{ 9 }

The Twenty Years Kaiser Permanente Experience with Psychotherapy and Medical Utilization: Implications for National Health Policy and National Health Insurance*

Out of necessity, and very early in its experience of providing comprehensive health coverage without the usual limitations, Kaiser Permanente discovered it had to provide mental health services to prevent over-utilization of medical facilities by otherwise healthy persons who were somaticizing. The 20-year clinical and research experience at Kaiser Permanente of providing mental health coverage as part of a comprehensive health maintenance program has a range of implications for national health policy. These implications include cost, utilization, scope of coverage, range of services, access to care, types of providers, and the role of program evaluation/research.

The Kaiser Permanente Health Plan, as the forerunner to the modern Health Maintenance Organization (HMO), was an early pioneer in the provision of comprehensive mental health care as an integral part of a total, prepaid health care delivery system. The HMO concept was born in the Mojave Desert of California during the severe economic depression of the 1930's. After receiving the contract to build the

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aqueduct to Los Angeles from Boulder Dam (later renamed Hoover Dam), a then unknown builder named Henry J. Kaiser experienced difficulty recruiting and maintaining adequate construction crews on the desert. This was due to the total lack of medical care in the desert and a resulting reluctance of workers to move their families there. Upon hearing of this problem, Sidney Garfield, a young physician, offered to provide all of the facilities and services necessary for comprehensive health care, not only for the workers, but also for their families. The cost of this package would be a nickel per employee work hour; there would be no fee-for-service no matter how adverse the experience. A further unique feature was that a significant proportion of effort would be expended to prevent illness, particularly problems such as sunstroke and heat exhaustion, which are perils on the desert.

The arrangement was made and the concept of a capitation to keep people healthy as opposed to a fee to treat the sick was implemented—perhaps out of necessity, perhaps out of Kaiser's ability to recognize a good idea. Seemingly overnight Kaiser built his shipyards during World War II, and brought along Dr. Garfield and a now greatly expanded prepaid health care group. The Kaiser Permanente Health Plan went public on the West Coast following World War II and immediately flourished. Its tremendous acceptance was obviously the result of the Kaiser plan's providing comprehensive treatment for all problems at low subscriber rates, without the exclusions, limitations, co-insurance and other troublesome features common to other health plans at the time. Kaiser Permanente has enjoyed three decades of growth and success to date and is still flourishing.

Today, there are 8.5 million subscribers. Its nearly three dozen hospitals are divided into semi-autonomous regions which, in order of establishment, are: Northern California, Portland (Oregon), Southern California, Hawaii, Cleveland and Denver. These regions enjoy a great deal of independence from each other, but are tied nominally together by the one Kaiser Foundation. This leads to health care delivery (and particularly mental health care delivery) varying considerably in format from one region to the next.

It was nearly 30 years before Dr. Garfield articulated his concept of "health maintenance" in a historic publication. His idea caught the attention of the federal government, and led to legislation to encourage the creation of Health Maintenance Organizations in the United States instead of the traditional fee-for-service health plan reimbursement.

This paper chronicles the 20-year experience in the first, or Northern California region, and particularly the San Francisco facility where the primary research was conducted.

THE BEGINNING OF THE KAISER PERMANENTE MENTAL HEALTH BENEFIT

Kaiser Permanente soon found, to its dismay, that once a health system makes it easy and free to see a physician, there occurs an alarming inundation of medical utilization by seemingly physically health persons. In private practice the physician's fee has served as a partial deterrent to over-utilization, until the recent growth of third party payment for health care services. The financial base at Kaiser Permanente is one of per capitation, and neither the physician nor the Health Plan derives an additional fee for seeing the patient. Rather than becoming wealthy from imagined physical ills, the system could be bankrupted by what was regarded as abuse by the hypochondriac.

