HEALTH CARE REFORM IN THE UNITED STATES:
IMPLICATIONS FOR TRAINING AND PRACTICE
IN MARRIAGE AND FAMILY THERAPY

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Americans are spending 12-14% of their income on health care, and costs are rising about 11-12% per year. These increases are fueled by many social problems and are not limited strictly to health matters. Many alternatives have been examined to limit the rapidly increasing costs. The long-term results of these efforts are likely to be a reduction in health care benefits for many and the continued development of a two-tier system of health care. This article addresses the place of mental health care in general and marriage and family therapy in particular in the emerging system. Suggestions for training and practice for the new health care system are given.

The current crisis in health care in the United States, as reflected in widespread public dissatisfaction with the American health care system (Blendon, Leitman, Morrison, & Donelan, 1990), has begun a transformation of our health care system. The first half of this paper discusses the health care system in general. The second half addresses the effect of cost containment in mental health services and the implications for the training and practice of marriage and family therapy. In the search for a solution to this crisis, the key questions are what are the causes of the increased cost of health care, what can be done to control these costs, and what are the implications of these changes for the training and practice of mental health providers in general and for marriage and family therapy in particular.

CAUSES OF INCREASING COSTS

The rapid acceleration in health care costs is well known, with most estimates pointing to an annual increase of 11-12%, from about $838 billion in 1992 (about 14% of the Gross National Product [GNP] [Bell, 1992; Weissenstein, 1993]) to over $1 trillion in 1994 (Wagner, 1994). The multiple reasons that health care costs are rising are embedded in the social fabric of the United States and most of the developed world (e.g., Day & Klein, 1991; Warson, 1994) and cannot be separated into strictly health matters. Rather, the rising costs in health care are related to many of the forces that are transforming our society. Some of the most important forces include: (a) an aging population, (b) changing disease patterns, (c) increases in numbers of poor, (d) legal liability, (e) violent crime, (f) fraud in the system, (g) increased costs of health care technology, and (h) focus on treatment of disease versus
preventative medicine.

Aging Population

Our aging population will continue to need more health care services. This is evidenced by the fact that the Medicare program provided $110 billion in benefits in 1991 and is expected to increase benefits to $259 billion in 1998 (Wagner, 1993).

Changing Disease Patterns

Changing disease patterns, such as the use of cocaine, fetal alcohol syndrome, AIDS, and addictions. For example, state government appropriations for AIDS rose from $9.6 million in 1985 to $278.9 million in 1990 while reported cases rose from 8,249 in 1985 to 41,595 in 1990 (U.S. Bureau of Census, 1992).

Increasing Lower Class

A growing population of poor is also leading to increases in the cost of health care. These costs are probably most clearly reflected in the expenditures for the Medicaid program, which is designed to provide health care for the poorest citizens. Recent data show an increase in expenses for this program from $23.311 million in 1980 to $64.859 million in 1990 (U.S. Bureau of Census, 1992).

Legal Liability

Increased costs associated with legal liability as reflected in malpractice insurance premiums and defensive medicine by which providers order what may be unnecessary tests and procedures as a means of self-protection. Other costs associated with medical liability are also passed on to the consumers and purchasers of health care. Although precise costs are not known, one estimate is that about $15 billion in health care costs can be attributed to such self-protective practices (Brostoff, 1992).

Violent Crime

Costs associated with increases in violent crime need to be considered. For example, one estimate of the medical costs due to crimes such as robbery, assault, and rape is given as more than $10 billion per year. Associated costs of $23 billion in lost productivity and another $145 billion in reduced quality of life (Miller, Cohen, & Rossman, 1993) are direct costs to crime victims, taxpayers, and the economy as a whole.

Fraud in the System

Increased fraud among greedy providers (although a minority) is a part of the current system. Fraudulent insurance billings and workers’ compensation costs add to the forces at work to produce a never ending spiral of increasing costs. Although difficult to estimate, one source suggests that between 10% and 25% of the total cost of the Medicaid program (which was $61 billion in 1989) is attributable to fraud by physicians (Jesilow, Pontell, & Geis, 1993).

