Making Do With Less: The Latest Challenge for Psychiatry

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After a period of relative price stability, health care costs are again increasing, at a rate of 8 to 10 percent a year, and reached 1.4 trillion dollars by 2002—an amount equivalent to 14 percent of the gross domestic product (1). Employers' contributions to their employees' health care coverage increased by 14 percent in 2002, reaching $5,134 per employee in 2003, representing an increase of 70 percent since 1998 (2). Employee contributions jumped by 24 percent over the same period, reaching $1,753 per employee, even though wages increase at a rate of only 3 to 4 percent a year (3).

Alarmed by this new round of spiraling costs, public and private payers, consumers, insurers, and the uninsured are demanding further cost containment. At the same time, patients continue to expect unencumbered access to affordable health care of an acceptable quality, regardless of budgetary constraints. These demands challenge our "medical industrial complex" (4) to develop strategies for making do with less. This column describes the proposed solutions, which fall into three main categories: reforms in health care financing, innovations in designing and delivering services, and fundamental changes in the systems and structures that support medical and psychiatric care.

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Health care financing reform

One group of solutions being offered to curb health care costs involve changing the mechanisms through which health care is financed.

Cost sharing and cost shifting

Cost sharing, in reality, means shifting more of the cost of care from the payer to the consumer. This shift is achieved by having patients pay a greater proportion of the premium, raising copayments and deductibles, and introducing tiered copayments. In employer-sponsored plans, out-of-pocket spending per family has risen to $2,790, from $1,890 in 1998, which amounts to a 48 percent increase in three years (5). Savings from cost sharing accrue to the payer through decreased payer contributions, with the dollars falling directly to the bottom line. Additional savings result when the patients bear the risk for the services and medications they consume, which has been shown to decrease utilization and spending.

Defined-contributions health plan

Under defined-contributions health plans (DCHPs), the employer caps its financial contribution toward an employee's health benefit. The employee selects from a mix of health insurance options the one that best fits his or her needs within the allowable budget. Contributions are made on a "use it or lose it" basis. DCHPs, also called consumer-driven health plans, result in savings for the employer by limiting the employer's financial responsibility and shifting more of the risks and coverage decisions onto the employee. This approach is reminiscent of the mid-1980s, when there was a "dental-mental trade-off" and substance abuse treatment riders that were purchased at the employee's own expense.

Medical savings accounts

Under medical savings accounts, an employee puts money aside in a tax-sheltered account to be used as needed. These accounts are small, especially in the beginning, and thus are backed by catastrophic insurance with a high deductible. Coverage is carried over from year to year and is portable to subsequent jobs. Employers save when they purchase a bare bones policy and their employees bear the risk for expanding coverage or going uninsured or underinsured.

Single-payer model

The single-payer model is essentially an expansion of Medicare—a universal health care system for a defined population. If a single-payer model were implemented, existing public and private insurance would be replaced by a single system financed through tax dollars rather than insurance premiums. A recent study by the Lewin Group for the state of Vermont concluded that a single-payer model could expand coverage to all Vermont residents, including the 51,390 uninsured persons in the state, while reducing total health care spending in Vermont by $118.1 million in 2001—a 5 percent decrease in costs (6). These savings were predicted to accrue through reduced administrative costs (15 percent or more in the private sector compared with 3 to 5 percent for Medicare) and the absence of corporate profit as an expense. Governments can further contain costs by

setting rates, reducing benefits, and introducing a means test or other tests to limit eligibility for coverage.

Clinical care and clinical services redesign

Another opportunity for savings involves developing and implementing new health care interventions aimed at managing care rather than managing dollars.

Expanded continuum of care

The medical portion of the continuum of care is a comprehensive array of services ranging from traditional outpatient services to acute 24-hour inpatient care. The community-based portion of the continuum has recently been expanding to include mobile crisis and treatment teams, therapeutic schools, school- and work-based services, psychiatric rehabilitation services, and foster care. The public sector has been particularly invested in developing these wraparound services, which also include case management, after-school programs, one-on-one therapeutic behavioral aides in the school and home settings, mentoring, and respite care. Savings are achieved through the replacement of expensive inpatient and facility-based services with less expensive alternatives.

Disease management

Disease management—population-based, disease-focused programs—promote public health by managing individual and population risk to improve cost and quality outcomes. Goals are achieved through the early detection of vulnerable or affected individuals, the implementation of evidence-based practices operationalized into formal treatment protocols, collaboration with service providers, patient education, and outcomes tracking. Savings accrue through prevention, the availability of case findings before illnesses become catastrophic, the utilization of best or most efficient practices, and enhanced patient adherence to treatment plans.