Early in its history, Kaiser Permanente added psychotherapy to its list of services, first on a courtesy reduced fee of five dollars per visit and eventually as a prepaid benefit. This was initially motivated *not* by a belief in the efficacy of psychotherapy, but by the urgent need to get the so-called hypochondriac out of the doctor's office. From this initial perception of mental health as a dumping ground for bothersome patients, twenty years of research has led to the conclusion that no comprehensive prepaid health system can survive that does not provide a psychotherapy benefit.

THE NSA PATIENT

Early investigations confirmed physicians' fears they were being inundated, for it was found that 60% of all visits were by patients who had nothing physically wrong with them. Add to this the medical visits by patients whose physical illnesses are stress related (peptic ulcer, ulcerative colitis, hypertension, etc.), and the total approaches a staggering 80 to 90% of all physician visits. Surprising as these findings were 25 years ago, nationally accepted estimates today range from 50 to 80% (Shapiro, 1971). Interestingly, over 2,000 years ago Galen pointed out

that 60% of all persons visiting a doctor suffered from symptoms that were caused emotionally, rather than physically (Shapiro, 1971).

The experience at Kaiser Permanente subsequently demonstrated that it is not merely the removal of all access barriers to physicians that alone fosters somatization. The customary manner in which healthcare is delivered inadvertently promotes somatization (Cummings & VandenBos, 1979). When a patient who has not been feeling up to par attempts to discuss a problem in living (job stress, marital difficulty, etc.) during the course of a consultation with a physician, that patient is usually either politely dismissed by an overworked physician or given a tranquilizer. This unintentionally implies criticism of the patient which, when repeated on subsequent visits, fosters the translation of this emotional problem into something to which the physician will respond. For example, the complaint that "my boss is on my back" may become at some point a low back pain with neither the patient nor the physician associating the symptom with the original complaint. Suddenly the patient is "rewarded" with x-rays, laboratory tests, return visits, referrals to specialists and, finally, even temporary disability which removes the patient from the original job stress and tends to reinforce protraction and even permanence of the disability.

Estimates of stress related physical illness are subjectively determined, whereas number of physician visits by persons demonstrating no physical illness can be objectively verified through random samplings of all visits to the doctor. After more or less exhaustive examination, the physician arrives at a diagnosis of "no significant abnormality," noted by the simple entry of "NSA" in the patient's medical chart. Repeated tabulations of the NSA entries, along with such straightforward notations as "tension syndrome" or similar designations, consistently yielded the average figure of 60%.

During the early years of Kaiser Permanente there was considerable resistance to accepting such estimates because it was reasoned that if 60 to 90% of physician visits reflect emotional distress, 60 to 90% of the doctors should be psychotherapists! This fear, as will be demonstrated below, was unfounded, because subsequent research indicated that a relatively small number of psychotherapists can effectively ameliorate these patients.

In an effort to help the physician recognize and cope with the distress-somatization cycle, Follette and Cummings (1967) developed a scale of 38 Criteria of Distress. These criteria do not employ psychological jargon; rather, they are derived from typical physician en-

tries in the medical charts of their patients. The researchers worked back from patients seen in psychotherapy to their medical charts on which the diagnosis NSA had been made. They gathered extensive samplings of typical entries which connoted distress and validated these into the 38 criteria shown in Table 1. Physicians were urged to refer patients for psychotherapy who scored three points or more on this scale as attested by the physician's own medical chart entries.

After expending considerable effort and time validating this scale, it was discovered that emotional distress could be just as effectively predicted by weighing the patient's medical chart. The reason is that patients with chronic illness (or those involved in prenatal care) tend to see a physician in more or less scheduled appointments, while the patient suffering from emotional distress tends to utilize drop-in services, night visits and the emergency room. In the instance of the chronically ill patient, the physician makes each entry in the chart immediately under the one bearing the date of the previous visit, resulting in several visits being recorded on one sheet front-and-back in the medical chart. By comparison, when emotionally distressed persons make nonscheduled visits the medical chart is not available and the physician makes the entry on a new and separate sheet which is later filed in the chart by medical records librarians. Repeating this practice through months and years builds up enormous medical charts, sometimes into the second and third volume.

