University of Richmond
UR Scholarship Repository

Bookshelf

6-1989

The Medical Offset Effect and Public Health Policy: Mental Health Industry in Transition

Jonathan B. Wight
University of Richmond, jwight@richmond.edu

John L. Fiedler

Follow this and additional works at: http://scholarship.richmond.edu/bookshelf

Part of the Economic Policy Commons, Economics Commons, Health Policy Commons, and the Public Policy Commons

Recommended Citation

Fiedler, John L., and Jonathan B. Wight. *The Medical Offset Effect and Public Health Policy: Mental Health Industry in Transition*. New York: Praeger, 1989.

NOTE: This PDF preview of The Medical Offset Effect and Public Health Policy: Mental Health Industry in Transition includes only the preface and/or introduction. To purchase the full text, please click here.

This Book is brought to you for free and open access by UR Scholarship Repository. It has been accepted for inclusion in Bookshelf by an authorized administrator of UR Scholarship Repository. For more information, please contact scholarshiprepository@richmond.edu.

THE MEDICAL OFFSET EFFECT AND PUBLIC HEALTH POLICY

Mental Health Industry in Transition

John L. Fiedler
and
Jonathan B. Wight

PRAEGER

New York
Westport, Connecticut
London

1

INTRODUCTION

> The great question is, not so much what money you have in your pocket, as what you will buy with it.
>
> —John Ruskin (nineteenth-century social reformer)

WHAT WE DON'T KNOW

Mental illness is a widespread and costly disease; it reduces productivity, increases absenteeism, shortens longevity, and produces untold human suffering. It is estimated that the provision of mental health services alone in 1980 accounted for an expenditure of between $23 and $30 billion in the United States. Adding the indirect costs of mental illness might bring the total annual burden to society to $54 billion or higher (Klerman, 1985: 588; Frank and Kamlet, 1985: 165; Research Triangle Institute, 1984: 4).

While there is agreement about the importance and seriousness of mental illness, there is no corresponding consensus about what to do about it. This, for the most part, is the result of two closely interrelated factors: first, the still inconclusive analyses of the effectiveness of psychotherapy; and second, the relative paucity of policy-related (specifically economic) analyses of mental illness and mental health treatment. Discussion and understanding of the mental health industry remain what they have long been: limited and piecemeal. As a result, policy-making about mental illness—in the public and private sector alike—continues to be based far too often on opinion, presumption, and hunch.

Meanwhile, economic forces march along to a different drummer. The staggering expenditures have induced a new cost consciousness resulting in "cost containments" that are now transforming the mental health industry, with few safeguards for quality and access considerations. John Ruskin's words, which are quoted above, are worth repeating here: "The great question is, not so much what money you have in your pocket, as what you will buy with it."

In that regard, two vital questions about how we spend our health care dollars remain to be answered. Can the timely purchase and provision of mental

health treatment services reduce a person's overall physical health treatment costs? And, if so, what types of mental health insurance policies and other public financing incentives would promote such gains in efficiency? We hope, in the course of this book, to establish a means by which researchers will be able to help answer these controversial questions about what is called the medical offset effect.

THE MEDICAL OFFSET EFFECT

We have noted that the treatment of mental illness alone is a staggering cost burden on society. But this is just the tip of the iceberg; for persons who suffer from mental illness consume an inappropriately large amount of general health services. This link between mental and physical illness, and their treatments, brings us to the heart of this book, the medical offset effect.

Providers of mental health services, such as psychologists, psychiatrists, clinical social workers, and others, have long asserted that the timely treatment of mental illness generates a corresponding reduction in the use of physical health care. If this is so, then the cost of mental health treatment is offset partially, if not entirely, by savings in the physical health sector. Hypothetically, a dollar spent on psychological evaluation and treatment could generate savings of two and three dollars for private insurance companies, Medicaid, and others involved in health care insurance and financing.

Although this alleged phenomenon, the medical offset effect, has been studied for two decades, there is nothing approaching a consensus about even whether or not such an effect exists. Until now, we believe that researchers in this area have labored under great difficulties, among which are different definitions and different measures of the concept, unique study populations, different experimental designs, and different statistical procedures. More fundamentally, research efforts have largely focused on identifying factors associated with the offset, rather than seeking to explain a consistent theory behind it. As a consequence, the results are difficult to compare and nearly impossible to reproduce: researchers are "talking past" one another.

So we are left with opinions and presumptions to guide policy about any potential offset. But to rely on opinion and presumption in a field as poorly understood by the public, as historically neglected and shrouded in mystique, and as subject to arbitrary and sometimes discriminatory policies as in the mental health industry, is to risk being very far from where an informed profession and polity should be. In short, there is an urgent need for those in the industry, whether practitioners, researchers, or policymakers, to begin a dialogue starting from square one.

There is a growing awareness that a larger framework for understanding, measuring, and estimating mental illness and treatment paradigms is essential if we are to develop rational public and private policies regarding the mentally ill. It is in light of these considerations that we offer this book as an attempt

to compile a comprehensive stocktaking of what is known about the hypothesized offset effect, and the forces which are presently affecting and will continue to affect it in the foreseeable future. Beyond this, we would like to synthesize the underlying theory behind the offset and provide a framework which will be useful for understanding and coordinating research methodologies employed in the future.

The book is therefore geared not only to active researchers in the field but also to mental health treatment providers, insurance companies, and government agencies that are directly affected by an offset. We hope the book will also serve as a useful reference to the general student on the evolution of the mental health industry, as well as a valuable compilation and review of the literature.

