

### Readings

- Sanchez, Lisa M., and Samuel M. Turner. 2003. "Practicing Psychology in the Era of Managed Care: Implications for Practice and Training." *American Psychologist*. 58 (7):116-129
- Dickey, Barbara, Sharon-Lise T. Normand, Richard C. Hermann, Susan V. Eisen, et al. 2003. "Guideline recommendations for treatment of schizophrenia: the impact of managed care". *Archives of General Psychiatry*. 60 (4): 340-348
- Good, Mary-Jo DelVecchio, et al. 1999. "Clinical Realities and Moral Dilemmas: Contrasting Perspectives from Academic Medicine in Kenya, Tanzania, and America." *Daedalus*. 128(4): 167-197

### Blackboard (Dr Fein—instrumental in medicare and medicaid)

Development of Insurance, Medicare and Medicaid

- 1900 Hospitals utilized more by the poor—"indigents"—who provided "teaching material" for physicians—they were most often non-paying
- 1929 Dallas, TX, Baylor Univ—when patients did not pay, physicians required payment in advance—Teachers paid \$6/year for all medical care and tests
- 1930s System is generalized and expanded to more employee groups in Texas, then to all—Nationally the model is applied by different state legislatures
- 1939 "Blue Cross" emblem is applied to this nat'l model by the American Hospital Assoc (AHA)  
Patients pay a deductible and cover up to 20% of medical costs = indemnity insurance→fee for service  
Didn't change payment depending on patient risks
- 1940 World War II/Blue Cross/Blue Shield—armed forces thought they should still receive care b/c they had needs; employers could subscribe through Blue Cross at relatively minimal cost; didn't fall under tax regulations and to employers benefit to provide these services. BCBS operated like a bank and profited from its subscribers
- 1950s Other insurance companies saw how profitable it was (John Hancock, MetLife)—for profit insurance companies. As individuals became older, a population hit retirement and had no healthcare whatsoever and some initiatives tried to provide federally funded healthcare—thus emerged Medicare, and Medicaid.
- July 30 1965 Medicare—over 65 and disabled; Medicaid—for the poor and low-economic class
- 1970s Healthcare crisis; debt crisis around the world—World Bank; also the oil crisis; global economy is struck; how to limit spending; how to make programs more efficient on a global scale; locally, rising healthcare costs lead to creation of HCO (health care organizations)

Definition: Deductible: certain percentage up front

## **“Practicing Psychology in the Era of Managed Care: Implications for Practice and Training.”**

- Primary Question: What is the impact of HCO on mental health care? Are patients receiving the same quality of care under previous system? Pre-paid, no-choice v Fee-for-service
- Paralleling—the practice of primary care or medicine; psychologists had more time to spend with patients
- Changing the type of practice that clinicians have to expose or use
- Their training was for a different service delivery; institutional changes force them to change their practices
- The use of less professional training to provide broader care of people
- Utilization review: biggest complaints of mental health care providers—want to argue that mental health issues are not necessarily rooted in biology/physiology, trying to impose generalized set of practices (treatment algorithms), is insufficient care for patients (James’s contacts)
- Concierge Medicine: general complaint about ideals of psychology, medicine
- Question of best practice guidelines, linked to evidence based medicine: one good that came out of managed care, the standard that people need to adhere to, to check on the quality of care. Government attempting to impose practice standards that are generalizable. Want clinicians to justify their actions to have favorable outcomes—data that your practice is efficacious—was not necessarily accountable for treatment outcomes. Behind that is federal regulations that ask clinicians to justify that their course of treatment and practice, whatever they practice, adhere to a set of generalizable standards. It’s about efficiency and money and how resources are best allocated.
  - Benefit: quality control
  - Negative: the type of illness that people in mental health may be very specialized and should or when should they be applied.
- Managed care—allocation of resources
  - More people get less care or fewer people get more care?
  - Is it better to provide better care
- Increased access; gatekeeping of doctors—will they be able to detect and get referred for care?
- Question of time: doctoring v drugs
  - Are meds being prescribed appropriately?
  - Who should be doing that?
  - To what extent are social workers providing mental health care?
  - Question of time and money: social workers are less expensive and can spend more time with them. Psychiatrists cost a lot more money
  - Psychology is concerned about its future—ScD v clinician manager types. Medicine and psychiatry and psychopharmacological enterprise—the clinician of therapy is getting squeezed out. To what extent is managed care good and to what extent has it had on patients
  - How does one study the efficacy of treatment? Should efficacy be studied?

- Type of medical health care in fee for service v managed care system—does there seem to be a difference?
  - How they assess care is empirical—their guidelines of better care is subjective; do they look longitudinally how long it will work and mental disease and health can last a long time (10-20 years); for mental disorders—what is efficacious for mental health
- Co-morbidity—more than one problem at the same time and may make it difficult for primary care doctor to diagnose
- Compromise of confidentiality in managed care system
  - Any kind of disorder (not specific to psychology or mental health)
  - Clinicians are not reporting accurate diagnosis in order to protect patient confidentiality (not diagnosis down, no treatment down—how to measure efficacious)
- Foucault readings—institution gaining tremendous amount of power through records, test and also resistance—the clinicians resisting practices and what does that mean down the line and should doctors be obligated to give an accurate prognosis. Or is it okay to be fuzzy in order to protect patient confidentiality.
- Very fuzzy in applying diagnosis; otherwise will get algorithm for care.

