Challenges to the Future of Psychiatry: Parallels with Primary Care

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In the wake of market-based restructuring of the U.S. health care delivery system during the past four decades, the business ethic of maximal profits has largely replaced the traditional service ethic of medicine in this country. Today, we have a market-based system that rewards profits and procedures over more time-consuming evaluative talking and listening with patients. This sea change in health care has had adverse impacts on the physician-patient relationship as well as on continuity and quality of care.

This article undertakes these objectives: 1) to summarize the twin crises in psychiatry and primary care, both of which are in decline for similar reasons; 2) to briefly describe the ways in which deregulated health care markets have led to these crises; 3) to discuss how incremental efforts over the past 40 years toward health care reform have failed to address problems of access, costs, affordability, and quality of care; and 4) to lay out an approach to real health care reform that will rebuild the future of psychiatry and primary care as essential building blocks toward more effective and personal medical and mental illness care for both individuals and populations.

TWIN CRISSES IN PSYCHIATRY AND PRIMARY CARE

Psychiatry

In a prescient article more than 20 years ago, Haavi Morreim of the Department of Human Values and Ethics at the University of Tennessee College of Medicine described how economics was rewriting American medicine:

“The ongoing economic overhaul of medicine creates two basic imperatives — boosting profits and containing costs — that pose special ethical and philosophical challenges for psychiatry... The economic pressure to fill beds translates into a commensurate pressure on the profession to expand the concept of psychiatric illness, and with it the criteria for hospitalization and other extensive (revenue-producing) care.”

Since then, we have seen these major trends in the practice of psychiatry:

• Shift of practice from mental illness to mental health, leaving a vacuum in the care of serious mental illness.
• Deinstitutionalization of mental illness care, with emptying out or closure of many public mental hospitals.
• Limited access to urgent psychiatric care (eg, only 12% of 64 facilities listed by Blue Cross Blue Shield of Massachusetts’s PPO plan offered appointments even after being seen in an emergency room for depression and instructed to get an appointment within 2 weeks).
• Marked decline in hospital stays for patients with psychiatric disorders.
• Inadequate reimbursement for time-consuming “talk therapy” without compensatory procedural reimbursement.
• Lack of parity of coverage for physical and mental illness.
• Rapid decline of psychotherapy and shift toward drug therapy and “med checks” practice.
• Expansion of criteria for psychiatric disorders in subsequent Diagnostic and Statistical Manual of Mental Disorders editions.
• Growth of various mental health pro-
fessions in practices not supervised by psychiatrists.

• Criminalization of the seriously mentally ill, with misuse of jails as mental hospitals.  

Here are some benchmarks of the crisis now involving psychiatry and mental illness:

• The most common “treatment” for serious mental illness is again jail, as it was in the 1830s.  

• A severe shortage of hospital beds for psychiatric patients (one psychiatric bed for every 3,000 Americans vs. one bed for every 300 Americans in 1955).  

• Psychiatric patients languishing in hospital emergency rooms for long periods without treatment.

• Draconian cuts in state budgets for mental health and mental illness care.

Primary Care

These are some of the major trends in U.S. primary care over the past four decades:

• Decline in the number of generalists (family medicine, general internal medicine, and pediatrics) as specialization dominates the physician workforce.

• Increasing shortage of generalist physicians threatening access to care.

• Advent of hospitalists, with little remaining role of primary care physicians in the hospital.

• Growth of group practice, and, more recently, employment by hospital systems.

• Inadequate reimbursement for time-intensive evaluative extended visits.

• Increased emphasis on brief outpatient visits.

• Erosion of continuity of care and physician-patient relationship.

These trends translate to adverse benchmarks for system performance of U.S. primary care:

• Restricted access to primary care physicians.

• Increased use of emergency rooms and unnecessary hospitalizations.

• Fragmentation of patient care among specialists with inadequate coordination.

• Compromised integration of care, especially for chronic conditions.

• Decreased quality of care for both individuals and populations (eg, worst rating among 11 advanced countries in the world for overall primary care).  

• Overstretched and tattered safety net.

Primary care and psychiatry have a number of things in common in their decline among clinical specialties over the last four decades. Both are undervalued and underfinanced. Both have faced pressures to reduce face-to-face time with patients because of our flawed reimbursement system that favors procedures and more specialized services. Both are at or near the bottom of physician incomes by specialty. And both have lost out to other specialties in career selection by medical students as they seek higher paying specialties.