WHAT YOU DON'T KNOW CAN HURT YOU

We cannot dally to reach some answers about the issues raised here; nor can we hope that these unresolved issues will somehow sort themselves out to our satisfaction. The mental health industry is being buffeted by powerful forces on an increasingly frequent basis; for example, the 1981 repeal of the Community Mental Health Act of 1963; the introduction of Medicare's prospective payment system—diagnostic-related groups (DRGs)—and the general supplanting of the cost-based reimbursement mechanism with one based on price; the rapid growth of prepaid-capitated care plans and of for-profit medicine; the aggressive and cost-conscious purchasing of health insurance along with a more effective use of utilization review; the growing physician glut; the slowing rate of growth of states mandating the offering of mental health insurance coverage; the rolling back of private insurance plan coverage. Together these forces are revolutionizing the American health care system.

Relatively little inquiry, analysis, or understanding of the implications for either the mentally ill or their providers was sought before most of these measures were undertaken. As far as the mental health industry input was concerned—with the conspicuous exception of psychiatric DRGs (shortly to be discussed)—these changes for the most part were fait accompli. Together these changes constitute a fundamental restructuring of the financial side of the mental health industry. It is hardly surprising, therefore, that they are having major and not always intended impacts on the patients and the providers of mental health services.

These forces transforming the health industry create powerful incentives to underserve the lower-income segment of clientele and to avoid altogether the indigent population. With increasingly less room for cost shifting, uncompensated care becomes an onerous burden, one which is unequally distributed and is having an inequitable impact on some hospitals' abilities to survive in this newly price-competitive world.

As dialectical processes, "the structural transformation of American medicine" (Starr, 1982) and the "industrialization of American psychiatry" (Bitt-

ker, 1985) are certain to continue. As they do, cost containment will continue its ascension to the assailable but unquestionably paramount position, further eclipsing the quality imperative and consumer sovereignty concerns.

Since people with mental disorders receive most of their care from the general medical care sector and account for a disproportionate amount of the total services of that sector, the question as to whether or not there is an offset effect is, and will be for some time, of major policy interest. Preoccupied with trimming budgets, eliminating "unnecessary" services, altering Medicaid incentive structures, and improving the performance of Health Maintenance Organizations (HMOs), public and private policymakers alike will increasingly turn to medical offset research findings for an understanding of present and future relationships between general medical care and mental health care services.

In his path-breaking *The Phenomenon of Man*, Jesuit philosopher Tielhard de Chardin wisely admonishes his readers, "So please do not expect a final explanation of things here." This caveat should serve to remind us, in this endeavor, not to expect to find easy answers or to provide the last word on the subject. Rather, we hope this work will contribute something to the ever-unfolding knowledge of man, his illnesses of the mind, and their effective treatments.

Before concluding this chapter with a brief overview of the book, we would like to acknowledge our deep debt and sense of gratitude to past and present researchers who have lugged the wagon of knowledge up the incline to its present point. That this present work owes much to many pioneers who charted many difficult courses in this field should be obvious to those familiar with the wealth of literature which we draw upon. And we do not doubt that this book is a first step, which with hindsight will appear obvious and primitive.

AN OVERVIEW OF THE BOOK

Chapter 2 traces the revolutionary transformation of the mental health industry in the post–World War II era, and provides a context for understanding the growth of public interest in the industry, specifically in the medical offset effect. Chapter 3 winnows through the offset literature in a stylized review, extracting and examining the major issues, problems, and findings of medical offset research.

To facilitate the conceptual integration of these studies and to synthesize their diverse findings, a behavioral model for explaining the medical offset effect is constructed in chapter 4. Estimation of a behavioral model offers the most precise and conclusive method for ascertaining the existence of the offset, as well as simultaneously providing an understanding of the underlying causal relationships. An understanding of these causal relationships is essential if policymakers are to gain insight into how to design policies to most effectively alter behavior of the mentally ill and their families, of psychotherapists, or of public and private insurance companies, to maximize any potential medical offset effect.

Empirical estimates of the offset effect are made in chapter 5, using a multivariate regression model and longitudinal (1980–82) Medicaid data from Georgia. In chapter 6 additional policy issues are analyzed and the Georgia results are compared to offset results for a similar Medicaid population in Michigan. The final chapter discusses the policy implications of our findings against the backdrop of the larger picture of mental health care, the mental health care industry, and general public health care policy as it evolves through the 1990s.

STUDY DOMAIN

Hospital and nursing home mental health care was estimated to account for 85 percent of total mental health treatment outlays in 1980. As documented in the next chapter, however, by far the largest and most rapidly growing component of mental health care is outpatient (as opposed to inpatient) care. This observation, coupled with our untested hypothesis that recipients of inpatient care are far more likely to be chronically ill—and, to the extent that they remain inpatients for long periods, are less likely to generate an offset—prompted us to concentrate on outpatient treatment. Although we occasionally discuss inpatient care—notably in the narrative account of the evolution of the industry since World War II contained in the next chapter—the primary focus (especially in the review of literature and the empirical sections) is outpatient care.

Frequently the mentally ill are defined to include alcohol and drug abusers. In the interest of precision we take a more narrow focus in our empirical section to ensure a more homogeneous study group. Technically, the types of mental illness examined in our empirical estimation include clinical module diagnostic codes 290, 293-302, and 305-316, of the International Classification of Disease (version 9). As in any empirical analysis, the unique characteristics of the data base demarcate the extent to which the results may be generalized. These considerations and a more complete discussion of the empirical analysis are covered in chapters 5 and 6.