**“Guideline recommendations for treatment of schizophrenia: the impact of managed care”**

- Length of study: in both first and second article, they suggest that studies need to not only be broad statistical but more local
  - Pay attention to the role of statistical methods play in showing efficacy. Both suggest that the way we do our studies is not addressing local realities. Applying the global and the statistical—patient experience over time v efficacy of particular forms of treatment
  - The science needs to shift; what future is there for psychology and has to shift itself and how clinicians are trained, how psychologist is becoming more of a clinician-scientist in order to deal with management and show efficacy and to create more of a role in the way and world that Managed Care has created
- Their method to determine how they would come up with these numbers and the difference between the two groups; a randomized trial is not necessarily the best thing to do because of the patient demographics but if you want to apply logistic linear regression, problems arise when certain things have to bias you and it becomes collinear and would skew the data. The study design is a good idea.
- Those receiving care through managed care organization:
  - Medicaid carved out its mental health services in Massachusetts to a private health organization and those recipients in managed care would have a lesser experience, not as good, one-on-one and more traditional. Surprised that they did not have any difference in care and countered to what the researchers expected.
  - Problem found in both sides that clinicians were not adhering to best practice guidelines and shifted debate to a different level.

- Both groups reported being relatively pleased with their treatment and question complains if managed care was really bad. Managed care—huge debate to evaluate if it was “evil” or not.
- Questioning this form of management, the state and federal government involvement in setting standard guidelines and may not be a bad thing but the question is, Who is being treated? Medicaid—treatment for poor and provides access—but is the quality as good? How would you address issues of inequity in this developed context, compared to resource poor nations?
- Psychosomatic: suggests not real? In essence is a mental disorder that affects the body, such as anorexia and could stem from a somatic cause as well as environmental factors (society, family) and other complex factors. Their pathology is not well known. Creating a standard for treatment when innovation is needed by physicians. Managed care restricts doctors role as a gatekeeper
- With managed care, by limiting the number of sessions, addresses only surface symptoms, through utilization review, must be reviewed to see if it is being effective and encourages the treatment of surface systems that are often physiological or somatic. Primary care physicians suffering physical pain but w/o physiological factor. The question of somatization.
- These clinicians may not be able to address personality, family, social context for the development of disease and on some level, limited care to a limited number of people with session limits of 10 at Harvard for example. How efficient can the provision of healthcare be and how far can the dollar be stretched?
- Drug companies have much more money to do studies with care with psychotherapy; not necessarily good that a certain topic on what is most efficacious with managed care plus pharmaceutical company done research/studies
- There will be a drug for every disease at some point with a pill? Perhaps not, and therefore important since the drug may cause more issues and complicated and should have a psychologist and therapy; compounds the problems. Treating disease v treating the symptom.
- The question of medicalization—to what extent is medicine taking over more the role of what is happening with the person and what they should experience at various stages of life and to what extent should we be viewing aspects of life from only a biological way and is that what we want, this reductionist way, and this is the criticism of medicine, for taking a greater role in dealing with mental health than say psychology or other disciplines

**“Clinical Realities and Moral Dilemmas: Contrasting Perspectives from Academic Medicine in Kenya, Tanzania, and America.”**

- Doctor burnout—doctors dealing with themselves and with patients, the sense of disempowerment, powerlessness and losing competence to treat other sorts of diseases
- Structural adjustment programs (SAP)—1970s, developing nations—African nations recently independent—in order to try to modernize took out loans from

- WB (World Bank) and IMF (International Monetary Fund), both part of UN system, to promote economic development globally and pegged to the US dollar. Unable to pay their debts and forced restructure in order to service debt and how best to manage funds most efficiently and many of these nations, eg Haiti, the government had to reduce its size and the state funded programs were shrunk—public health care and education—and SAP reduced total expenditures, fewer funds for treatment, privatization of state run industries.
- Doctors are trained in the west, but work in resource poor countries with no technologies and medications and overwhelming cases of HIV/AIDS
  - What can doctors in these countries do to enhance morale and moral voice while in contact with terminal patients “the political economy of hope”
    - Multi-tiered system: institutionalizes inequalities in the quality of care provided to patients
  - Are there international obligations to resource poor nations? Mostly in drugs, few grants.
    - Medical aid will be needed for a long time and economic aid would be better than medical?? Question is: helping
    - New purification method created by India—pharmaceutical industry needs to look at manufacturing but don’t have much incentive and their current profit deters them from doing more
    - International drug pricing—there’s this international pharm. companies, trying to increase production cost v reduce patient cost
  - Political economy of hope—refers to the idea that doctors must provide hope for patients as they discuss treatment options for patients—the ethical idea that they will at least provide some hope for their patients
    - The advancements of biotechnology and pharma provide hope for both patients and clinicians because it may be able to provide a cure and the depiction of medicine as curative rather than palliative and to what extent should medicine be trying to find these heroic measures, salvage through bone marrow transplants—should we be using these extremely expensive measures—could those resources be put somewhere else for a better use?
  - Is research simply a matter of hope? There is this underlying idea, an industry that could possibly emerge from it. Scarcity of resources built into system at all level.
  - Palliative v Curative medicine: technology—article suggests that physicians should develop ethics around palliative medicine to come to terms with reality of death. Is there a global ethics that we should be thinking about?
    - “yes everyone should get the same quality of care.”