent mental illness in systems that are still driven almost entirely by cost-containment." (Flynn LM, 'The Impact of Managed Care', National Alliance for the Mentally Ill, 1996, namiofc@aol.com). National Alliance for the Mentally Ill has identified the following caveats for effective managed mental health care:

- A partnership with consumer and families - major representation on advisory committees, and consultation on all matters affecting them
- Family members respected for the contributions they can make
- Accountability for performance based upon published standards and protocols
- Individual Plan process to be implemented and a commitment to longitudinal assessment
- All planning and delivery of services must be culturally sensitive to ethnically diverse populations and the communities in which they are located
- Explicit criteria applied in making individual case decisions which respect consumer choice in the design and development of the program
- Ethical requirements set out in a patients' bill of rights
- The latest medications to be made available to all consumers
• A comprehensive array of community support services to be available and open to the incorporation of new treatment modalities
• Retention of experienced professional providers
• Managed care staff who are truly qualified in the delivery of mental health services
• Clear mechanisms for achieving second opinions and encouragement of the use of expert consultation
• A published procedure for appeal of decisions and mechanisms for rapid administrative review in any disputes about treatment or services
• Quality and outcomes to be monitored and regularly reported
• Independent on-site visits and case reviews
• A strong internal program of evaluation of outcome measures
• Ongoing efforts to reach to underserved and difficult-to-engage populations
• No dropping of chronic heavy users of services for cost avoidance
• Public resources saved by reduced utilization of hospitals and through other system efficiencies should be reallocated to expand services to the priority population
• An independent annual review of planned performance, goals, and objectives, including confidential interviews with a cross-sampling of providers, consumers, and their families, and
• Public hearings to be held regularly.

**Improving Managed Care**

Some of these concerns appear to have been incorporated into some of the newer state run managed care initiatives. A number of states have moved to a more regulated form of managed care called managed competition in which bodies something akin to regional health authorities purchase standardised health care plans which have no exclusions because of pre-existing conditions like mental illness. Managed competition has a strong emphasis of public accountability of managed care companies and mental health providers, using report cards in which service evaluation reviews are made public. Specific organisations, called behavioural health organisations, have sprung up specifically to develop mental health care plans. New York's Special Needs Plan for mental health services, developed in conjunction with consumers, families and providers, includes a comprehensive quality assurance programme, protocols for service coordination, and consumer protection requirements (mandated options, disclosure of options, grievance procedures). Consumers will choose who will be their mental health care coordinator wherever practical. Re-insurance cover will be purchased for adverse selection and catastrophic cases and the state retains the responsibility for rate setting, standards, certification, regulation and oversight. The number of managed care providers will be carefully controlled. Other states, such as Vermont and Indiana, again with considerable consumer and family involvement, have developed managed competition models.

Where does this leave us? The incentives for some form of managed care are enormous. The costs of health care and particularly mental health continue to rise. The Minister of Health said recently that he was not sure that the $32 million of Mason money that we have spent this year had had any demonstrable
effect - many would agree. Because GPs are generally poorly equipped to provide mental health services, the development of IPAs into providers of comprehensive health care plans may present risks to the purchase of effective mental health services, particularly for Maori and Pacific Island people. Maori are alert to these risks and some groups are keen to develop their own health care plans. Because the health and mental health paradigms (in prevention, diagnosis, treatment, and outcome) and health risks for Maori may differ considerably from that of the mainstream it is possible that quite different funding formulas would need to be developed.

Poorly structured managed care presents many risks to providers and consumers and it would pay to develop first the features important to controlling the excesses of managed care - a depth of consumer, family and culturally appropriate involvement in the planning of our mental health services, and highly effective quality assurance mechanisms including utilization reviews and report cards - before embracing its undoubted economic potential.