

FORUM MANAGED CARE AND PSYCHIATRY

The economics of mental health care in the USA and the potential for managed care to expand into Europe.

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Introduction

Defining managed care is actually more difficult than it seems. Because managed care is such a complicated issue, no one definition appears to describe it adequately. Thus, I provide four different views. The first is my own [1].

I have described managed care as consisting of four elements - as a way of providing care, a philosophy of care, a way to finance care and a way to control costs - all of which are intertwined. It provides care by using provider groups, provider networks, and, in the case of mental health, mental health carve-outs. Its philosophy of care involves health maintenance, prevention/limitation of hospitalization, and an emphasis on alternatives to hospitalization. It is a way to finance care. For example, managed care companies use only certain 'providers' (e.g. doctors) who sign contracts with them, agreeing to provide services at lower costs, which are determined in advance in the contract; thus, the companies can better predict the cost of care. Persons who get their care through such companies are then obliged to use those providers. Finally, it is a way to control costs, by covering some but not other illnesses, by utilizing guidelines for treatment, and by employing reviewers to determine the 'medical necessity' of the care proposed.

A second way of viewing managed care is that proposed by Sharfstein [2]. In a recent contribution, he began by describing the difference between demand-side and supply-side cost containment. In demand-side cost sharing, the relationship between the third-party (e.g. insurance company) and the patient makes patients 'think' about cost through the use of deductibles, copayments, and premium shopping. In supply-side cost sharing, instead, the relationship between the payer and provider of care makes the providers 'aware' of costs and even share risks by using organizational entities such as health maintenance organizations, preferred provider organizations, and independent practice organizations to regulate the care given.

However, Sharfstein noted that both forms of cost containment 'manage' costs as opposed to care. On the demand-side this is done by restricting benefits, 'tight' benefit design, and 'additional' deductibles or copayments for mental health care, as well as utilization review and determination of 'medical necessity' prospectively, retrospectively and concurrently using gatekeepers and reviewers. On the supply-side this is done by sharing risk, predetermining payments, and using salaried staff or provider networks. Sharfstein also noted that the government uses an additional method - global budgeting and fee-setting; this is typical of 'Western democracies', which may also set provider incomes. In this sense, many experts in Europe, as well as those who work in state hospitals or the Veterans Administration system in the USA, would argue that they have always had managed care.

Finally, Sharfstein described several types of care as opposed to cost management: determining 'medical appropriateness', using case management for 'high-cost' patients; an emphasis on

alternatives; individual treatment planning; and utilization of guidelines, protocols and case reviews.

Another view is that provided by Sabin (personal communication, 1999), in which he describes five elements: (1) that the health care for individuals is considered within the context of a budget for a larger population; (2) that as a result, the judgment of the treating physician is not the determinative factor, because the individual being treated is part of a larger group for whom there is a budget; (3) that in order to make this interaction between individual need and desire and population focus work with some kind of order, a set of managerial processes are created, such as utilization management, gatekeepers, and, in Canada, global budgets, etc.; (4) that these managerial processes are enormously different, varying from systems that are driven by a public health model-epidemiological survey of the population, priority-setting within a budget, program evaluation, quality improvement, and some degree of dialog with members of the system, to bureaucratic, adversarial, management-by-harassment programs, which have no true population focus but 'manage' with an eye on keeping costs down; and (5) the technologies that have attracted most of the media attention in the USA, for example external review of medical decisions, Kafka-like questioning of the medical plans, and the like.

The fourth and final description is that provided by Hoge et al. [3]. They describe 10 dimensions, which, although intended to apply to managed care in the American public sector, are equally useful to look at when addressing the situation in the USA and Europe. These dimensions are as follows: (1) objectives, such as cost-containment, expanding eligibility to the uninsured and enhancing quality of care; (2) scope, to include various size and types of populations; (3) organizational structures and authority, from governmental agencies, through program management to service providers; (4) enrollment, whether mandatory or voluntary, including options and assessment of the process; (5) benefit package, including covered services, annual or lifetime limits and ceilings; (6) strategies for managing utilization, such as network development (limiting number), controlling access (e.g. prior approval procedures) and determining 'medical necessity'; (7) best practices, for example providing the best care at the lowest cost, through the use of research, treatment guidelines, peer review and provider profiling; (8) financing, for example reducing duplication, discounted fees, capitation and other ways of sharing/reducing/avoiding risk; (9) quality management and outcomes measurement, including state and county evaluations, National Committee for Quality Assurance and performance contracting with financial penalties and bonuses; and (10) impact on the public system.

What has been happening "recently" in Europe?

Before the discussion of the existence of managed care in Europe (if indeed it does exist), I wish to make a diversion to discuss some of what has been happening recently there that may sound to Americans like the 'hoof beats' of managed care. I remind the reader that I am generalizing, and not all things have happened in all countries, but every one of these developments is happening in at least one country (and the others, especially the 15 in the European Union, are looking over every other country's shoulders). In this section, I have also included some examples from Canada [4,5], because it is sort of in-between the USA and Europe; it sits looking even more closely over the shoulders of the USA and its market-driven system change, while maintaining a basically 'European' system.

Pharmaceutical products were an early target of cost conscious bureaucrats, and this is perhaps the first area in Europe in which the actions of cost-cutters may sound familiar to Americans. Steps taken to date include the following: formulary restrictions (especially on me-too copies of older drugs, newer atypical antipsychotics and selective serotonin reuptake inhibitors); limitations on the number of drugs prescribed (French patients are reported by the lay press to walk out of each visit with an average of four or more different drug prescriptions); generic drug substitution [6]; and

promotion of over-the counter substitutes (Boots Pharmacies in the UK have reportedly hired primary care givers in their drug stores to offer/promote such practices).

There have also been changes and revelations regarding coverage. Europeans usually say and Americans usually believe that there is universal coverage in Europe. Certainly, the numbers of uninsured or underinsured is nothing like in the USA (where it is reported to be 40 million or up to 20% on any one day), but it might be higher than was thought. In France, for instance, the government recently proposed [7] universal coverage to insure the 2.5% of its citizens who are uninsured (150 000) and the 9% (550 000) who are poorly insured through private plans. This may partly, but not totally, explain the fact that 25% of French patients refuse medical treatment, because they have only partial coverage. In addition, it should be noted that one of the sore points [8] that provoked a 3-week strike at the Louvre and other museums and monuments was that many employees were on yearly contracts without full benefits, some for as long as 11 years and at least 200 for 3 years; these sound like US practices of employment. Finally, the number of 'working poor' in France is reported to have doubled during the past 15 years to 10% [9]; again, though, these figures are nothing compared with the numbers in the USA (17%).

There have also been developments in the "globality" of coverage and governmental control/funding/administration of such programs. There continues to be public (e.g. governmental) ownership of the health system, except in Belgium, Greece and Switzerland. Again, as an example, the Scandinavian countries have ownership of both purchasers and providers of health care [10], and in Finland 20% of mental health care is 'carved-out'. Along with public ownership comes the public health approach, involving epidemiological data (famously present in Scandinavia), catchment area responsibility (France's 13th arrondissement effort being one of the first [11]), and some emphasis on prevention (although physical and dental hygiene [12], smoking and seat-belt programs are not as visible as they are in the USA).

However, every single Western European government is concerned with the rising cost of health care and its share of the gross domestic product (although once again this is much less of a problem than it is in the USA), and in France the Sécurité Sociale is constantly in the red. (It is interesting to note that in the former Soviet bloc, the intertwined problems of under-funding, under-supply and inability to provide basic services are much bigger concerns.) However, very few countries, except Switzerland, have tried health maintenance organizations a la *Americaine*.

