Letters

Funding for Mental Health Care: Inadequacies Must be Addressed

"Champions in the Fight against Depression: U-M's collaborative team takes the lead," proclaims the cover of your Summer 2002 issue. Inside, a glowing article describes the U-M Medical School's "cutting-edge" approach to the devastating illness that is clinical depression. Dr. John F. Greden, chair of the Department of Psychiatry, tells us that depression is near the top of the World Health Organization's list of the world's most important diseases, that it is a neurobiological illness that cannot be attributed to stress and lifestyle factors alone, and that suicide is only the most obvious lethal effect of depression. We are also told that the U-M is footing the bill for a new Depression Center, a "beautiful new facility," one that is "light, airy, warm, inviting, and a community resource." Greden seems to show real compassion for those who suffer from depression, and that, combined with the U-M's dedication to research and state-of-the-art treatment, paints a rosy picture indeed.

For those of us who suffer from this illness, however, the true picture is far less idyllic, and the U-M cutting-edge approach seems a bitter irony in light of the fact that M-CARE, the insurance arm of the University of Michigan's medical facilities, provides mental health coverage that is completely inadequate for the severely, and even the moderately, afflicted.

M-CARE's policy is to provide all patients with a maximum of 20 visits with a mental health professional per year. Even then, the patient's co-pay for mental health services is higher than that for the treatment of so-called "physical" illnesses. In fact, however, M-CARE's distinction between mental and physical illness is artificial and is based on out-of-date science. Mental illnesses are physical illnesses, as Greden makes clear in the article. M-CARE, however, does not recognize this in its policies, which seem based on earlier concepts of depression as something that is under the patient's control. Even if that were the case, however, even if patients with depression were making choices that somehow caused their illness, M-CARE's coverage would still be discriminatory. M-CARE does not deny or limit coverage for those whose choices contribute to what are considered physical illnesses. If I smoke three packs of cigarettes a day, live on steak and brandy, drive while intoxicated, and engage in risky sports, M-CARE will pay for whatever medical care is made necessary by my actions. Because I have what is classified as a mental illness, however, I used up my allotted treatment for the year 2002 during the summer, and now I must pay for adequate care out of pocket. For me this means that, even though I have cut down to seeing my psychiatrist every other week when I should be seeing him weekly, I am still currently spending 20 percent of my monthly net income for psychiatric treatment. The resulting financial stress, of course, has a negative impact on that treatment.

Greden touches on the issue of insurance. He acknowledges that a lack of adequate coverage is a serious problem. He even expresses hope that the state of Michigan will soon mandate parity for mental health coverage. But how much praise should we heap upon the University's program if it will take legislation to force its own insurance company to provide adequate coverage for those who most need this program? One may argue that the Department of Psychiatry does not control M-CARE's decisions on coverage, and no doubt that is true. But M-CARE is a part of the University, and I find it hard to believe that the doctors who somehow persuaded the University to provide this beautiful new facility can have so little influence on M-CARE's policies, which result in a situation in which the ordinary working people who most need the Depression Center cannot take advantage of the "light, airy, warm, inviting" atmosphere without suffering financial devastation. I find myself wondering if psychiatrists, whose incomes, though low among physicians, are significantly higher than those of the average patient, fully understand the tremendous effect that lack of adequate coverage has on their patients. When Greden, who is clearly a thoughtful and caring physician, discusses the reasons that those with depression do not seek treatment, he fails to mention what seems most obvious to me: many working people

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In the next ISSUE

of *Medicine at Michigan:* Organ-assist and replacement devices in trial or use at U-M extend patients' lives and improve quality of life ... a new combination CT/PET scanner takes U-M's medical imaging diagnostic capabilities further than ever before ... and the Health Sciences Scholars Program prepares undergraduates for studies and careers in medicine and other health science professions. Also: Match Day and Commencement 2003.

with otherwise adequate insurance coverage simply cannot afford psychiatric care. The stress of inadequate coverage in itself can be a terrible burden for those who already suffer from depression, complicating the treatment the University is so proud of. In a sense, the University, through M-CARE, sabotages the efforts of its own physicians.

Clearly the University's Department of Psychiatry has a lot to be proud of, but because of the nature of depression, the separation between treatment and the patient's ability to pay for that treatment is artificial. I would hope that those who put so much care and work into treating people with depression would understand the tremendous importance of the financial issues for those who suffer from this disease and then *act* on that knowledge, pressuring the University to provide parity treatment for mental illness even though it's not required by law. That would *truly* be cutting-edge.

Clare Cross
Ann Arbor

John Greden, M.D., executive director of the U-M Depression Center, and Zelda Geyer-Sylvia, M.P.H., executive director of M-CARE, respond:

As a nation, we put too few financial resources into mental health treatments. While support in every other sector in health care is increasing, mental health is the one area that is decreasing. The reasons for this are multiple, but the current situation compromises and endangers services.