HOW DEREGULATED MARKETS HAVE LED TO THESE CRISES

The business ethic that has permeated our market-based system in recent decades has altered the entire landscape of health care. Health care is now a commodity for sale on the open market. Many parts of the system are investor-owned, ranging from insurers to hospitals, nursing homes, and dialysis service chains. Many not-for-profit parts of the delivery system are difficult to distinguish in the marketplace from their for-profit counterparts. Physicians are now termed “providers” and not distinguished from the growing number of other health professionals. The physician-patient relationship lacks the intimacy that was common in earlier years, to the point that many of today’s physician encounters with patients amount to strangers treating strangers. As the depth and continuity of the physician-patient relationship has eroded, the patient’s narrative has been lost in both psychiatry and primary care. There is not enough listening time in clinical practice today, because the economics of practice in a for-profit enterprise now dictate how medicine is practiced.

“Productivity” has become the byword in practice. More than one-half of U.S. physicians are now employed by other organizations, mostly hospital systems but now even by some insurers. In their pursuit of financial bottom lines, employers push physicians to shorten patient visits and provide more well-reimbursed procedures and services.

As a result of this sea change, the physician’s capacity to heal has suffered immensely. Dr. Howard Brody, Director of the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston and author of Stories of Sickness, reminds us that:

“What counts as a ‘right and good healing action’ is easy to see when a sickness can be cured, or when no sickness exists and the patient simply requires reassurance that this is not so. But, when sickness is more or less chronic, we cannot understand what the sickness is doing to the person’s self-respect, to his life plan, and to the narrative account of his life.”

Most physicians have been passive in accepting and adapting to their new employed status. Their employers shield them from many of their previous administrative burdens of private practice while their incomes become more predictable. In many instances, physicians game the marketplace in their own self-interest through conflicts of interest with drug and medical device manufacturers, ownership of specialty hospitals, ambulatory surgery and imaging centers, and even unethical relationships with Wall Street. Too many physicians in this current generation now see medicine as more of a well-paying job, often even part-time, than a profession with a long tradition of service.

LONG FAILURE OF INCREMENTAL REFORM EFFORTS

The four major systemic problems in U.S. health care continue, after more than
four decades of various incremental reform attempts, to be: 1) soaring health care costs; 2) increasing unaffordability of care; 3) inadequate access to essential health care; and 4) variable and often mediocre quality of care. Far from being partially resolved, all of these problems are actually increasing today as market forces dominate how health care is financed and delivered.

Medicare and Medicaid, enacted in 1965, are the most durable of these efforts. But they deal with only parts of our population, and have been exploited in recent years by private for-profit plans offering less personal care of lower quality. Payment reforms for hospitals based on diagnostic-related groups (DRGs), although a worthy attempt to rein in costs, proved ineffective in containing hospital expenditures. Managed care of the 1990s also failed to control costs, as health maintenance organizations (HMOs) were discredited because of a wide range of deceptive practices and conflicts of interest, including false advertising, under-treatment and denial of services, disenrollment of sick enrollees, and gag rules on physicians.

The Affordable Care Act of 2010, even if it is fully implemented (unlike in our current political climate), will fall far short of universal coverage, fail to contain health care costs, provide underinsurance to many of the newly “insured” (covering no more than 60% or 70% of patients’ health care costs), and add new layers of waste and bureaucracy. It is a bailout of a failing private health insurance industry and will not be sustainable. As described in my 2010 book Hijacked: The Road to Single Payer in the Aftermath of Stolen Health Care Reform, corporate stakeholders in our market-based system successfully crafted the bill to their own interests. Market failure is still not widely recognized as the wellspring of our ongoing system problems.

A PATHWAY TOWARD REAL HEALTH CARE REFORM

As most advanced countries around the world learned many years ago, universal coverage is an achievable goal when governments step in to assure fairness and accountability of private markets. Systems based on one large insurance pool contain costs better than private markets even as they provide universal coverage to all necessary health care.

Single-payer national health insurance (NHI) along the lines of the “Medicare For All Bill” (John Conyers, D-MI, H.R. 676) — public financing coupled with a private delivery system — would assure access to all necessary health care for our entire population; provide free choice of physician and hospital, together with portability and reliability of coverage regardless of age or employment; save at least $400 billion in administrative costs by replacing 1,300 mostly for-profit private insurers with one not-for-profit public financing system; contain costs through administrative simplification, negotiated budgets, reimbursement reform, bulk purchasing (e.g., as the Veterans Administration already does in getting the costs of prescription drugs down to about 58% of what we pay now); and provide an evidence-based coverage process that prevents useless or harmful products and procedures from coming to market.