In addition, although the data are poor [13], there does seem to be a decrease in the portion of health funds going to mental health care, a trend that has also been noted in the USA. The problem with obtaining good data, on this and other matters, has hampered some reforms and blemished some reports, but almost everyone is agreed that both data and information systems need upgrading, and this is being done quickly. It should be mentioned, however, that Europe is not uniformly 'dataless'; indeed, some case-registry research in Europe (notably that conducted in Verona and the UK) is viewed by Americans as pioneering.

Finally, it should be mentioned that, according to Guimon [13], significant progress has been made in terms of accreditation of hospitals, standards of care in hospitals (France, The Netherlands, Switzerland and the UK), skills assessment (Belgium, The Netherlands and Switzerland), and operational procedures (Spain and Switzerland).

Some purely economic/monetary changes have also been made in the European systems. What used to be 'full care for everyone at whatever cost' has changed. For instance, a recent article in *Le Monde* [14] suggested that, in order to keep the system afloat, there will have to be "a reduction in coverage or supplementary deductions/ co-payments". Most Americans are familiar with the stories in the national newspapers about the UK problem with rationing of care, 'incredible' waiting

periods for hip replacements, bypass surgery, etc., in older persons, and the plight of UK (and Canadian) patients who have sought care outside their country's borders, if they can afford it. A story reported in the New York Times [15] has as its headline Britain's Prescriptions for- Health Care.- Take a Seat. Some Americans may even have a vague idea that fees are controlled (more vigorously than say with Medicare), and that unions or quasi-unions have been established to negotiate fees. What they usually do not understand or comprehend is that many countries overtly or covertly control the number of physicians produced, what specialties they may enter and in what numbers, and where they may 'practice' [5].

In addition to global budget constraints and 'caps' as they are known, there are also billing amounts that simply are 'pulled' or 'clawed' back, because of cost over-runs [4]. In the UK, where care used to be 'free', deductibles and copays now exist. In Lithuania, there is a limit of four on the number of consultations in a year [16]. In France, the government now only reimburses anywhere from 60 to 100% of expenses [7]; granted, this is nothing like the situation in the USA. Diagnostic related groups are commonly used, which leads predictably to 'gaming' [17]. Capitation, whether global or smaller population ordered, has appeared (in Canada and Lithuania) and there has been the appearance of performance contracting, albeit in Quebec, which is even more able to look over the shoulder of the USA than are European countries [18].

Many changes have affected psychiatric clinical practice in Europe (most of these are chronicled by Guimon [13]). Just as in the USA, there have been hospital closure and a conscious attempt to shift toward primary care (France [19] and the UK), including primary care gatekeeping (Switzerland and proposals in France). An announcement appeared in the French press promising to eliminate extra charges to patients if they signed up with a primary care physician. Although they are nothing like what Americans experience and are by now used to, there are pretreatment, current and post-treatment reviews in the UK and Switzerland. There is also perceived to be (e.g. in Switzerland) an insidious shift in the relationship between patient and physician as insurance companies increasingly come between them; in the diminished provision of psychotherapy, especially long-term psychotherapy; and in a focus on 'customer satisfaction'. Again in Switzerland, there are benefit exclusions, increasing paperwork, and decreased autonomy of the physician. There is also an increasing effort to introduce practice guidelines in Italy and Switzerland. Finally, some countries, even including Austria, Portugal and Switzerland, but especially those that have emerged from behind the 'Iron Curtain', find themselves woefully lacking in community services, social workers and rehabilitation experts.

What then is managed care, and does Europe have it?

Naturally, I prefer my own description of managed care but, given the wisdom of collective thinking, I have put together the four versions described above into one schema (Table 1). Being a "splitter" rather than a "lumper", I have used more categories and many more subcategories than others have.

There are many elements of managed care that can be considered as objectives and goals, although arguably some could be listed elsewhere. Cost control or cost containment is a goal of almost all reforms now going on all over the world, by whatever method. A recent poll of those persons who consider themselves on the political 'right' in France [20] showed that the highest consensus for what symbolizes the right over the past 15 years is the control of health care expenditures. Universality [or 'expanded coverage', as Sabin puts it (personal communication)], however, is a much more distant goal for the USA than for European countries; for example, whereas 30-0% of the US population is uncovered at any one time, only 3.3% of French persons are. Regarding a public health orientation, the USA certainly has the ability to produce data and create academic expertise far exceeding Europe's, but European countries implement the

concepts that are embodied in 'public health' and the USA no longer does; most notably, catchment areas have almost disappeared in favor of serving other population-based groups (e.g. employee groups). None of us does health maintenance despite the verbiage, and both Americans and Europeans are trying to bring their practices (e.g., the superiority or at least equivalency of alternatives to hospital care) in line with scientific evidence. The US system certainly involves more risk sharing with providers and probably more customer service, but both the USA and European countries are struggling with providing a full array of services: the USA with keeping them, and in several European countries with developing them.

European governments are certainly more involved in national health planning and provision than in the USA, whereas the USA has a bottom-up system in which managed care decides on most things. The USA has a great deal of organizational involvement at the service level with well-developed provider networks and carveouts, but European countries have preserved physician decision-making for the most part. Both the USA and European countries use carved-out service groups.

The attempt to shift to more primary care is universal, but the techniques are very different. Europeans certainly rely more on national limitations, whereas Americans have been emphasizing gatekeeping and utilization of the primary care physician. In France, Prime Minister Jospin proposed a 'reform' of medical studies to "abolish the hierarchy between generalists and specialists" [19].

The USA and Europe utilize many of the same purely financial techniques [e.g. global budgeting, capitation and salaried staff (in different ways), as well as fee setting, and to a very much lesser extent predetermined payments and performance payments]. However, the USA is pioneering in restricting benefit packages, using private insurers, utilizing deductibles (including additional ones for mental health), premium shopping, annual/lifetime limits, case management of high utilizers and copayments (although the French demand approximately 19.2% copayment versus 2.2% in the Uly [21]), whereas European countries are the masters of income setting.

Although recent European economic health care reform began with pharmacy restrictions, the USA was way ahead in limiting coverage depending on diagnosis, procedures and treatments, and in insisting that treatment must meet the standard of 'medical necessity'. In addition, US reviews of patient care are light-years more developed (which is not necessarily something to be proud of).

With regard to enrollment, European countries attempt to enroll everyone in usually single systems, whereas the USA has multiple options, but neither assesses the consequences adequately.

Both sides of the Atlantic have been active in improving quality and standardization; the USA has many more standards, protocols, treatment guidelines and credentialing processes (which are also not necessarily something to be proud of), as well as having invested more heavily in huge data/information systems, and certainly has an almost unique set of utilization management processes. Nobody does a great job at quality control.

I believe that the question regarding what the impact of all this reform on society will be is a long-term issue that will take years of research to resolve.