Once the patient enters the somatization cycle there is an ever-burgeoning symptomotology because the original stress problem still exists in spite of all the physician's good efforts to treat the physical complaints. The patient's investment in his/her own symptom is only temporarily threatened by the physician's eventual exasperation, often accompanied by that unfortunate phrase, "It's all in your head." A new physician within the care system is found, and one whose sympathy and eagerness to determine the *physical* basis for the symptom have not been worn down by this particular patient. The inadvertent reward system continues, as does the growth of the medical chart.

THE EFFECT OF PSYCHOTHERAPY ON MEDICAL UTILIZATION

In the first of a series of investigations into the relationship between psychological services and medical utilization in a prepaid health plan setting, Follette and Cummings (1967) compared the number and type

Table 1. *Criteria of Psychological Distress with Assigned Weights*

One point	Two points	Three points
1. Tranquilizer or sedative requested.	23. Fear of cancer, brain tumor, venereal disease, heart disease, leukemia, diabetes, etc.	34. Unsubstantiated complaint there is something wrong with genitals.
2. Doctor's statement pt. is tense, chronically tired, was reassured, etc.	*24. Health Questionnaire: yes on 3 or more psych. questions.	35. Psychiatric referral made or requested.
3. Patient's statement as in no. 2.	25. Two or more accidents (bone fractures, etc.) within 1 yr. Pt. may be alcoholic.	36. Suicidal attempt, threat, or preoccupation.
4. Lump in throat.	26. Alcoholism or its complications: delirium tremens, peripheral neuropathy, cirrhosis.	37. Fear of homosexuals or of homosexuality.
*5. Health Questionnaire: yes on 1 or 2 psych. questions.	27. Spouse is angry at doctor and demands different treatment for patient.	38. Non-organic delusions and/or hallucinations; paranoid ideation; psychotic thinking or psychotic behavior.
6. Alopecia areata.	28. Seen by hypnotist or seeks referral to hypnotist.	
7. Vague, unsubstantiated pain.	29. Requests surgery which is refused.	
8. Tranquilizer or sedative given.	30. Vasectomy: requested or performed.	
9. Vitamin B_{12} shots (except for pernicious anemia).	31. Hyperventilation syndrome.	
10. Negative EEG.	32. Repetitive movements noted by doctor: tics, grimaces, mannerisms, torticollis, hysterical seizures.	
11. Migraine or psychogenic headache.	33. Weight-lifting and/or health faddism.	
12. More than 4 upper respiratory infections per year.		
13. Menstrual or premenstrual tension; menopausal sx.		
14. Consults doctor about difficulty in child rearing.		
15. Chronic allergic state.		
16. Compulsive eating (or overeating).		
17. Chronic gastrointestinal upset; aereophagia.		
18. Chronic skin disease.		
19. Anal pruritus.		
20. Excessive scratching.		
21. Use of emergency room: 2 or more per year.		
22. Brings written list of symptoms or complaints to doctor.		

* Refers to the last 4 questions (relating to emotional distress) on a Modified Cornell Medical Index—a general medical questionnaire given to patients undergoing the Multiphasic Health Check in the years concerned (1959–62).

of medical services sought before and after the intervention of psychotherapy for a large group of randomly selected patients. The outpatient and inpatient medical utilization by these patients for the year immediately prior to their initial interview in the Kaiser Permanente Department of Psychotherapy as well as for the five years following that intervention were studied for three groups of psychotherapy patients (one interview only, brief therapy with a mean of 6.2 interviews, and long-term therapy with a mean of 33.9 interviews) and a "control" group of matched patients demonstrating similar criteria of distress but who were not, in the six years under study, seen in psychotherapy.