Most parties win with NHI. Most importantly, all Americans gain access to affordable care on which they can count. Comprehensive benefits will include men-

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**TABLE 1. Alternative Scenarios for 2020**

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<th>Multi-Payer (2010 Affordable Care Act)</th>
<th>Single Payer (H.R. 676)</th>
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<tr>
<td>Cost Containment?</td>
<td>No. Out of control, with no remedy in sight.</td>
<td>Yes. Made possible by $400 billion a year in administrative savings, bulk purchasing, and negotiated fees and budgets in a not-for-profit system.</td>
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<td>Affordability?</td>
<td>No. Severe rationing by ability to pay; high cost-sharing; increased medical bankruptcies.</td>
<td>Yes. No cost-sharing; patients and employers pay less than they do now.</td>
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<tr>
<td>Comprehensive Benefits?</td>
<td>No. Severe tiering by actuarial value of coverage.</td>
<td>Yes. For all necessary and effective care.</td>
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<td>Quality of Care?</td>
<td>Highly variable. Increasing numbers of preventable deaths; increased public dissatisfaction.</td>
<td>Improved, through universal access and reduction of inappropriate and unnecessary care.</td>
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<td>Bureaucracy?</td>
<td>Greatly increased.</td>
<td>Greatly reduced.</td>
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<td>Sustainability?</td>
<td>No. Widespread system collapse.</td>
<td>Yes. Through simplified administration in a more accountable system.</td>
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H.R. 676 = U.S. House of Representatives resolution 676, “The Expanded and Improved Medicare For All Act” sponsored by John Conyers (D-MI).
tal health parity, long-term care, dental services, and prescription drugs. Business and labor join the winners’ circle as they both get more by spending less. Employers will gain a healthier workforce while employees will no longer stay in a job that they do not like simply for the health insurance or fear loss of health insurance if they lose their job. All patients will pay into the new system and will enjoy the dignity of being paying patients. Most physicians will fare better, with much-reduced overhead costs and predictable reimbursement. They will bill a single-payer for their services, have more clinical autonomy, and no longer be hassled by the current bureaucracy of our multi-payer financing system. Payment reforms based on need and value of services should improve the economics of primary care, psychiatry, geriatrics, and other specialties that are based more on cognitive care than procedures. At the same time, it is likely that the incomes of some procedure-based specialties will drop, especially if they have been involved with over-reimbursed procedures that are inappropriate or unnecessary.

The prognosis for U.S. health care in 2020 is stark if we continue to muddle on with our inefficient and exploitive multi-payer financing system, as shown in Table 1.

Admittedly, the power and money of corporate stakeholders will fight to retain the status quo and continue to resist single-payer NHI. Can we ever expect NHI to be enacted in this country, where money so dominates the political process?

These are hopeful signs that seem to make NHI inevitable and only a matter of time:

- Income inequality and class differences have reached historic highs in recent years, now pitting the 99% percent against the 1%. Political pressure is certain to mount from the grassroots as an ever larger part of the population cannot afford necessary care. Already 50,000 Americans are dying each year (136 a day) for lack of health insurance.12

- In these times of austerity budgets, it will become more obvious that we can no longer afford the waste, duplication, and profits of private payers. Public payers are more efficient, provide more value, and control costs better than private payers, as demonstrated over the years by traditional Medicare.13,14

- A sizable majority of the public (two-thirds in some polls) support a larger role of government and public financing of health care.15

- Support for single-payer NHI is strong and growing within medicine and other health professions as illustrated by activist positions taken by the American College of Physicians, the American Psychiatric Association, Physicians for a National Health Program, the American Public Health Association, and the California and American Nursing Associations. A 2008 national survey of more than 2,200 U.S. physicians in all specialties found that 59% support NHI.16

- Progress of single-payer initiatives in Vermont, Hawaii, and Montana.17-19

- Opposition of small business organizations to the Citizens United decision of the U.S. Supreme Court that opened the floodgate to private funding of political campaigns.20

In primary care and psychiatry, we know how important and essential our work is to our patients and communities. The current system seriously threatens our future and that of our patients. It is also unsustainable, and as the well-known economist Herbert Stein reminds us: “If something cannot go on forever, it will stop.”21 I feel it is high time that we all become activists for real health care reform. The stakes for our patients, communities, and society are too high for inaction on our part.

REFERENCES

11. The Expanded and Improved Medicare For All Act, HR 676, 113th Cong (2013).