Table 1. Managed care in the US and Europe

Features	USA	Europe
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Objectives/goals		
Cost control	+++	++
Universality		++
Quality of care		
Public health model (e.g. epidemiologic studies)	+ (good data)	+++ (fewer data)
Catchment areas	+ (dying)	+++ (alive and well)
Health maintenance	(+) verbiage	(+)
Implementing science	+	+
Sharing risk with providers	++	
Customer service orientation	+	(+)
Full array of services	++	+ (varied amount of community care)
Organizational involvement		
Government	+	+++
Programs (e.g. health maintenance organizations)	+++	+
Services	+++	
Provider networks	+++	
Doctor determines care		++
Carve-outs	+++	(+++)
Primary/tertiary care shift		
Limit numbers and specialties		++
Gatekeeping	+++	(+) beginning
Provider shift (primary care practitioner, alternative)	++	+ (control supply)
Economic elements		
Benefit package	+++	(+) redesign
Global budgeting	+++	+++
Fee-setting	+++	+++
Income-setting		++
Private insurers	+++	(+)
Deductibles	+++	(+)
Copayments	+++	(+)
Premium shopping	+++	
Additional mental health deductibles	+++	
Annual/lifetime limits	+++	
Case management of high utilizers	+++	
Predetermined payments	+++	(+)
Salaried staff	++	(++)
Capitation	+	++
	(American way)	(European way)
Performance payments	++	(+)
Limits		
Medication	+++	+
Diagnoses	+++	
Procedures	+++	
Treatments	+++	
Medical necessity	+++	
Reviews	+++	(+)
Enrollment issues		
Options	++	(+) minimal
Assessment		
Quality/standardization		
Standards	+++	(+) in process
Protocols	++	(+) in process
Treatment guidelines	++	(+) in process
Quality control	+ (academic)	
Individual treatment planning	(+)	(+)
Utilization management		

Input	+++	
Output	+++	
Data/information systems	++	
Credentialing	++	+
Impact on society		+

What has happened with managed care in the USA?

Before I go on, I should mention that as all this inspection and consideration of the US system has gone on in Europe, the USA has not stood still and European countries have watched what is happening. For instance, Europe is aware of the following in the USA:

- (1) arguments about carving in or carving out mental health care [22];
- (2) the appalling number of uninsured citizens;
- (3) the fact that research is less common in heavily 'penetrated' markets [23];
- (4) the fact that health care costs, including those incurred by managed care, have resumed an upward trend and premiums are once again facing a 'sharp increase' [24], after managed care 'wrung out' much of the 'profit' [25] and 'waste';
- (5) the relative loss of mental health funding as compared with that for other care;
- (6) the 'limitation of mental health treatment' featured in many news stories (for example [26];
- (7) the failure of 'parity' reform to date [27];
- (8) the impossibility of fighting appeals due to the Employment Retirement Security Act law of 1974 [28];
- (9) the disputes between patients and managed care organizations chronicled in personal accounts [29], some by physicians [30];
- (10) the exiting of 'sicker', 'public' populations from managed care [31]; and
- (11) the high cost of administration, estimated at 2540% of the total [32].

Discussion

The aim of this project was to determine whether American-style managed care has been adopted in Europe and whether American-style managed care techniques would be adopted in the future. The answers to me now seem clear - 'no' and 'yes'; American-style managed care has not been adopted in Europe, but American-style managed care techniques are and will be adopted in the future.

The Scandinavian countries present a good example of this 'split decision'. As Pylkkanen [10] describes the situation in these countries, there are almost no fundamental similarities in the basic systems of the USA and Europe. For example, in Europe care is population based, health care is a right, it is totally tax based, everyone is insured and has access, the physicians are all salaried and receive salaries based on capitation, the system is not 'tightly managed', and there is good cost control.

However, changes are beginning to occur because of concerns regarding cost. For example, in Finland, although the health system is still government owned, risk, which was born by the health authority, has been shifted; new publicly owned purchaser roles have been introduced, allowing the local authorities to either contract for psychiatric services or create them themselves; budget ceilings have resulted in more tightly managed plans; there has been a separation of purchasers' and providers' roles; and most dramatically, all 452 plans are now totally decentralized (like health maintenance organizations), each serving 5000 persons. Consequently, health care now competes with other social benefits. In addition, 22.4% of mental health services have recently been 'carved-out' at less cost. Although Pylkkanen [10] states that both the Scandinavian and US systems are 'managed', in the former the 'managers' are public health authorities that manage the

expenditures and plans with the goal of serving everyone. However, he fears an undermining of the current system and destruction of the "core values and primary aims of adequate psychiatric health care" because of "new management trends" prompted by "financial incentives". He predicts that, even in Scandinavia, which has a taxation rate that is "top-high in the world", they will manage plans (not care) more tightly (he implies using US-style methods) and come "closer" to the US system.

Jacobs [33] gives another example of the differences between the USA and Europe, especially the UK. That author shows that, although there may have been convergence "upon the instrument of the market incentive", there is "considerable divergence in the content and aims of their reform strategies".

However, European countries, to varying degrees, have already adopted many US-style managed care techniques, such as pharmacy control, gatekeeping, global budgeting, etc. They also have instituted methods to control their programs and budgets that the USA does not fully utilize, such as control of physician numbers, specialty proportions, and billing addresses. But the European countries have not bought the whole package, and neither are they likely to. This is because 'we [the Europeans] are not like them [the Americans]', because there is a deep anti-American streak in many European countries, and because Europeans still see nuances in solving problems whereas we see all-or-nothing solutions (whether this is regarding deinstitutionalization or our foreign policy on China). The USA persists in thinking that because European adolescents wear Oakland baseball caps, watch movies like Titanic, learn English and eat hamburgers, they will take to all things American. Especially in medicine and psychiatry, where we are all exposed to the same literature, all click on the same databases on the Internet and regard US 'science' with awe, Americans assume that Europeans will want to conduct medical practice in the same way as them. This is not true. As Light [34] points out, the UK has achieved "managed competition for the whole system", whereas the USA can only "achieve bits and pieces of it".

What the Europeans are really doing is watching what scientists do in this big social laboratory called America, and they are most eager to learn from this experience [35,36] (Schreter R, 1999, unpublished paper) about how to avoid what some call 'the American disaster' and are very carefully picking and choosing what to try themselves. Any insurance company that thinks otherwise will learn the Pepsi and Disney way.

Conclusion

If forced to boil down my conclusions into a few words and one figure, it would go as follows. Looking at these elements of the way that both continents have dealt with health care and financing reform during the past 2 years leads an American (even an American writing about France [37]) to say "That's managed care", but the European to say "That's Government cost-cutting". In truth, to some extent it is a question of "What's in a name?"

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Commentaries

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Wendy Max

The mental health sector in the USA underwent some major changes during the 1990s. At the same time as a major shift towards the provision of mental health services in managed care organizations, the principal of parity was adopted. Historically, managed care has been successful at cutting costs. John Talbott discusses the evolution of managed care in the USA, and how mental health care has been incorporated into it. At this point in time, mental health is at a crossroads at which attention needs to be focused on patient outcomes, rather than on costs. That is, it is time to evaluate the experience with mental health managed care and the role of parity, paying attention to the impact that cost cutting has had on the quality and delivery of care.

Mental illness is common and costly. It is now believed to affect one in five Americans [1]. During the 1970s and 1980s, mental health care costs rose faster than medical care costs [2]. In 1994 nearly US\$100 billion was spent on mental health care in the USA [3]. Adding the value of lost productivity resulting from lost time and premature death brings this estimate to almost US\$200 billion. These high and escalating costs have been accompanied by growing interest in containing costs in the mental health sector, resulting in the widespread adoption of managed care models to provide this care. Between 1993 and 1999, the number of Americans enrolled in managed behavioral health care plans more than doubled to 176.8 million Americans, accounting for nearly 80% of all those with private or public insurance [4].

At the same time, concern over the need for Americans to have the same access to mental health care as they do to medical care became a major topic of discussion. This concern was reflected in the Clinton administration's proposed Health Security Act of 1993, which would have broadened mental health coverage for most Americans.

Although this act failed to be passed, the Mental Health Parity Act of 1996 was passed by Congress. The Act, implemented in 1998, mandates that mental health benefits cannot be more restrictive than other medical or surgical benefits in terms of annual or lifetime dollar limits of coverage. Hence, the need to ensure that people receive equal access to mental health and medical care was addressed through parity of insurance coverage. As of 1999, 24 States have adopted more specific health parity acts, and 20 more are considering such legislation [4].

There are good reasons why mental health and medical health needs should be considered together. It is reported that those with mental health conditions may use more physical health services [5], may experience worse outcomes when receiving medical care [6], and may be more difficult to treat due to their mental disorders [7].