The findings indicated that: (a) persons in emotional distress were significantly higher users of both inpatient (hospitalization) and outpatient medical facilities as compared with the health plan average; (b) there were significant declines in medical utilization by those emotionally distressed individuals who received psychotherapy, as compared with the "control" group of matched patients; (c) these declines remained constant during the five years following the termination of psychotherapy; (d) the most significant declines occurred in the second year after the initial interview, and those patients receiving one session only or brief psychotherapy (2 to 8 sessions) did not require additional psychotherapy to maintain the lower level of medical utilization for five years, and (e) patients seen two years or more in continuous psychotherapy demonstrated no overall decline in total outpatient utilization (inasmuch as psychotherapy visits tended to supplant medical visits). However, even for this latter group of long-term therapy patients there was a significant decline in inpatient utilization (hospitalization) from an initial rate several times that of the health plan average, to a level comparable to that of the general, adult, health plan population.

In a subsequent study, Cummings and Follette (1968) found that intensive efforts to increase the number of referrals to psychotherapy by computerizing psychological screening with early detection and alerting the attending physicians did not significantly increase the number of patients seeking psychotherapy. The authors concluded that in a prepaid health plan setting that already maximally employs educative techniques to both patients and physicians, and provides a range of psychological services, the number of subscribers seeking psychotherapy at any given time reaches an optimal level and remains constant thereafter.

In another study, Cummings and Follette (1976) sought to answer in an 8th-year telephone follow-up whether the results described previously were a therapeutic effect, were the consequences of extraneous factors, or were a deleterious effect. It was hypothesized that if better understanding of the problem had occurred in the psychotherapeutic sessions, the patient would recall the actual problem rather than the presenting symptom and would have lost the presenting symptom and coped more effectively with the real problem. The results suggest that the reduction in medical utilization was the consequence of resolving the emotional distress that was being reflected in the symptoms and in the doctor's visits. The modal patient in this 8th-year follow up may be described as follows: She or he denies ever having consulted a physician for the symptoms for which the referral was originally made. Rather, the actual problem discussed with the psychotherapist is recalled as the reason for the psychotherapy visit, and although the problem is resolved, this resolution is attributed to the patient's own efforts and no credit is given the psychotherapist. This affirms the contention that the reduction in medical utilization reflected the diminution in emotional distress that had been expressed in symptoms presented to the physician.

Although they demonstrated in this study, as they did in their earlier work, that savings in medical services does offset the cost of providing psychotherapy, Cummings and Follette insisted that services provided must also be therapeutic in that they reduce the patient's emotional distress. That both cost savings *and* therapeutic effectiveness were demonstrated in the Kaiser Permanente studies was attributed by the authors to the therapists' expectations that emotional distress could be alleviated by brief, active psychotherapy that, as Malan (1976) pointed out, involves the analysis of transference and resistance and the uncovering of unconscious conflicts, and that has all the characteristics of long-term therapy except length. Given this orientation, it was found over a 5-year period that 84.6% of the patients seen in psychotherapy chose to come for 15 sessions or less (with a mean of 8.6). Rather than regarding these patients as "dropouts" from treatment, it was found on follow-up that they achieved a satisfactory state of emotional well-being that continued into the 8th year after termination of therapy. Another 10.1% of the patients were in moderate term therapy with a mean of 19.2 sessions, a figure that would probably be regarded as short-term in many traditional clinics. Finally, 5.3% of the patients

were found to be "interminable," in that once they began psychotherapy they seemingly continued with no indication of termination.

In the most recently reported study, Cummings (1977) addressed the problem of the "interminable" patient for whom treatment was neither cost-effective nor therapeutically effective. The concept that some persons may be so emotionally crippled that they may have to be maintained for many years or for life was not satisfactory, for if 5% of all patients entering psychotherapy are "interminable," within a few years a program will be hampered by a monolithic case load, a possibility which has become a fact in many public clinics where psychotherapy is offered at nominal or no cost. It was originally hypothesized that these patients required more intensive intervention, and the frequency of psychotherapy visits was doubled for one experimental group, tripled for another experimental group, and held constant for the control group. Surprisingly, the cost-therapeutic effectiveness ratios deteriorated in direct proportion to the increased intensity; that is, medical utilization increased and the patients manifested greater emotional distress. It was only by reversing the process and seeing these patients at spaced intervals of once every 2 or 3 months that the desired cost-therapeutic effect was obtained. These results are surprising in that they are contrary to traditionally held notions about psychotherapy, but they demonstrate the need for ongoing research, program evaluation, and innovation if psychotherapy is going to be made available to everyone as needed.