Increased Costs of Health Care Technology

Although estimates of the direct cost of technology are difficult to obtain, many authorities agree that the costs of technological advances may be “. . . the most important cause of the rise in medical costs” (Glazer, 1988, p. 511). This includes such factors as
increased use of expensive diagnostic equipment and tests, as well as increased costs of providing services such as heart surgeries, kidney transplants, and so forth, that were unimaginable 20 years ago.

Focus on Treatment of Disease Versus Preventative Medicine

The focus on treatment of disease versus preventative medicine is also considered by some to be a major cause of increased costs (Smith, 1990). The concern here is that the majority of health care resources are being spent in treating illnesses once they occur. Many argue that significant savings could be achieved by increased emphasis on preventative measures such as routine physical examinations, immunizations, prenatal care, and so forth.

HOW TO CONTROL COSTS

General Considerations

The possibility of effectively limiting the growth in health care costs is small because of the accelerating need for services of several kinds. These needs are real and are not likely to diminish if the causes behind the need for services are not altered. For example, until the population of older persons as a percentage of population decreases or illnesses associated with aging are diminished, an increasingly aged population will require increasing amounts of health care. If the spread of communicable diseases is not curbed and addictions are not decreased, health care costs will increase. If the health-related consequences of an enlarging lower class are not addressed, their need for health care will continue to increase, thus adding to the rising cost of health care. The causes of crime need to be addressed in order to lessen the trickle-down impact on health care costs. Consequently, the demand for services has been growing at a rapid rate and will likely continue to grow for the foreseeable future.

Historical Patterns

A good example of this process is the National Health Service (NHS) in England. When the NHS was established after World War II, politicians were stunned by the “enormous hidden demand” for health care that emerged once services were provided free at the point of service (Potter & Porter, 1989). The same phenomenon occurred when the United States introduced Medicare and Medicaid 20 years later. There seems to be no reason to believe that demand for health care services would decrease if they became more available; rather, if the NHS example continues to hold true in the U.S., the demand for services will likely increase as these services become more available to our citizens.

Political Assumptions

Since the November 1991 senatorial election in Pennsylvania, health care has become a dominant political issue. Politicians who wish to be reelected will find it difficult to decrease expenditures for health care, particularly in the areas of Medicare and Medicaid. The problem is that the only effective way of controlling costs may well be to exclude nonessential services and to ration others. In theory, setting limits makes sense, but establishing such limits will be very difficult and will evoke tremendous conflict and debate.

In a democratic society, it will be very difficult for elected officials to tell voters that they are now going to have to wait for needed health services or that once they reach a certain age (or health status) certain life prolonging procedures will no longer be available. Consequently, our desire to be egalitarian in providing access to health care for all citizens will also
continue to fuel demand for health care services.

Business Requirements

The basic principle in business is that in order to survive, those who pay for health care services must effectively limit the growth in the cost of health care. The terms that are most often used in the industry to describe this principle are cost containment and managed care. Among the strategies that have been used thus far include preauthorization (where a proposed treatment must be approved prior to delivery of the service) and peer review, in which the need for services is reviewed on a regular basis to determine the length and progress of treatment, and decreasing benefits or imposing benefit limits.

Other cost control strategies include having an employer provide a fixed dollar amount of health care benefit to employees and having the employees select from a bundle of options for their own care. With this process, employees choose among physician visits, hospital coverage, prescription medication, dental, chiropractic, optometry, and psychotherapy services. If the benefit amounts available from the employer do not cover all of the available services, employees may then purchase the optional coverage at their own expense.

Another more common and more direct method of limiting costs has been to reduce the number of covered services and to reduce the amounts that are paid for the services that remain. Examples include increasing the consumers' deductibles and co-payments and removing benefits such as dental and optometrist services from the coverage.

Restructuring the System

There seems to be no question that, in the long term, participation in some form of managed care system for most citizens will emerge. The major arguments currently concern the form of the program not the presence of such programs. There is, and will continue to be, considerable debate about what sort of system is best, and no one can presently predict what will happen as the various proposals are considered, debated, and eventually enacted into legislation. In the beginning, most provider groups will probably be included for coverage, but if the momentum of the forces accelerating health care costs continues to accumulate, the pressure to eliminate provider groups and the types of services covered will mount.