Talbott suggests that parity reform has not been successful. However, the criteria for evaluating this assertion need to be clearly spelled out. If parity is defined purely in insurance terms, then great progress has been made. However, it may be simplistic to determine what services can be covered purely on the basis of whether they pertain to medical or mental health. Just as there are differences in the treatment needs of people with acute and chronic medical problems, so are there differences in the needs of people with acute and chronic mental illnesses. Mechanic and McAlpine [8] suggested that parity may be harmful to those with severe mental impairments, who are now subject to the same coverage restrictions as their less ill counterparts. If parity is evaluated on the basis of its impact on health care costs, then the results are more difficult to analyze. When the Parity Act was passed, it was initially feared that it would result in large cost increases due to increases in demand for mental health services. This seemed likely, given that demand for mental health care is known to be much more price responsive than demand for medical care. The feared increase in mental health costs has not occurred, but this is probably because of the widespread application of managed mental health care during the same time period [2]. Burnam and Escarce [9] suggested another criterion for evaluating parity. They suggested that parity would be achieved if a patient with a mental health problem would be as likely to be offered a service as a patient with a medical health problem, when the costs and benefits of the services are equal. Thus, the success or failure of parity needs to be evaluated in terms not only of its impact on costs, but also in terms of its ability to ensure quality of care, access, and equity in the presence of cost containment.

During the past 5 years, great strides have been made in terms of ensuring that Americans have access to needed mental health care services, and this has been achieved without a corresponding increase in costs. However, it is not yet known whether this goal was achieved by compromising the quality of care received. Better measures of outcomes of mental health care need to be developed so that quality of care can be carefully monitored. The focus needs to turn from cost cutting to the evaluation of the outcomes of mental health care received in order for parity to be successful in the future.

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Both the USA and parts of Europe, coming from very different directions, are attempting to correct problems with health care delivery by introducing competitive, marketplace incentives.

The US health care system, until recent decades, was a market-driven system in which consumers purchased what they needed from providers, but the superimposition of third-party payers - health insurance companies removed the normal cost controls that are inherent in the market. Service utilization and costs consequently escalated until health services were consuming 13-14% of the gross domestic product (GDP), adding a considerable burden to the cost of consumer products by way of the producer's contribution to employees' health insurance. Eventually, the radical voice for health care reform began to come from large manufacturers such as General Motors, who found that they could not compete successfully with foreign producers whose costs were not so inflated by health insurance. Even government health insurance schemes such as Medicaid and Medicare, which were traditionally operated under fee for-service mechanisms, failed to control utilization and costs. Unchecked by normal market pressures, medicine became a giant industry. Across the US hospitals grew larger until they dominated their communities, as did the manufacturing mills of the industrial revolution. Despite this glut of service consumption, many citizens those with no formal health insurance - have starved. Managed care is essentially a device that is designed to reintroduce competitive market pressures into the third party payer system of service delivery to control costs, but there is no mechanism to make health care universal, and, currently there is no strong lobby or political plan to achieve such an ideal.

In Europe, health care has generally been a government managed tax-funded system, providing services to all, or virtually all, citizens, and keeping costs down to around 7-9% of the GDP - nearly half the US figure. Under this system, the major problems have been lack of choice of provider, restricted access to care, and inadequate quality control. Competition between providers would seem to be a possible solution to these problems. As Talbott describes, government-funded health-care provision in a number of countries, such as Finland, has been restructured to create local 'purchasers', who hold the funds and who contract with competing 'providers' of service. Such a system appears to offer the prospect of increasing efficiencies and transforming antiquated systems of care into more flexible, community-based models. Will it work?

A recent example from Colorado of the effect of competition in mental health service system provision serves to illustrate some pitfalls. A new method of funding mental health services for people with Medicaid began in August 1995, throughout much of Colorado. Under this plan, the

federal government permitted the Colorado Division of Mental Health to become the administrator of federal and state Medicaid funds for mental health care in the state. The state entity, as purchaser, contracted with existing mental health agencies as providers under a new capitation agreement. Instead of billing Medicaid for every unit of service, the treatment agency received a predetermined amount of money for every person on Medicaid in the area. The capitated funding method was designed to create an incentive for the provider to develop more efficient treatment for its clients, and to allow the agency to use any savings for other clients and programs. In one area, at least, it was demonstrated that capitation fostered new treatment approaches that were not covered under the previous fee-for-service arrangement, services that were more flexible, individualized and closer to the client's home, and that produced better outcomes for seriously mentally clients [1]. In other areas of the state, however, a for-profit managed-care company won the provider contract, took a substantial percentage of the contracted funds to support the administrative cost-control bureaucracy, and to pay shareholders a profit, thus reducing the amount of money available for service provision. Where private hospitalization costs had previously been high, the provider was able to achieve efficiencies. It is unlikely that freedom of choice improved much, if at all, under the new funding system, but some improvements in accessibility were noted in some parts of the state.

After the first 5-year funding cycle, the purchaser issued a request for proposals (RFP) to re-bid the Medicaid capitation contracts for every part of the state in 2000. This time the purchaser specified many quality and quantity service requirements that it wished to see in the proposals, and awarded a substantial number of extra points for providers who bid to reduce their costs. It was known that a large nonprofit managed-care entity intended to submit a bid, in competition to the current providers, for every part of the state. Discussion between bidders on the subject of costs was forbidden under antitrust 'price-fixing' legislation. Consequently, every current provider around the state bid well below their prior level of funding, and the cost factor proved to be the one that determined which providers won the contract. There was little variance in the scores given to different proposals with respect to service provision because each bidder tended to parrot the requirements of the RFP; only the cost proposal provided clear-cut measurable grounds for distinguishing between providers' bids. The result of the process was that the service providers remained unchanged, but the funding they received was drastically reduced. Seven million dollars, over 5% of the total, were lost from annual state and federal Medicaid mental health service funds. Some hotly contested regions of the state lost over 20% of funding. The mental health system took such a blow, a blow that was largely unforeseen by state planners and unwelcome to them, due to the loss of federal funds, that the state legislature is now reconsidering whether future purchaser-provider bidding processes should be competitive at all.

What conclusions can we draw from this illustration? First, competition can certainly reduce costs, whether the providers be for-profit or nonprofit entities. Managed care purchaser-provider mechanisms, however, can only lower costs without reducing quality of care in inefficient systems; where cost-efficiency is already high, the added burden of the managed-care bureaucracy must inevitably decrease service volume and/or quality. Will the introduction of purchaser-provider relationships in European health care delivery systems reduce problems of accessibility, efficiency, restricted choice, and quality control? Based on this illustration, one would have to be cautious about drawing such a conclusion. Where the system of care is antiquated and resistant to change, the creation of new, relatively independent providers could certainly lead to vigorous innovation and efficiencies. Where the system is functioning well, the draining of funds into the purchaser's administrative bureaucracy will mean a reduction in resources available for service delivery. Freedom of choice of provider, as is seen in the untrammelled marketplace of medicine, is not a likely benefit of any managed-care system. Accessibility can improve if an inefficient system is rendered more efficient, but in an already efficient system it will worsen if purchaser administrative

costs are significant. Competition is not a panacea, but in some cases it may be beneficial. For it to work, we need to be able to measure the efficiency and effectiveness of the care system. In the field of mental health we still have a long way to go in this important area of assessment.

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Managed care is the effort to control health costs by modifying access to and the quality of health care. It denotes a wide range of organized utilization review and delivery systems that make the necessary trade-offs among access, quality, and cost of health care. In the USA, managed care attempts to combine the advantages of third-party financing with multiple competing insurers and cost-constraint incentives based on market economics. Much of managed care is accomplished by shifting economic risks from the payers to the patients or the providers of care. These economic risks are then combined with clinical risks as patients and their doctors cope with the world of cost constraint. Managed care has become mostly managed cost, to control the American insatiable appetite for access to the highest quality care, regardless of cost.