The Kaiser Permanente findings regarding the offsetting medical cost-savings of providing psychological services have been replicated by others (Goldberg, Krantz, & Locke, 1970; Rosen & Wiens, 1979). In fact, such findings have been replicated in over 20 widely varied health-care delivery systems (Jones & Vischi, 1978). Even in the most methodologically rigorous review of the literature on the relationship between the provision of psychotherapy and medical utilization (Mumford, Schlesinger, & Glass, 1978) the "best estimate" of cost savings is seen to range between 0% (but more appropriate treatment) and 24%.

IMPLICATIONS FOR NATIONAL HEALTH POLICY

The 20-year clinical and research experience at Kaiser Permanente of providing mental health coverage as part of a comprehensive health maintainence program has a range of implications for national health policy. These implications include cost, utilization, scope of coverage, range of services, access to care, types of providers, and the role of program evaluation/research.

In debates about the inclusion of a mental health component in national health insurance the foremost concern is cost. Fear and apprehension abound regarding the possibility of over-utilization, inappropriate utilization, and runaway costs. However, the experience at Kaiser Permanente clearly demonstrates that the inclusion of mental health benefits within a comprehensive healthcare plan will *not* bankrupt the "healthcare financing system." It has been incorrectly argued that mental health services are overly costly and cannot be controlled. Yet, the cost of providing mental health coverage at Kaiser Permanente only increased 3.5% per year between 1959 and 1979, while nationwide general medical costs have increased between 12% and 20% per year (Kiesler, Cummings, & VandenBos, 1979). It has been erroneously argued that utilization rates cannot be predicted, and, hence, that mental health is "uninsurable." However, it has been shown at Kaiser Permanente that utilization rates will rise to a predictable level and remain stable thereafter, despite intense efforts to increase it.

All of the false speculation about mental health coverage has gone on as if there were no data on and/or experience with the delivery of mental health care within large organized systems of care. Even beyond the Kaiser Permanente system, there are considerable data that address these concerns.

Dörken (1977) found that, within the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), mental health utilization rates overall were less than 2%, ranging from 0.7% to 3.9% for various states. The rates were stable over three separate years. The average length of mental health treatment per actual user in that program was 13.9 visits, and 83.7% of all mental health treatment was completed in 24 or fewer sessions.

It is also important to note an incidental finding by Dörken. Data on "mental health care" which are tabulated by primary diagnostic code can be grossly inaccurate. He found a 50% exaggeration in mental health utilization rates when such tabulation was done, tabulation by service code showed 644,650 mental health visits as compared with 941,755 visits when diagnosis codes were used. This results from routine physical health visits being classified as "mental health care" just because the patient is also receiving mental health care. Tabulation by actual treatment procedure eliminates this error.

Within the Federal Employees Health Benefits Plan it has been found that the utilization of intensive psychotherapy is miniscule, even when such treatment is available through the joint decision of the patient and the therapist (NIMH, 1976). In this particular analysis, 80% of all mental health patients were seen for 20 or fewer sessions.

The utilization of mental health services was studied by Blue Cross of Western Pennsylvania as the benefit was introduced in a particular health care plan (Jameson, Shuman, & Young, 1976). They found a progressive increase in the use of such health services over the first several years, but the utilization rate stabilized at about 1.5% for that particular population.

It has been a recurring finding in the psychotherapy research literature of the past twenty-five years that the average length of outpatient psychotherapy is between 6 and 12 sessions, and that 80% of all mental health treatment is completed in fewer than 20 sessions. Experience in the delivery of mental health services within organized systems of care has repeatedly found that mental health utilization rates and the length of mental health treatment are predictable and stable. Mental health benefits are obviously "insurable."