As mentioned earlier, the net effect of all of the impending changes will probably result in a more explicit two-tier system of health care. There will likely be a managed care health plan that will provide basic health care services to the middle and lower classes by some sort of managed competition organization (Enthoven, 1993) that will determine what services can be given and what providers will be recognized. Because of increasing demand, this system will likely become very expensive unless the services available within the system are specifically limited.

The first tier of health care services, the private payment market, will be for those who can pay for services directly. This system will exist as supplemental to an individual’s managed care program, and in some cases it may completely supplant managed care for some affluent consumers.

Consumers who participate in a managed care system will have their basic health care needs covered by their insurance plan. If they wish additional services, the cost will be out of pocket. These consumers will be able to supplement their own care from sources that are separate from the state-owned system. These will include private clinics, hospitals, and private practitioners.
Marriage and family therapists have an excellent opportunity to appeal to both the private payment and the managed care markets because our treatment models are generally short and consequently more affordable than other models of therapy. In addition, marriage and family therapy is (at least) intuitively more efficient because we involve more members of the family system in treatment. As such, many middle-income consumers may well be able to afford such services on a cash basis. In addition, marriage and family therapy is often more acceptable to consumers since they are not required to accept a mental illness diagnosis or the stigma often associated with other types of mental health care.

Along with the medical care in general, the mental health market place will also likely evolve into a two-tier system. Providers in the first tier, the private payment market, should continue to prosper as long as the forces that contribute to the demand for mental health services continue to increase and if they are in the market position necessary to capture a share of this tier. That is, if they are perceived as offering a high-quality service that is in demand.

In mental health services, the second tier system, the managed care plans, may experience an initial growth in demand for therapy services. This growth may be fueled by the same forces working to increase the need for health services in general. In addition, increased availability of therapy services through a managed care system may allow those who are currently uncovered to obtain services, many for the first time. However, over the long haul, as health care costs continue to mount, there is a possibility that the health care plans will gradually become more and more limited, with increased emphasis on those who are severely and chronically mentally ill and those who need acute care. Consumers without severe and chronic mental illness or acute needs may be forced into the private market for service. Those providers with a strong identity and market position in the community will benefit because they can be identified as high-quality service providers.

Does this mean that the poor and lower classes will be unserved in the area of mental health? Unfortunately, no one can be sure. One would hope that services could be maintained or even improved for all members of society, but it is too early to tell just how sensitive public and private policy makers will be to the mental health needs of all citizens.

Rationing

Most authorities agree that it does not seem possible to provide everyone with all of the health care services that they may need or want. Some limits and priorities will have to be adopted even if basic care is to be assured for all Americans (Callahan, 1987). Unfortunately, this will be a difficult process since many people are reluctant to consider the necessity of adopting such limits. Health care rationing, then, becomes a distinct possibility as demonstrated in the system recently adopted in Oregon (Fox & Leichter, 1991). The major feature of this plan is the listing of over 700 medical problems and their treatments ranked by seriousness and probability of returning the patient to health. The state would then pay for the top 500 plus problems and their treatment and not for the other less critical problems or for problems that had a very low probability of success. The principle is for everyone to be able to receive basic primary care that benefits a large number of people before other high-cost procedures which benefit relatively few people are provided.

Mental Health Benefits

Governments, employers, and society in general have a large investment in the health, welfare, and safety of their employees and citizens. When a company has spent literally thousands of dollars in training an employee, it most often will want to try to rehabilitate
rather than have to replace him/her and retrain another person.

Because productivity decreases and accidents, absenteeism, and other problems increase as social problems enter the workplace, employers will almost certainly want or need some form of program for their employees. Those employees with drug, alcohol, and emotional problems will be likely candidates for referral to mental health services. Demand for mental health services, particularly those that are directly related to the retention of employees, should continue to be strong.

