MARRIAGE AND FAMILY THERAPY IN HEALTH CARE REFORM: A RESPONSE TO PATTERSON AND SCHERGER

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This paper is written in response to the critique of my health care article (Crane, 1995) written by Patterson and Scherger (1995). My original article set out to identify changes in the health care venue and to explain potential adjustments that educators and practitioners can make in anticipation of those changes.

Overlap
In the authors' explanation of their view of health care reform, they make several points that reiterate my initial assertions. They are: (a) health care reform is inevitable, (b) consumers will have multiple choices in the health care marketplace, (c) marriage and family therapists (MFTs) need business and team management training, (d) training in cost-effective forms of therapy is important, (e) therapists need to be well trained in diagnostic skills, and (f) therapists may trade private business for a more secure income in a managed care setting. Additionally, I agree that lack of knowledge is dangerous, but would add that lack of knowledge about all of the options available to therapists in the evolving marketplace is the greatest danger.

Contribution
The main contributions that the authors make to this subject are in the discussion of capitation, primary care management models, and the specific situation and experiences in San Diego, California and at Sharp Healthcare.

The discussion on the issue of capitation is particularly helpful. The authors provide a very good description of the process and how it is changing the focus of many health care providers from service utilization to service conservation. The article also describes the issue of a changing focus toward primary care in a useful and informative manner. The primary care work settings available for MFTs appear to provide a good opportunity for an expanding market.

The discussion about how health care reform is proceeding with or without major government action is also helpful. The forces driving the increased costs of health care are continuing to mount and the health care industry has had to transform itself.

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Criticism by Patterson and Scherger

There are two main criticisms aimed at my article. They are: (a) that my assertion of the evolution and existence of a two-tier system is too simplistic and (b) that there is no place in the market for a "unique fee-for-service therapist."

Response to the Criticisms

Two-tier system. My claim that there is a two-tier system finds support both in traditional health care and in managed care settings. In the managed care system there is no logically required reason to believe that all possible needs or wants of a client group can or must be handled within the organization. In fact, managed care organizations profit not by the amount of service they provide, but by the amount that they do not. In this environment, participants may well be forced out of their managed care system to obtain the services they desire. Even in countries with highly centralized medical care systems, such as Canada and England, private care has remained a viable option for those who can afford it.

The issue of privacy may also impact on the willingness of consumers to seek mental health services outside their health care system. If employees are required to release their health care records to current or potential employers, some may not wish to utilize their managed care system. Since records of mental health treatment are part of the larger patient health history, information about mental health treatment will be released to a variety of sources.

No place for unique services. It seems unwise to ignore the success which people have had in providing unique services within many fields. Many occupations exist today that did not exist 25 years ago because someone identified a need and worked to meet it. For example, lawyers practice intellectual property law, environmental law, sports and entertainment law, to name a few—fields that were unheard of before the 1960s. To suggest that there is no room for inventiveness or adaptation to new market forces other than to become an employee of a managed care system in a traditionally self-employed profession ignores history and the ability of private enterprise to adapt to change. It also ignores the possibility that therapists who offer a unique service may be attractive to managed care companies precisely because of a therapist's ability to handle a unique set of problems.

My Critique of Patterson and Scherger

There are three assumptions underlying this paper. First, the authors seem to perceive that the evolution of HMOs is health care reform when HMOs have existed for many years. Second, that the PPO/HMO adaptation to medical care is the only valid or predictable outcome, rather than one manifestation of health care reform. Third, many of their arguments and suggestions for training seem to demand the development of what might be called "the employee model" of mental health providers. This form of practice may become more dominant, but given the fact that after years of furious health care reform in medical practice, only about one third of physicians are employees (Burda, 1994), it may or may not be accurate to assume that most or all MFTs will be.

The other major weakness in this paper is that several broad claims are made without substantiation from data or professionally refereed sources. Instead, the authors rely on a number of sources such as personal communication, newsletters, and workshop presentations that may not be generalizable beyond the opinion of a single person.

There are a number of striking examples. First is the assumption implicit in their discussion that all areas of the country will eventually closely resemble San Diego. It is
unclear whether San Diego is truly representative of the United States as a whole or if that particular local economy has led to market developments that are in fact unique. It is probably more likely that there will be significant regional variation in health care management that is determined by the local economy, employers, labor unions, the number of uninsured consumers, and the size and age of the population.

Second, no data are provided for the claim that overspecialization of physicians has led to significantly increased health care costs. Also, the claim that the majority of Medicare expenditures for the elderly occur in the last 6 months of life is not referenced. A conversation with a Kaiser employee is offered as substantiation of HMO data. In addition, a quote from an ophthalmologist about specialization options in that field is not necessarily generalizable to those who practice MFT. References to published sources could strengthen those claims.

Finally, no data are provided to suggest that HMOs will be implementing a wellness model as the philosophical underpinning of health care delivery. In a for-profit setting, one could convincingly argue that profit might be the overriding philosophy.

Other Ideas and Recommendations for Training

Their section on course work at the University of San Diego provides some interesting ideas that other training programs may wish to consider. Several other possibilities also exist. At Brigham Young University we have made several changes in our curriculum that are designed to help prepare our graduates for the changing marketplace. First, we seek to increase students' awareness of the variety of employment options available to MFTs. We teach about such options as academic, medical school and medical service organization practices (e.g., private and public hospitals), employee assistance programs, and managed care systems (e.g., HMO and preferred provider systems). The importance of professional organizations at the state and national level that can be influential in developing contacts with business and legislative bodies is emphasized.

Second, we have developed two new courses called "Clinical Specialization." The purpose of these courses is to help students (a) identify one or two areas of clinical specialization they wish to emphasize in training, (b) develop the knowledge base of the current "state of the science" research related to their chosen area, and (c) begin to seek additional clinical experience in working with the problem class or diagnostic group of choice. Examples include such issues as group therapy processes, sexual abuse, family violence, gerontology, trauma, divorce and remarriage, sex therapy, adolescent and children problems, attention deficit disorders, and others.

CONCLUSION

Overall, the commentary and additional information contained in the Patterson and Scherger (1995) article makes a valuable contribution to the understanding of health care reform and the role of MFTs in emerging health care systems. However, I continue to remain optimistic about the future contributions of MFTs to the emotional well-being of society. This optimism is grounded in two ideas. First, systemic therapy ideas have been and will continue to be influential in developing effective forms of therapy. Second, many of the forces behind the increased costs of health care, such as increases in crime, divorce, and family disruption, are also increasing the demand for all kinds of therapy services. The demand for services will continue to grow, even as the forms of payment for such services will continue to evolve. Successful MFTs will be aware of these changes in structure,
anticipate their impact, and be able to take advantage of the new opportunities that will arise as the systems evolve.

REFERENCES