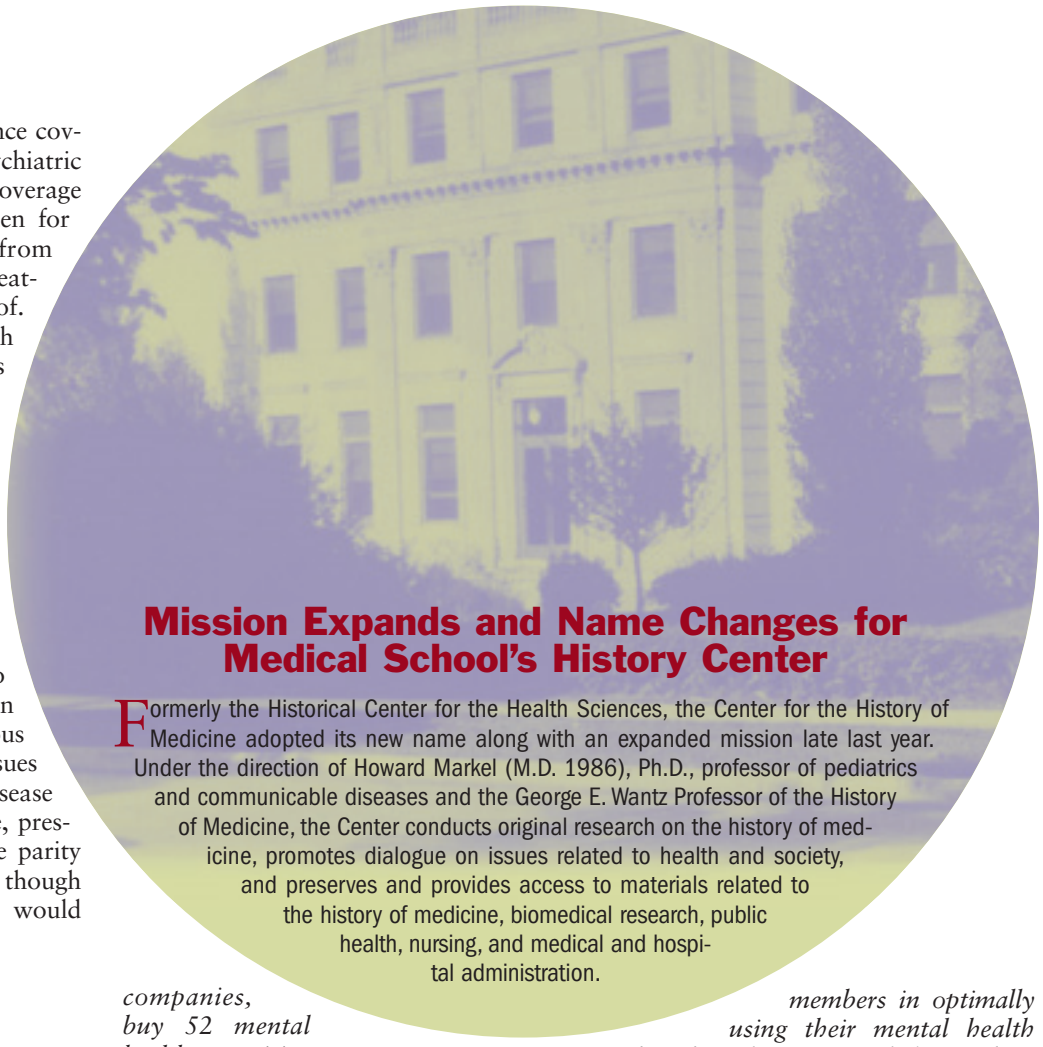
The sources that control mental health coverage are the purchasers of health care plans. Half come from public sources (Medicare and Medicaid); half come from employers. Purchasers buy a certain level of mental health care benefits, and the insurance company, such as M-CARE, administers the benefit the employer buys. These levels vary considerably. Some employers, like major auto companies, buy 52 mental health care visits per year under M-CARE, while other employers limit their purchase of mental health care to 20-25 visits. There are also differences in co-pays, depending on what benefit the employer purchases.

This is not to blame employers for insufficiencies in mental health benefits. Employers, like all of us, are faced with escalating health care costs. And increases in costs are, unfortunately, passed back to the individual employee. It is a complicated and critical national problem.

M-CARE has taken steps to invest in programs aimed at identifying and facilitating the treatment of members with depression. Recently, M-CARE implemented a Depression Disease Management Program that provides information and educational materials to members regarding depression, as well as providing case management services.

M-CARE contracts with central diagnostic and referral services to assist members in optimally using their mental health benefits. These services help members organize their treatment plans so that, whenever possible, they do not exhaust benefits before treatment is completed. In instances where this cannot be accomplished, they assist members who have used all their benefits to find alternative care.

But, of course, none of this makes up for the fact that, as a society, we have yet to recognize that all humans have both bodies and minds, and that psychiatric medicine is important to our well being. The work of the University of Michigan Depression Center is to help further the understanding that treatment works and is a proper place to invest valuable health care dollars. This scientific and clinical knowledge, coupled with articulate spokespersons like Clare Cross, can make the case that we as a society must take measures to adequately fund mental health care in the U.S. m



Mission Expands and Name Changes for Medical School's History Center

Formerly the Historical Center for the Health Sciences, the Center for the History of Medicine adopted its new name along with an expanded mission late last year. Under the direction of Howard Markel (M.D. 1986), Ph.D., professor of pediatrics and communicable diseases and the George E. Wantz Professor of the History of Medicine, the Center conducts original research on the history of medicine, promotes dialogue on issues related to health and society, and preserves and provides access to materials related to the history of medicine, biomedical research, public health, nursing, and medical and hospital administration.