The experience at Kaiser Permanente suggests that the *failure* to provide mental health services is the factor that actually has the potential to bankrupt the healthcare financing system. When all barriers to access to medical care are removed, the health care system becomes overloaded because 60% or more of all physician visits are being made by patients manifesting somatized emotional distress. The exclusion of psychological services from national health insurance would encourage somatization and expensive over-utilization of general medical services.

Patients with concerns and symptoms related to social, interpersonal, and work difficulties do not tend to receive appropriate and responsive care within general health care systems. A perfunctory and unsympathetic response is most typical. As previously discussed, if the patient, however unconsciously translates this distress into a low back pain, the patient is immediately "rewarded" by the physician in the form of x-rays, laboratory tests, medications, and return visits. Even worse, temporary disability may be offered—which removes the patient from the presence of the stressor and renders unconsciously mandatory the continuation of the chronic pain as the only possible solution to what originally was an interpersonal problem. This is both costly and low-quality care.

Once studies at Kaiser Permanente showed that it was critical to provide mental health coverage, it had to be determined what type of mental health coverage to provide. The Kaiser Permanente experience has shown that when active, dynamic, brief psychotherapy is readily available and provided early in the individual's contact with the health care system by psychotherapists who are enthusiastic and proactive regarding such intervention, it is the treatment of choice for about 85% of the patients seeking mental health care. Such intervention yields a high cost-therapeutic effectiveness ratio, and is satisfactory to both patient and therapist. It dramatically reduces somatization and over-utilization of medical facilities. In the vast majority of cases, the provision of such brief therapy as the initial treatment intervention makes it economically feasible to provide long-term psychotherapy to the approximately 10% of patients who require it for therapeutically effective treatment.

The twenty year Kaiser Permanente experience indicates that mental health benefits should be included in national health insurance, and that the mental health system should emphasize readily available, brief, outpatient psychotherapy. This would make it possible to provide additional, second-level, mental health benefits to patients with certain emotional/behavioral problems, such as substance abuse, which require more extensive measures for treatment to be effective. We believe it is obvious that mere across-the-board inclusion in national health insurance of all traditional mental health service delivery modes (and the routine ways of determining which mode to pay) would be costly and inefficient. Clinical trials and systematic comparison of alternative methods of treatment for particular difficulties would determine what specifiable emotional/behavioral difficulties require more extensive treatment and would be eligible for reimbursement. This is how mental health coverage developed at Kaiser Permanente and continues to evolve.

National health insurance should avoid artificial limitations, upfront deductibles, and constant co-insurance. They are only partial solutions. Moreover, such mechanisms can block appropriate utilization of mental health services and appropriate use can prevent unnecessary medical costs as well as unnecessary human suffering. Rather, NHI should have no separate deductibles and co-payment should gradually increase the longer the patient receives service. The points at which co-payment percentages increase would occur should vary from specific problem to specific problem.

The organization of mental health service delivery at Kaiser Permanente is central to its effectiveness and cost efficiency. Mental health care is readily and directly available. This insures that the most clinically effective service is provided at the lowest possible cost. In order to accomplish this, multiple entry points exist. Early in our experience with mental health care it became clear that if there was only one entry point for gaining access to care, and this point was controlled by one profession with one orientation, mental health care, as well as the entire health care system, would be costly, biased, and nonresponsive. It is inefficient to require that the patient must first secure the "permission" of a primary care provider before seeking mental health services. Such a requirement wastes a medical visit, and primary care providers are not the most knowledgeable professionals to determine whether or not psychological care is indicated. The experience at Kaiser Permanente has shown that there are serious limits to the effectiveness of in-service education of primary care providers concerning the utilization of mental health services. Despite objective evidence that their patients need mental health services and specific recommendations to the physician that a referral should be made, a large percentage of primary care providers do not make needed referrals because of what appear to be professional biases.