Talbott, in his important paper on managed care in Europe, tries to apply what is a unique American experiment to a European culture of health care that has traditionally combined universality of coverage with a variety of government regulatory approaches, again in the effort to balance to access, quality, and cost. The unique combination of both socialized medical approaches with market-based incentives provides a useful perspective of the choices that Western societies must make in providing medical and other health care to their citizens. Also, there is the 'special' status of psychiatry and behavioral health within each health system, and the challenge of the robust epidemiology of mental illness with the scientific revolution emphasizing psychopharmacology and psychosocial treatments specially targeted to the severely and persistently mentally ill in community-based settings.

In Europe, as in the USA, the challenges and dilemmas of providing health care to all in need are quite similar: scientific breakthroughs combined with expensive new technologies; rising expectations of people for the latest in health care; the evolution of new systems for providing that care within a context of continuous quality improvement; a rising burden of chronic illness, especially mental illness; the active involvement of patients and families, utilizing the Internet for more information on health care choices; and, above all, the need for a budget that establishes a level of national health spending within an overall set of other priorities, such as education and welfare. Key questions must be answered. Will patients and families be able to choose their doctors and treatments freely? Will clinicians have the primary control over what is prescribed for their patients? Will these providers be held liable for their mistakes, and therefore be expected to practice costly 'defensive medicine'? What can physicians expect to earn for their labor? Can patients trust their physician to be their advocate in what is an increasingly common phenomenon in both the USA and Europe of a highly bureaucratized system of care that rations treatments sometimes rationally and sometimes irrationally?

Talbott concludes that American entrepreneurial ingenuity will lead to the use of more American-style managed care within European health care systems in the future. At some point, I would like to see the opposite trend, with the importation into the American health system of basic European

approaches such as universality of coverage and a right to care, as well as 'single-payer' methods, which eliminate much of the administrative waste that we find today in the American health system.

For psychiatry, the key researchable questions for the future in comparing European countries with each other and with the USA include what will be the role of psychiatric hospitalization and, in particular, the specialty psychiatric hospital; the division of labor among the various mental health professions, and the extent to which nonphysicians receive 'prescribing privileges'; the implementation of more aggressive efforts in community based settings to ensure patient involvement and cooperation with treatment and care; the relative role of pharmacotherapy and psychotherapy for the wide variety of psychiatric disorders; and the role of general physicians as gatekeepers and primary treatment providers in contrast to more specialized mental health professionals. The zone of clinical uncertainty in medicine and psychiatry is wide. There are many choices regarding how we provide care, by whom, where, and how much. We can learn much from each other.

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Talbott is to be congratulated on his exposition of the principles of managed care and their applicability to Europe. The paper is thought provoking, not least because in the UK managed care along US lines has been received very badly by clinicians, appalled by horror stories about mental health care from across the Atlantic. On the other hand, administrators have been much more open to the ideas if not the actual practice of managed care. I will respond to Talbott's paper from a UK perspective.

At one level it is apparent that all health care is managed, if only by default. Thus, budgets are invariably finite and any health management decision carries with it an opportunity cost. Thirty years ago, management of mental health care in the UK was based on the persuasive rhetoric of senior clinicians in important institutions. This led inevitably to inequalities in provision. This ran counter to the spirit of the UK National Health Service, which is strongly driven by two complementary ethical principles, those of proportionality and equity. Equity is relatively easy to identify in the breach; an unequal provision of services stands out. However, proportionality is more difficult. It implies that the level of service should be proportionate to the severity of the condition and the resulting disablement, and therefore requires that severity be quantifiable. This is quite hard to do, and there are those who argue that a balance has not been struck between the sorts of services available to people with relatively minor psychiatric conditions, such as anxiety and depression, and to those with major conditions such as schizophrenia or severe bipolar disorder. In the UK there has been a tendency to focus secondary services on this latter group.

A further principle of the National Health Service, repeated as a mantra, is that the service is free at the point of delivery. As Talbott points out, this is often not the case in Europe, and it is not the case in the UK. In the National Health Service as a whole, patients contribute costs toward eye testing and dental services. Accident victims contribute to the cost of their care. However, cost-sharing is a relatively small element of mental health services. The obvious contribution that patients make to the cost of their treatment is through prescription charges. However, many groups are exempt from these charges, and a high proportion of people with psychiatric disorders do not pay for prescriptions. Contributions to social care, often an important component of the overall care package for people with psychiatric disorders, are based on the patient's assets.

Again, most people with severe mental disorders lack the assets on which a contribution might be levied.

Finally, in many parts of the National Health Service, people entering hospital can increase the comfort of their accommodation by paying for privileges such as a private room. Once more, this facility is rarely available within the mental health services, and the patients admitted are rarely able to afford it.

Talbot's description of managed care as comprising four elements is a good starting point for seeing to what extent the UK mental health services can be said to contain aspects of managed care. If we can consider it as a mechanism for providing care, then it is clear that the US system has influenced developments in the National Health Service over the past decade. Thus, the separation of purchasing institutions from provider organizations has been made. The purchasers remain part of the National Health Service, and thus distribute public funds. They shape the provision of mental health services and provide a budget within which providers have to operate. Providers are also generally part of the National Health Service, although in some instances private organizations fill gaps in public provision. Thus, beds required for overflow may be obtained in the private sector. In a few instances this may be a permanent arrangement, as with some forensic provision.

However, there was very rarely any competition between providers, and most of the arrangements arose through a process of negotiation. Nevertheless, the separation between the two groups helped to focus attention on what was being purchased and for how much. This innovation was brought in by the last Conservative Government, and the current Labour Government is seeking to remove the purchaser provider split.

It may be that the development has performed its function, in that there is now much more focus on value for money. The split did add noticeably to the bureaucracy of the National Health Service, whose low management costs are largely responsible for the relatively small proportion of gross domestic product (GDP) allocated to health care in the UK, which currently stands at 6% of GDP, in comparison with the European average of 9%. The continuation of the concern with value for money proceeds by other mechanisms, noticeably the strong pressure for adherence to evidence-based medicine, and the establishment of institutions that mediate this development. The National Institute for Clinical Excellence is charged with providing information on which rational choices about treatments can be made and with monitoring provision of treatment on this basis.

Talbot's second element is a particular philosophy of care, involving health maintenance, the avoidance of hospitalization and the promotion of alternatives. The UK National Health Service has historically been an illness service, and has been relatively poor at primary prevention. However, the current philosophy of mental health care does cover secondary and tertiary prevention. Thus, community mental health teams (CMHTs), when functioning ideally, are intended to reduce relapse rates and, if possible, disability. This is particularly true of special versions of CMHTs, such as those dedicated to assertive outreach and crisis resolution. An increased provision of such teams forms part of the current National Service Framework [1]. Although some of the impetus of these developments arises from local evidence and considerations, it is also informed by experimental practice that became incorporated into the managed care philosophy (for review [2]).

UK initiatives have been successful in reducing the number of hospital beds from 152 000 in 1954 to 34 000 in 1999. Very few of the latter are now in large mental hospitals. This bed reduction has been most effective in ensuring that long-stay beds have been replaced by community

alternatives. Its success in reducing the use of hospital beds for acute illnesses has been less. The beds have certainly been closed, but the result has been vastly increased admission rates (the 'revolving door') and bed occupancies, in London at least, of up to 130% (over 100% by dint of using leave beds and overflow beds in the private sector). The further consequences are an increase of compulsory admissions, more violence on the wards, and possibly in the community, and increased stigmatization. The strategy for dealing with this is to provide more resources for both generalist and specialist community mental health teams. It remains to be seen how successful this will be, but there is no doubt that the UK practice shares with managed care a strong commitment to reduce and avoid hospitalization.