Another compelling reason to include mental health services in managed care programs is the possible offset effect of such services. An offset effect occurs when use of mental health services leads to a reduction in the use of other kinds of medical services. Thus, the cost of providing mental health services can be offset by savings in total medical utilization (Shemo, 1985-86). Several review articles have shown the presence of an offset effect with decreases in medical utilization following psychotherapy services (e.g., Jones & Vischi, 1980; Mumford, Schlesinger, Glass, Patrick, & Cuerdon 1984). Consequently, it may be argued that psychotherapy services could be included in managed care programs without additional costs.

Society in general also has a stake in maintaining a strong and healthy populace. Recent literature suggests that citizens who have addiction or emotional problems are less healthy and productive. An economy with a large percentage of unproductive or impaired citizens is bound to decline. Consequently, the need for mental health services related to debilitating emotional problems will continue to increase.

One solution to the need for mental health coverage has been the development of programs to address employee needs. Specialized companies provide specific services to employees for a specific length of time for a specific price. These providers can be either internal or external to the host company. Internal providers are most often called Employee Assistance Programs (EAPs). These units operate within the host company structure and the individual providers are employees of the host company.

External providers are companies such as American Byodine, Community Psychiatric Centers, and many others. These companies generally concentrate specifically on providing behavioral health care to specific employers, government agencies, or insurance companies. They often do not use private practitioners because they recruit and hire their own employees who provide services to those with whom the company has contracted (often called a staff model of managed care).

Companies may also operate in a network model in which they are operating as brokers of services. In the network model, the company develops its own list of providers in a given area who agree to provide services at a reduced rate. After developing the network (often called a provider list, a preferred provider organization, etc.), the network managers then seek contracts with employers in the area to provide services for a specific period at a fixed amount.

IMPLICATIONS FOR MARRIAGE AND FAMILY THERAPISTS

Demand for Mental Health Services

The same factors that shape the demand for general health services create a demand for mental health services. The need for mental health care should continue to grow as long as social problems such as divorce, disintegrating families, drug abuse, addictions, violence, depression, suicide, and the physical, sexual, and emotional abuse of children continue to
Ironically, the adoption of managed care health programs may also lead to an increased demand for mental health services. Many citizens who are not currently included in health insurance programs have significant mental health needs. These needs are met somewhat by both private and public organizations. When managed care programs are adopted, access to mental health services may well increase for those who are currently underserved.

**Competition Among Disciplines**

The new environment for health care will be increasingly competitive. Fierce competition may well develop among the different disciplines (marriage and family therapists versus psychologists versus psychiatrists versus social workers versus counselors) as each group struggles to obtain a share of the resources committed to mental health problems. One form of competition that is likely to continue is the adoption of marriage and family therapy (MFT) practice by mental health disciplines other than MFT professionals. Those who adopt the practice may then use such skills to enhance their credentials within their own professions. MFT professionals, on the other hand, will need aggressively to pursue recognition as an independent discipline of providers through state regulation and the education of managed care organization administrators.

However, a better strategy for all of the potentially competing groups of mental health providers would be to band together to work toward the inclusion of mental health treatment for all those who need it. Otherwise, mental health coverage and psychotherapy may be considered an optional benefit. If forced to choose between life-saving care and other benefits such as dental, psychotherapy, and optometry, which will subscribers and payers select?

The real competition, then, becomes between mental health service providers in general and other types of providers such as dentists, optometrists, and chiropractors. The level of competition will be among services rather than among providers of similar services. Instead of competition among types of mental health providers, the services provided by mental health providers may be seen as optional after basic medical, hospital, and medications are covered.

**Marriage and Family Therapy in Practice**

**General Considerations**

One major advantage that MFTs will have is that in most states, there are relatively few licensed or registered practitioners. This means that the MFT specialty may be a distinct marketing advantage to those seeking employment in large group practices and managed care organizations. MFTs will provide managers a real opportunity to add diversity of providers to their operation.

Another highly successful adaptation to new market forces will be extensive specialization in a specific problem area (such as depression, sexual abuse, chemical dependency, attention deficit disorder, etc.) that will create a unique market position for a practitioner. This approach will also make an individual more interesting and desirable to a large group practice or managed care organization.