Case management

Future Health, Inc., of Maryland defines case management as a holistic process that includes assessment of individual patient needs, creation of an individualized treatment plan, hands-on coordination of a wide range of medical and community-based services, ongoing monitoring of program effectiveness, and modification of the plan as appropriate. Savings are anticipated—though not guaranteed—through the application of the 80/20 rule, under which 80 percent of the health care dollar goes toward the care of the top 20 percent utilizing patients (7). Focusing case management on these high-cost patients promises the greatest return for money and time invested. Typical patients include those suffering from bipolar disorder with concomitant substance abuse or those with chronic mental illness or developmental disabilities.

Wellness programs

Wellness programs shift the focus from the treatment of disease to maintenance of wellness and prevention. One set of programs empowers patients to eliminate damaging activities such as substance abuse, child abuse, and exposure to lead. Another set of programs supports activities that maintain wellness, such as violence prevention programs, stress management workshops, and Head Start programs for children. The financial return on investment accrues through prevention and by empowering patients to make more educated, health-preserving choices.

Structural and systems changes

The third set of solutions being offered to resolve the current health care cost crisis involves fundamental changes in the structures and infrastructures that support health care delivery.

Integrating services and fusing funding

The carve-out approach, which is typical of the private sector, and the multiple funding streams approach, which is a hallmark of the public sector, have unintended consequences resulting from fragmentation. Services and dollars are driven into independent silos, which encourages cost shifting rather than cost containment. As managed care reduced the dollars directed toward behavioral health services from 6 percent to 3 percent of total health care spending in the private sector, costs have been shifted into worker's compensation, short-term and long-term disability, and employee assistance programs. In the public sector, costs are shifted from state and federal mental health budgets to departments of justice, education, and social services with no overall savings. The silo approach also increases spending when it becomes impossible to support effective services or track costs and outcomes in order to refine the system. Savings are anticipated to accrue when the integration of services and funding streams closes gaps, eliminates costly duplications, increases access to efficient services, and removes barriers to the analysis of costs and outcomes.

Outcome data research

The health care sector has lagged far behind many industries in its ability and commitment to collect and make the maximal use of information. Too often, data are not collected, and the aggregation and analysis of data across large systems and populations is virtually impossible in most settings. For behavioral health care, outcome data research involves monitoring meaningful measures of clinical performance—suicide rates, hospital days per thousand, days absent from work or school, or progress as documented on rating scales. Access to these data will make it possible for us to provide genuine evidence-based treatment supported by evidence-based treatment guidelines.

The initial investment in information technology will be daunting. However, long-term savings can result from the identification and tracking of relevant indicators and variables, the application of best or most efficient practices, and a reduction in complications. Outcome data research can also reveal under- and overutilization, both of which are associated with significant costs.

A focus on patient safety

In an attention-grabbing 2001 report by the Institute of Medicine, it was estimated that between 48,000 and 98,000 Americans die annually in hospitals because of medical errors (8). In a recent study by Zhan and Miller

(9), the annual cost of providing treatment for the 32,500 patients who have common but potentially avoidable complications during hospitalization was estimated to be $9.3 billion annually (9). At present, hospitals and physicians are discouraged from reporting untoward medical events for fear of legal discovery and damage to their reputations. Under a continuous quality improvement approach, physicians and hospitals would report these events and related data to an organization with a role similar to that of the Federal Aviation Administration. The data would be studied to isolate causes and trends, a corrective action plan would be designed and implemented, and the situation would be reassessed to ensure that the desired quality improvements were achieved. Direct savings would result through the reduction of avoidable treatment expenditures below the $9.3 billion annual cost. Indirect savings would result from enhanced productivity, decreased economic costs associated with morbidity and mortality, and reduced human suffering.

An equitable system for allocating resources

In any given year, 20 percent of the American population has a diagnosable mental health or substance use disorder. Only 20 percent of these children, adolescents, and adults receive any treatment for their condition (10). This robust epidemiology guarantees that there will never be enough money to treat all affected individuals for all their mental health difficulties. Two prominent health care policy makers—Alain C. Enthoven and Uwe E. Reinhart—recommend acknowledging this reality and creating an independent commission resembling the Federal Reserve Board to evaluate the costs and benefits of all available interventions and to ration care (11). Savings would result from having a transparent process that sets national priorities, limits expenditures, and allocates resources among competing social claims and claimants.

Conclusions

No one can predict, with certainty, where health care is heading. Some of the approaches reviewed here will likely shape the next evolution of health care. Ultimately, success will come to the systems that manage care, not simply manage dollars, by using approaches that are supported by evidence of superior outcome. These outcome data must inform a system that successfully balances health care cost, access, and quality in a manner that is acceptable to the American people. ♦

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to be seen how common the phenomenon will become. Studies now under way will tell us more about the utility of advance directives in psychiatry—for example, whether, given the current state of the mental health system, advance directives actually have an impact on subsequent care (9). At a minimum, however, it seems likely that *Hargrave,* as it becomes more widely known, will chill enthusiasm for psychiatric advance directives among many clinicians. Because clinicians' suggestions that patients consider completing advance directives probably play an important role in encouraging the completion of such directives (10), *Hargrave*'s legacy may be to inhibit the use of this once-promising tool. ♦

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