

# ANNOTATIONS

## PSYCHIATRIC INSURANCE

Avnet, Helen H.: *PSYCHIATRIC INSURANCE*, New York, Group Health Insurance, Inc., 1962. 280 pp.

THIS is a well-written, interesting report on an experiment run by Group Health Insurance, Inc. of New York, jointly sponsored by the American Psychiatric Association and the National Association for Mental Health, and financed largely by a grant from the National Institute of Mental Health. Actually, it reports on insurance against *short-term* psychiatric treatment, a rather more restricted area than the title would indicate, but it is of great value none the less. Insurance actuaries and medical care plan administrators have for years eschewed *any* kind of insurance against the cost of psychiatric care because of the difficulty (they said impossibility) of defining and limiting the scope and cost of psychiatric services. In part, too, the outcast position of psychiatry in medical care played a role in this exclusion. It is only recently that a majority of Blue Cross plans (58 out of 83 in 1961) offer in-hospital care for psychiatric diagnoses comparable to that for other disorders. Only 13 plans offer as much in benefits for mental illness as for physical illness. The situation is changing, and community (the "Blues") as well as commercial and industrial insurance programs provide some coverage for psychi-

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atric illness, usually in-hospital—more cautiously for ambulatory care.<sup>1</sup>

The great problem, in addition to poor information about the actual extent of mental illness, is “if all the people ‘in need’ of psychiatric treatment were to seek it more or less simultaneously under an insurance arrangement, neither the psychiatric treatment facilities nor the insurance resources would be adequate to cope with the demand. It follows that this possibility must be discounted if insurance plans are to offer psychiatric coverage without bankrupting their membership.”<sup>2</sup>

PSYCHIATRIC INSURANCE reports on an effort to demonstrate how and why “this possibility can be discounted.”

GHI is a group insurance program against the cost of physician care in home, office and hospital. A cooperating physician is promised a fee according to a fee schedule for services he renders insured clients. Of the 670,000 insured persons, 76,168 were selected as the sample to be studied. The selective sampling method used, to obtain a large enough sample of various occupational groups, avoided randomization of the GHI population—wisely. This enabled the investigator to assume characteristics of utilization about occupational groups, a more useful conclusion than one that might have derived from characteristics of the GHI population which is not representative of any other community. The sample population was entitled to psychiatric treatment by “Psychiatrists who are members of the American Psychiatric Association and who become participating psychiatrists under the Project; non-government hospitals, licensed to treat mental patients, which become participating hospitals under the Project; psychologists to be paid only for testing; no allowance for clinics, social workers, or treatment by general practitioners,”<sup>3</sup> for the duration of the project.

The project lasted 30 months. From July, 1959 to July, 1961,

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<sup>1</sup> INSURANCE COVERAGE OF MENTAL ILLNESS 1962, Washington, D.C., Joint Information Service, American Psychiatric Association and National Association for Mental Health, 1962.

<sup>2</sup> Avnet, *op. cit.*, p. 12.

<sup>3</sup> *Ibid.*, p. 20.

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923 persons (1.2 per cent) availed themselves of the service; there were fewer the second than the first year—(541 against 382). More than half the APA members in the area agreed to participate, but only 491 of the 1,200 saw a patient. Fees were not unreasonable and the patients paid a modest part—25 per cent—with a limit of \$225 to the plan for any one case.

As might have been expected, different occupational groups varied in their utilization. White collar workers, higher educational attainment, spouseless marital status (single and divorced), family income below \$2,000 and over \$10,000, women, boys, members of small families, age groups 20 to 39—were all associated with relatively higher utilization. Executives with college degrees were the highest utilizers of all.

Costs and utilization were far less than anticipated. Certainly the argument that only lack of money and lack of available psychiatric service prevents large numbers of people from getting psychiatric care is unfounded. Despite the reasonably open access, the project was not swamped, and new referrals declined over the 30 months of experience, even with an intensive “educational” program to encourage referrals.

The report offers a number of interesting sidelights, too. The conclusion is drawn that only patients who needed help applied for it, since virtually every patient who applied for care was judged by the psychiatrist to be in need of care. In only 10 cases did a psychiatrist consider treatment unnecessary, and in 44 other cases “uncertain.” In view of the fact that only half the cases were referred by a physician or agency, (the rest by self, relative or friend) one might wonder at the definition of “needed”—particularly since the group referred by physicians includes larger numbers in the categories of brain damaged and psychotic patients than it does in the psychoneurotic, personality disturbance or situational types. Self-referral blurs the outline of need for a psychiatrist, though not for help.

Those with more education tended to seek help on their own, and the question of definition of “illness” and “need” is certainly raised by this fact. As a larger proportion of the population completes high school and college, the trend toward self-referral and larger use of psychiatric service can be predicted.

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But as Avnet writes, "In the present stage of acceptance of psychiatry, there appears to be little danger that the costs of insuring the extent of coverage offered by the Project would be prohibitive if spread over an average cross-section of the 1960 population."<sup>4</sup>

In weighing the data, one wonders about the segment of the population already worn down by mental illness, deprived of the work opportunities that might lead to eligibility for health insurance, or without the funds or job to buy insurance. Is their exclusion a possible bias? Is there a possibility that a large number of patients sought help from psychiatrists outside the project and thereby lowered the expected rate? Neither of these is a very strong reason for not accepting the data. For those interested in eventual comprehensive medical care coverage, the study is stimulating.

The conclusion that short-term psychiatric care is insurable does not rule out the uninsurability of unlimited treatment which might be necessary, but this was not tested in this experiment, as the author herself points out.<sup>5</sup> A great deal more needs to be done in the organization of medical practice, to define the role of the psychiatrist in the care of mental illness, to define the conditions under which psychiatric care must be given and to define the role of other workers—social worker, psychologist and nurse as well as family physician—in the care of mental and emotional illness. This study is a good beginning, illustrating the feasibility of limited care and limited insurance for psychiatric illness; but it is only a beginning.

GEORGE A. SILVER, M.D.

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<sup>4</sup> Avnet, *op. cit.*, p. 258.

<sup>5</sup> *Ibid.*