The element of managed care that is related to methods of funding is perhaps most distinct from the National Health Service. In the UK, although there was a flirtation with competitive tendering to provide care in the early 1990s, this was never established in a major way and has been quietly dropped. Reduced costs were unacceptably related to reductions in quality of care. Moreover, the National Health Service is not truly insurance based. The National Insurance component of deductions from wages is not truly hypothecated, and is related only to income, not to individual levels of health needs.

The final element of managed care described by Talbott is the drive toward cost control. This is the procedure in the UK that dare not speak its name, but it nevertheless exists and has always existed in the National Health Service. In the past, budgetary limitations have provided a crude weapon for constraining costs across the board. Local decisions would then determine the shape of available care. This is changing, in as far as the new National Institute for Clinical Excellence is charged with producing guidelines for what procedures will be paid for by the National Health Service. These guidelines are based on the available research-based evidence, and the object is to save money by cutting out treatments that are ineffective. However, this is as much about realizing opportunity costs as about actually saving money. Indeed, the main drive in the National Health Service recently has been about quality; the term 'clinical governance' has been introduced to describe the process of monitoring quality, and, perhaps for the first time, a duty of quality has been laid upon a health service by a jurisdiction.

Thus, although Talbott is quite right to spot echoes of managed care in many polities in Europe, in the UK at least the shared elements are not that great. It is not clear either that they will increase, given that the main political imperative here is to improve quality and increase public funding. Moreover, the shared aspects are not necessarily the outcome of observations of US methods, but may have arisen because similar constraints engender similar solutions.

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The paper by Talbott, as illustrated by the title, compares two entities that are not directly related. The economics of mental health care in the USA is widely viewed as a blueprint of what not to do in Europe, whereas aspects of managed care are clearly beginning to creep into the European systems. The most important difference, in my opinion, is the fundamental way in which health care is viewed in the USA and Europe. In the USA, health care is a service that can be bought if one can afford it. The entire system, including both insurance and provider schemes, is aimed at

selling the service for a profit. In Europe, health care is generally seen as a right, and all the schemes across countries are aimed at providing this right to as many people as possible. Costs are ultimately controlled by what people, including employers, are willing to pay in the USA and by what governments are willing to pay in Europe. Because someone must pay, cost control is an issue in both continents, and paradoxically Europe, with aggregate costs at or under 10% of the gross domestic product (GDP), is looking to the USA, with aggregate costs at about 14% of the GDP, for ways to cut costs. This is due to the enormous creativity that the drive for profit has brought to cost cutting in the USA at the level of care delivery. This ignores the enormous administrative costs such controls appear to carry with them.

The European systems have many differences. The systems in northern Europe in particular have a variety of controls that both limit cost and regulate the conditions of practice. These include limiting the density of specialists throughout the country (one cannot set up a practice anywhere one chooses), the use of global pharmaceutical budgets, and separation of hospital providers from community providers. Mental health care in Europe, as in the USA, has moved from large institutionalized care to regional hospital services and increasing outpatient care. Unlike in the USA, this shift in many countries has involved the development of extensive community services for the chronically mentally ill. One dramatic consequence is that the number of mentally ill homeless patients is far lower in Europe. In Mannheim, the city my hospital covers, a recent extensive survey revealed that about 3% of the homeless population was psychotic; compare that to an industrial US city, with rates reported from 30 to 60%. Thus, mental health systems in the USA are in no way regarded as models for European services.

What all providers are studying is how to contain costs. Here many of the ideas utilized in managed care plans in the US are being considered. In Germany, a shift from full coverage of actual hospital costs to a scheme involving diagnosis related groups is now being implemented. This will not include psychiatry at present but, as was the case in the USA in the 1980s, it is designed to force bed closures and is planned to decrease bed capacity by 30%. Psychiatric beds have been phased down, and an increased emphasis on outpatient services is planned. The German system mandates health insurance for every citizen. A mix of public and private insurers who compete with one another provide the coverage. Some of the same strategies seen among managed care providers, such as selective exclusion of high-risk cases, is being reported.

These signs suggest that elements of cost containment used in managed care plans in the USA will make their way into various European systems. As long as the fundamental basis governing the structure of health care delivery is to aim for universal coverage, managed care as such will not sweep across Europe. This idea of health care as a right is fundamental to Europeans; while adopting the free market strategies in business, European societies, especially in the north, are determined to maintain social solidarity. A cornerstone of this view of society is basic universal health care. Thus, some aspects of managed care such as carve-outs will never be acceptable. In Germany the idea of established preferred provider networks, for example, is almost impossible; all fees for services are regulated and all providers receive the same fee for a given service - one cannot bill what one chooses. This extends throughout many professions and totally eliminates the possibility that a group would offer reduced fees to capture more business. Because the density of psychiatrists is regulated, new practices can only be started in areas that are underserved. Each practitioner has about the same population to serve. Thus, there is far less advantage in undercutting fees to get patients, and the motives that lead to many of the managed care models are simply missing.

The drive to cut costs as medical treatment and diagnostic approaches become more refined and more expensive will intensify. However, I see Europe picking and choosing very carefully from the

managed care practices in the USA. Most importantly, I do not see, and hope never to see, the idea that health care is a right abandoned in Europe.

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Luis Salvador-Carulla and Teresa Magallanes

Is there an alternative to the American approach to managed care? This question was raised in nearly all of the meetings on health services that I have attended during the past 10 years. Generally, the discussion focused on technicalities and implementation forecasts for managed care in various European countries, as the shift to this particular care model has been taken for granted. Talbott's paper takes the topic a step backward. He reviews the conceptual framework and the different definitions of managed care. He also provides a qualitative analysis of the ongoing situation. As a high-speed train that stops unexpectedly in a small railway station, Talbott's paper brings the topic to a different arena, leaving aside detailed studies on the efficiency/ cost-effectiveness of managed care alternatives in different health organizations and settings, while highlighting major conceptual issues that lay behind the model of care, and the links and relationships between these concepts on both sides of the Atlantic. Manage or perish? Many health researchers have forecasted a complete shift to the American model by the turn of the century in a number of European Union countries, but, at present, experiences of managed care at this side of the Atlantic are short-lived.

According to Talbott's review, there is little agreement on the definition and characteristics of 'managed care'. After reading his paper, many would probably agree to ban this term from any operational glossary on health services, as it only brings more confusion to the topic. Talbott and others provided a list of managed care components, such as cost-containment strategies, pharmacy control, gate-keeping or other restrictions to access to care, global budgeting, quality assurance, clinical practice improvement through guidelines and other appropriate methods, separation of purchasers and providers, and managed competition. To some extent, all of these processes have taken place in most Western countries, irrespective of the care model. As a matter of fact, some of these processes started first in countries other than the USA (including Canada, Australia and New Zealand). Examples of managed care have been traced back to the 14th century in Catalonia, Spain [1].

Certainly, the categories mentioned above are not exclusive components of American-style managed care. They are aspects of efficient care management everywhere, except for state-centred totalitarian countries. What, then, are the particularities of American managed care? Let me give another definition. 'Managed care' is a particular approach to care management that is characterized by a set of bottom-up, purchase-centred strategies, procedures and rules for managing the care process in a full market economy. Health business does not follow the rules of perfect market economy anywhere, not even in the USA. Nevertheless, the US health system is the closest example to health prices fixing through offer-demand and full market competition worldwide. Can 'managed care' be exported to other countries? This depends on the degree of liberalization of the health market in every country. As long as national health services and central health policies persist in many countries, any European 'managed care' strategy will end up quite different from its American counterpart. It may be interesting to note that the American health system is more inefficient than many other health systems in the Western world. As a matter of fact, inefficiency was one of the main reasons for developing and implementing managed care in the USA. Undoubtedly, it has improved the health system from the purchaser's point of view, but it has not solved the structural problems of the American health system from a societal perspective.