Practitioners with master's degrees may compete well against those with doctoral degrees for positions in managed care organizations because their salaries can be lower than those of doctoral degree holders. This advantage would not apply, however, if the doctoral degree holders accept what have been master's level salaries. On the other hand, practitioners
with doctoral degrees should do better than those with master’s degrees in the private payment market since the additional education and experience denoted by the doctoral degree may imply a higher quality of service.

Finally, MFT professionals will need to demonstrate their ability to provide accurate diagnosis of major emotional disorders. This will allow rapid and clear communication between mental health disciplines, provider groups, and managed care administrators.

Private Practice

Solo or small practices. The number of solo private practices should decline because of the decreases in third-party payments in general. A smaller pool of clients that are supported by third parties will increase competition between providers and provider organizations.

The notable exception will be those practitioners who market themselves to the affluent. Consumers in this group are more likely not to need to rely on a third-party payment and in many cases would prefer not to have claims of mental illness submitted for them. These consumers will focus on the perceived quality of the service as measured by the location and furnishings of the office, as well as by the reputation of the provider.

Independent practitioners who are recent graduates or newcomers to a city will have a harder time breaking into the preferred provider organizations that have already been developed. Assistance can be found in the provider groups a clinician may join. In an effort to attract practitioners to their group, such groups may be quite willing to support applications to provider organizations as they expand their membership.

Increased opportunities will exist in contract employment. In these situations, employers will hire providers on a part-time contract basis as a way of decreasing their overall cost of employee benefits. Thus, opportunities to contract for work will expand.

Other practitioners that will prosper will be those who develop and market alternative delivery systems. For example, home care and 24-hour intervention teams should compete well against expensive inpatient therapies. Brief systems-oriented treatments should also do well since efficiency may be better.

Large group practice. Private practice will probably experience changes very similar to those that have occurred in medical practices over the past 10 years. Following the lead of physician group practices (Kenkel, 1994), large groups of multidisciplinary mental health practitioners should band together into corporate or other business structures. In general, the larger (and more diverse) the number of providers in a group practice, the better the groups should do. This is because these groups can contract with specific purchasers of behavioral health care to provide specific services. Examples would include the formation of external EAP organizations, establishing contracts with institutions such as governmental units or other companies who wish to have access to mental health care who do not want to own the provider staff but who want to be able to limit the cost of this employee benefit.

Group practice providers will need to provide a full range of services to their clients. Thus, those that include multidisciplinary staffs will compete very well against those that are less diverse. These groups will need to emphasize cost effective treatment procedures such as family versus individual therapy, group therapy, and a whole range of support groups. These modes of treatment are generally more cost effective since more than one treatment can be given at once.

Large group practices will also be able to hire administrators, marketing, and other staff support personnel that will allow the organization to market their services, develop contracts with managed care companies, and otherwise compete against other groups and individual
private practitioners.

**Both types of practice.** Look for opportunities to work with mental health care companies that are vertically integrated. These companies offer services that include outpatient, day treatment, inpatient, and long-term residential care. In so doing, they will appeal to many market segments, and once a patient enters their system, they will be able to receive a full range of services.

Individuals or private practice groups will benefit if they affiliate with these large vertically integrated systems since the practice groups will be able to provide a large number of services to the companies and at the same time benefit from the large advertising budgets of the host companies. Additionally, the company using the provider or provider group benefits because it can avoid all state and federal employee taxes and benefit costs by not hiring providers directly.

**Marriage and Family Therapy Training Programs**

In many ways the old rules for training are in transition. Historically, it has been important to teach students to be good clinicians, to develop referral networks, and to provide a good quality service. These skills are all still necessary, but new skills need to be added in order for students to compete effectively in the emerging market. New skills such as how to become a member of established panels of preferred providers and how to work with and within managed care organizations need to be discussed early in training programs.

Training programs will need to prepare students for both tiers of service provision. Some students will wish to work in managed care programs, others in the private payment market, and others will want to combine both. Programs should teach student therapists how to be successful in both tiers of service.

**Private system.** Preparation for a career in the private system can be accomplished first by teaching students about their choice to be or not to be part of the managed care program system with the reduced income opportunities but greater numbers of clients and benefits. For those that elect to work in the private payment market, greater emphasis in training should be placed on specific areas. These are brief therapy models, marketing to a specific income and social economic group, alignment with managed care companies, opportunities of specialization in specific treatments or service to specific populations (to provide a distinct identity in the community), required course work that covers small business management, general entrepreneurial skills, and survival strategies for managed care (e.g., Feldman & Fitzpatrick, 1992; Goodman, Brown, & Deitz, 1992).

Examples of important specializations might be aging, AIDS, bicultural treatment and language skills, providing group therapy, children and adolescent disorders, intervention related to gangs, sexual abuse, addictions, treating victims of violence, and so forth. The possibilities are almost limitless. By providing students with an opportunity to begin to develop a specialization, they may be able to branch out into areas of their own interests as well as allow the profession to address the consequences of many of our society's more serious social problems.

Another way to specialize might be in terms of geography rather than presenting problems. Rather than establish a single office in a large metropolitan city, a practitioner could establish several small offices in rural areas and commute to the various locations on a regular basis. Since rural areas are often underserved, this approach would allow the practitioner to develop his/her practice or to join managed care organizations by increasing the geographical diversity of the practice or organization.
Public system. For those that wish to emphasize working in the managed care market, training that will provide skills that will be most important will be issues such as accurate record keeping for treatment plans and progress reports, marketing oneself to these managed care companies (e.g., Feldman & Fitzpatrick, 1992; Goodman et al., 1992) and to Employee Assistance Programs (e.g., Smith, Salts, & Smith, 1989), case management work including referrals and access to community resources, and working on multidisciplinary teams. In addition, training programs can provide more experience and training in the assessment and treatment of chronic mental illness. This will allow students to compete effectively for government, public agency, and managed care positions. Marriage and family therapists will also be able to appeal to the managed care systems if they can document the cost effectiveness of their treatment methods, familiarity with emotional illnesses, and ability to work as a team member in a large organization.

Other possibilities include training students to work as utilization review staff persons who can be employed by the behavioral health care contractors. Students in these positions will work as gate keepers to refer, to screen, and to monitor the services provided by others.

Pressure on educational training clinics to service all of the available clients will likely increase because of cutbacks in services in both the private and public sectors. As a public service, training program clinics could become major service providers in their respective communities. This does pose a problem for training, however, since clients who are seen in training clinics are likely those who are less able to pay for treatment on the open market. Consequently, students will have the majority of their training experience with less affluent clients. This is a disadvantage for those who will be looking to work primarily with affluent clients after training. Training programs more thoroughly prepare students if they provide students with clients from the entire spectrum of socioeconomic, educational, religious, and occupational possibilities.

Opportunities in combining managed care and private pay markets. In many situations, the distinction between managed care and private systems may represent an artificial dichotomy. Many providers will work in both environments. Some clients will be supported by private insurance from their employers, others will be self pay, and still others will be from various managed care programs. The purpose of the present discussion is to help identify the different market segments and discuss the opportunities in each.

SUMMARY

The future of psychotherapy in general and marriage and family therapy in particular is destined to be stormy but no different from that of the rest of the health care system and medicine in general. The reforms in health care that have appeared on the horizon will lead to wide-ranging changes in the mental health care marketplace. Those that will prosper will be able to plan for and adapt to the new mental health care marketplace by developing large group practices, intensive specialization, and market strategies for those in the first tier (the private payment market) of consumers.

As a profession, and because we offer a unique orientation to mental health service, marriage and family therapy has an excellent opportunity for increased market share. These opportunities will be in developing new forms of treatment and making a unique contribution to large provider groups.

Opportunities exist for MFTs since they represent a unique addition to many traditional provider panels, EAPs, and other managed care organizations. MFTs will also be valuable
additions to provider groups who will be trying to broaden their market appeal by including as many services and disciplines as possible.

REFERENCES