The unfinished health reform of the Clinton administration put a major emphasis on European national health services, and US rates of uninsured and underinsured population are the highest in Western world. It is sad paradox that the strongest economy in the world fails to achieve levels of infant mortality seen in some middle-income countries [2].

This brings the discussion to a key question: Is health a human right or a market good? That is, to what extent can illness treatment and prevention be regarded as a human right, and to what extent is it a market good? In this bidirectional/dimensional line, European countries are closer to the 'human right' end, and the USA is closer to the 'market good' side. This may explain why health policy is such a critical issue in many European countries. A historical analysis of the American-European crosslinks between full market and welfare economics, particularly in the health sector, are beyond the scope of this commentary. However, setting minimum health targets for society as a whole may provide gains for specific health aspects in the long run (i.e. insurance companies or other purchasers). A number of economic models and theories, such as human capital approach, welfare economics and environmental economics, share in common the need to take into account all costs of every alternative from a societal, environmental or global perspective [3]. Managed care may have reduced direct health costs in the USA by shifting them to other parts of the system. These hidden costs may eventually emerge.

Alternatives to US managed care do exist in many countries where health policy has been tailored from the principles of welfare economics since the 1940s. In European countries the health system does not fit into a perfect market model (as happens in the film industry or agriculture). The categories listed by Talbott can be provided in these countries from a top-down, society centred model, and global health targets can be defined and analyzed. Examples of a European-style welfare care management that takes into account some 'managed care' strategies have been implemented in European countries, such as Spain [4]. Rodriguez et al. [5] provide an in-depth analysis of the pros and cons of what is now an efficient and equitable health system in comparison to the US system. Managed care, or managed care methods applied to care management, will eventually make their way to Europe. I guess that the results will be as different as American cinema is to its European counterpart.

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Talbott's paper is an excellent contribution to our understanding of managed care.

Managed care links philosophy and provision of care with finance of care and cost control. The four partners are not equal in this linkage. Rather than putting these elements of care on a democratic platform, managed care organizes them under one umbrella of cost-containment. Finance and cost-control overshadow philosophy and provision of care.

American and European versions of managed care differ in terms of strength of values given to the philosophy of care. In North Europe the basic philosophical difference has been tax-funded universal public health care.

The Scandinavian health care systems have always been, and continue to be, managed in the European way, 'government cost-cutting', as Talbott expresses it. The balance of power between the four elements of finance, cost-control, philosophy and provision of care is here traditionally biased towards the philosophy of universal care. This is the European umbrella for cost-containment.

From the patient's point of view, the links between cost control and other elements of care were not very prominent during the long build-up phase of the welfare state. Controlling the number of professionals and their salaries by government regulations was not so visible to the patient. However, it did control the cost while still keeping everyone insured. The patient had access to those resources that were available.

Now, managed elements have been brought closer to the patient in North Europe. This is not done by using demand-side (payer-patient) cost sharing, but rather by emphasizing the supply-side (payer-provider) cost sharing. The payer and provider in the tax-based system are closely interconnected through legislation and administrative structures.

As Talbott points out, governments are concerned with the rising share of health care of the gross domestic product (GDP). Finland is an example of choosing a different way. The share of health care costs of the GDP has been steadily going down to reach the lowest level of European Union: 7.7% (1996), 7.3% (1997), 6.9% (1998), 6.8% (1999), and 6.7% (2000). The share of households of the health care costs has risen up to 20% (1999), which cuts the share of public funding down to 5.2% (1999) of GDP.

Three policies have contributed to this outcome: the finance of health care is heavily decentralized (since 1993) to 452 independent authorities; there is no 'health budget' - public owners of health care provision and funding share in their budgets health care with other financing responsibilities (social welfare, schools etc.); and the roles of ownership, purchasing and provision are not split.

In response to the above developments, Finnish doctors struck on March 12, 2001.

Some sectors of health care are managed more than others. Psychiatry has not been doing well within the context of highly decentralized funding. The philosophy of universality has not been of great help to psychiatric patients. Their treatment has suffered from cuts more than other sectors of health. The crucial disaster has been lack of data. There is no problem if there are no data to point out that there is a problem. Universal care has no value if there are not adequate data for follow up.

The official government policy has been to cut down the number of beds and to promote community care. A register was created by government for follow up of the beds. However, nothing was done by the local authorities to follow up community care, which was their direct responsibility. Not until a study was reported in 2000 was the public made aware that during the 1990s both psychiatric beds and community care were targets of remarkable budgetary cuts by local authorities.

Within a public funding and universal care policy, the value and necessity of adequate follow-up data cannot be overestimated.

Universal care as a basic value - in spite of past bad experiences - still makes a difference to managed care approach. In the case of Finnish psychiatry, a trend toward better balance has started.

The Parliament finally took over the responsibility that had been allocated at the local authority level by introducing a policy of positive discrimination for psychiatric services for children and adolescents (1999/2000). By allocating ear-marked resources to vulnerable psychiatric populations, the Parliament put the value of management of the needs of patients before the value of managing cost-containment. The philosophy of universal care has now again been given a special value in the dynamically changing structure by which provision, philosophy and control of finance are linked together.

Finally, health care is a very complicated system, and it is further complicated by the diversities of psychiatric care. The basic assumption guiding decision making about priorities in health tends to follow guidelines formulated by Maynard Keynes:

"There is nothing a politician likes so little as to be well informed, it makes decision making so complex."

It is an ethical obligation to psychiatrists to keep cost containment complex by promoting the basic values of medical ethics, also in managed care environments.

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In Talbott's paper, in which he discusses the existence of managed care in Europe, and compares its characteristics in the USA and Europe, he concludes with a philosophical question: 'What's in a name?' This question remains crucial throughout this stimulating review, in which the aim is stated to be twofold: first, 'to determine whether American-style managed care had been adopted in Europe'; and second, 'whether American-style managed care techniques would be adopted in the future'.

Actually, his paper starts with this question. First, a comprehensive evaluation of views on the complicated issue of defining managed care is presented. Later, using the key concepts of four definitions of managed care, Talbott provides an excellent survey of the current status of managed care in the USA and Europe in his comparative table, in which the features of managed care in general are also clarified.

If we give attention to the overlapping features of these definitions, we may point out a hidden discussion on a series of tensions. The first is the tension between the population-focused strategies and those focused on the individual, or the tension between marketing needs and health-medical needs. This tension has long been reflected in the preference of terms; a critical choice is made between using the term 'the patient' (the individual who shows patience for any kind of suffering) or 'the client' (the individual who buys a service). The second is the tension between the medical-ethical approach to medicine, particularly as regards mental health, and the pragmatic-technical approach of economics. The final tension is that between 'the American style' and 'the European style'.

In this new era of socioeconomics, in which the paradigm of 'the social state' has passed away in the ex-socialist countries, and is dawning in the rest of Europe and in many other countries in the world, there appears to be a serious effort to create balances between the above tensions. In this sense, it is hard to separate 'the market needs' and 'the medical needs' because they are intertwined. Should managed care in Europe be considered a search for a new balance between these two needs? Understanding what has been happening in Europe may help us to answer this question. In this context, Talbott's authoritative review indicates that 'American-style managed care has not been adopted in Europe, but American-style managed care techniques are and will be adopted in the future.'

If we re-read this discussion from a clinician's perspective, either in the USA or in Europe, the effects of managed care in psychiatry carry a special importance. This issue is particularly problematic because the therapeutic alliance between the psychiatrist and the patient, which is the main factor that determines the outcome of psychiatric treatments, is only as good as the underlying soundness of the mental health care system.

It was estimated that 50% of psychiatrists had at least one contract with a managed care organization in 1994 in the USA [1]. Furthermore, being 'the simplest way to control escalating health costs', managed care seems to be the way in which mental care will be delivered in the future [2]. Thus, the tools of managed care (e.g. utilization review, the determination of 'medical necessity', the use of triage and treatment guidelines) will be increasingly adopted in mental health clinical practice.

Here, a series of questions arise. Does managed care address the specific mental health needs of patients with severe and persistent mental illnesses [3]? Because many physicians complain about the effects of managed care structures on their 'treatment autonomy' and 'medical professionalism', are new concepts of professionalism needed [4]? How do psychiatrists feel about managed care imposing unprecedented changes on their daily practice? It has been stated that managed care 'encourages psychiatrists to spend less time on empathic discussion and to use more standardized, less costly treatments', and, as a consequence of these trends, 'psychiatrists will spend less time with individual patients and more time planning and guiding the treatment of severely impaired patients' [5]. What might be the 'threats' perceived by mental health professionals of managed care? 'The possibility of deprofessionalization and the potential for deterioration in the quality of care' [6] are serious areas to be surveyed. In a changing milieu of economics of mental health care, psychiatry is facing some challenges not only in defining future professional roles, but also in the training of new psychiatrists [7].

The field of mental health involves many ethical issues. As mental health care systems change to meet the demands of managed care, it is important to address the effects on the ethical considerations of providers and patients [8]. If the assumption that 'for-profit managed care is more interested in profits than in quality of services' [9] is valid in practice, then what would be the consequences of this trend on special patient groups (e.g. those who have long-term serious mental illnesses [9], on children and adolescents [10], or on multicultural populations [11])? It seems that the efforts to establish equity and quality of mental health care in both continents should take 'the American style expanding to Europe' and 'the European style inherited in America' into consideration simultaneously.

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After reading the seminal article of Talbott, we can appreciate that the implementation of globalization in the field of mental health services is an optimistic expectation. The present situation in developing countries (the strained economies, the minimum resource allocations for health and education vis à vis arm supplies) makes managed care a remote possibility.

The growing financial resources allocated in many countries to the providers of health care and the calls for controls on health care expenditure suggest a need for consideration of the repercussions of mental illness across society, the costs related to health care provision, and the health and economic return due to care and assistance. There are several major issues in measuring the economic cost of mental illness, which are potentially large in magnitude and controversial in their implications. These are the costs to families of care of a mentally ill member, comorbidity costs, capital costs, labour market impact of mental illness and nonproductivity losses due to presence of illness. Other costs are those associated with improper measurements, unreliable diagnostic systems and inappropriate measures of reliability. These costs are felt when resources and talents are used in a wasteful fashion, and misleading information leads to wayward avenues of research [1], or when those resources are limited to start with, as is the case in the majority of developing countries. The extent of those costs depends on several factors: the duration of the disease, the level of impairment caused, the nature of specialized service required, the age of onset and duration of the disorder. Finally, the total costs to society depend on the size of the population affected by the disorder. Mental health problems constitute 12% of the global distribution of health burden (1999) as measured by the percentage of disability adjusted life years (DALYs). Depression is ranked the second in developed and the fourth in developing countries (DALYs 1999) among the 10 most frequent diseases that cause disability. Depressive disorders represent the highest percentage of disability among mental disorders (17.3%), and psychosis represents 6.8%, drug dependence 4.8%, Alzheimer's disease 12.7% and epilepsy 9.3%. In the year 2020, unipolar depression will be the second of the 10 leading causes of DALYs, and among

females it will be the first cause of disability in both developed and developing countries [2]. In developed countries, the cost of medication, including novel ones, does not exceed 10-20% of the total cost of hospitalization. The reverse is true in developing countries, where it is estimated to be 40-50%, as the cost of personnel and hospital care is low [3].

The USA and most European countries have been concerned about escalating costs of health care, including mental health care. Many nations have implemented or considered prospective payment or prepaid care to help contain rising costs of health care. However, despite the recognized need for cost containment, clinicians, policy makers and consumers should be concerned that cost containment could adversely affect quality or outcomes of care, especially for vulnerable populations such as those with serious psychiatric disorders.

Health services in all Arab countries are provided by public (government) and private sector facilities. In some countries insurance systems contribute to the provision of the service. The proportion of the use of the different health providers varies from one country to the next depending on the prevailing economic policies. Nongovernmental organizations (NGOs) have come to be recognized as an important factor in the provision of health services, especially in countries with internal instability. In Lebanon, NGOs were prominent during the late 1980s, because of the internal instability, but their role diminished since 1990, when the large-scale wars were over. In Palestine, the absence of a state and consequently of a stable government led to a situation in which NGOs continue to play a major role in the provision of health services to the people.

With the introduction of structural adjustment policies and the gradual withdrawal of third-world governments from the subsidy and support of health services, cost recovery and fee-for-service systems are gradually replacing free service provision. Insurance schemes work only for citizens who are employed by an institution that provides health insurance. Outside those umbrellas, citizens are expected to buy their health services out of their own pockets, which in many occasions leads to neglect of medical consultation.

According to World Health Organization (WHO) estimates, public expenditure on mental health should not be less than 10% of the total health budget. Recommended WHO figures include 0.25-1 psychiatrist per 10 000 population, and mental health beds in the ratio of 5-8 beds per 10 000 citizens [4]. In all Arab countries the ratio of psychiatric beds to population leaves much to be desired. The priorities for community healthcare services are not for mental health, but rather care for more endemic health problems (malnutrition, parasitic infestations, maternal and child morbidity, and drug abuse) which impacts on the allocation of resources for mental health services.

Mental health care does not require costly technology. It requires a sensitive deployment of properly trained primary health care providers in the recognition and treatment of mental disorders, and upgrading of mental health services as back-up to first-line workers. In this context primary health care should be the ground base, especially in developing countries suffering from shortage of mental health personnel. Family-orientated primary health care should play a role in the prevention of mental problems, early detection, diagnosis and treatment of nonadvanced mentally ill patients, referral of more advanced cases to psychiatrists, shifting from hospital-based mental health care to outpatient-based mental health care, and focusing on children and adolescents, and recognizing mental health as part of the basic benefits package.

In planning for mental health, we should be guided by general principles that should constitute the basis for the formulation of a mental health policy. Such a policy should be based on

decentralization of service, an integration of mental health policy into the general health policy, comprehensiveness of the policy outcome and equity. People should have equal access to the health care, which dictates an equitable distribution of resources and, maybe, a legislative matrix that promotes the social values and protection of mental patients. Such policies should be sustainable. The main element in securing sustainability is the participation of the stockholders in its formulation. Community and civil society participation in the formulation of their health policies in general and the mental health policy in particular is mandatory to the credibility of such a policy and its support by its target beneficiaries: our patients, their families and the communities in which they live.

To implement those objectives, we should raise the awareness of the population regarding mental health and mental health problems, have a comprehensive database of mental health morbidity, have a planned budget, train and update available human resources, and possibly generate new resources and redistribute our bed strengths. Because of the very tight budgets and limited resources available at this time and as a transitional period, the best plan for developing countries, the Arab region being no exception, is to train and update general practitioners to look after chronically ill patients and their families. The preference of patients and their families to attend the primary care facilities, the natural course of the referral system and the family role of support can give a better service to mental patients in developing countries than the present system of community care or managed care systems in industrialized Zones.

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