The patient at Kaiser Permanente plays a major role in determining what services to seek and when to seek them. Our experience has shown that when the patient believes they should seek psychological treatment it is most cost efficient to allow them to seek such services, knowing that there are checks on the mental health provider. Referral to appropriate services, mental health or otherwise, is, of course, provided when the patient is unaware of the service or its potential value to them. Kaiser Permanente is an efficient health care system because it encourages educated consumers to utilize their knowledge to obtain the most appropriate service to meet their needs. National health insurance should include such cost-efficient mechanisms through freedom-of-choice in the selection of provider provisions.

It should be noted that the American public is far more knowledgeable about mental health problems and mental health resources than often realized. For example, the Survey Research Center at the University of Michigan recently conducted a large-scale nationwide study (Kulka, Veroff, & Douvan, 1979) replicating a 1957 study done for the Joint Commission on Mental Illness and Health. The samples for the two national surveys were independently selected using area-sampling

probability methods to constitute representative cross-sections of individuals 21 years of age or older living in private households. It was found that 60% of the respondents had utilized or felt they would utilize mental health services for particular problems. There was a substantial increase in the proportion of the general population who had actually utilized mental health services—from 15% in 1957 to 26% in 1976. Further, there has been a change over the past two decades as to where help for mental health problems is sought. In 1957, 30% of those who had utilized mental health services sought help from their family doctor (or primary care provider); this dropped to 21% in 1976. Concurrently, there has been a dramatic increase in those seeking help from mental health providers, from 28% in 1957 to 47% in 1976. These data suggest two things. First, the stigma attached to having mental health problems and seeking mental health treatment has decreased over the last 20 years. Second, there has been a concommitant increase in the use of providers who are appropriately and specifically trained in the delivery of mental health care. Our 30-year effort to increase the number and quality of mental health services has had a positive effect. These data suggest that a strategy geared toward increasing the amount of advice given by family physicians about emotional and behavioral problems is regressive. Such a policy would tend to push mental health service delivery backward toward an inadequate and inappropriate system of health and mental health care such as that which existed twenty years ago. The public has been educated about mental health care. National health insurance, in order to be cost efficient, should utilize this public knowledge by incorporating multiple entry points into mental health care, just as Kaiser Permanente has been doing for the last twenty years.

Kaiser Permanente learned long ago that in order to provide mental health care in an effective and efficient manner, mental health care must be provided by professionals who are specifically trained to provide such care. While primary care providers are given in-service training to help them identify patients with mental health problems and make needed referrals, mental health care should be provided by fully-trained mental health professionals from the four core mental health professions. National health insurance should take the same course of action. Only those providers who are well-trained specifically in the delivery of mental health care should be allowed to provide and be reimbursed for such services. Standards for reimbursement of mental health services must be dependent on relevant mental health training,

not professional degree independent of specialized training and supervised experience. Individuals without adequate professional training, such as general care physicians with a three-day introductory seminar on mental health issues, should not be eligible for reimbursement for the provision of mental health services. In addition, national health insurance should utilize the full range of fully trained mental health professionals to adequately meet the mental health needs of the nation at the lowest possible cost. No one profession, treatment approach, type of service, or system of service delivery is the most appropriate for all patients and all problems. If national health insurance should rely on only one profession or one treatment approach, it would be ineffective, costly, and nonresponsive. We learned this lesson long ago at Kaiser Permanente.

Inappropriate over-utilization of any health service will introduce unnecessary cost to a comprehensive health care system. At Kaiser Permanente a variety of reviews are utilized to monitor health care utilization and eliminate inappropriate over-utilization. This requires that patients who are over-utilizing medical services be identified and targeted for special alternative services which will eliminate their inappropriate over-utilization. Providers who inappropriately prescribe various laboratory testings and other services also need to be identified and provided with appropriate in-service training. Much of this can be done through appropriate management information systems, but multidisciplinary review of the appropriateness of care, both physical health care and mental health care, is also necessary. This serves as a check against inappropriate treatment and runaway costs, as well as serving to educate health and mental health care providers about the appropriateness and effectiveness of alternative health care services. Review of all types of health care delivery should occur under national health insurance after a certain number of visits or a certain dollar amount has been reached. Such reviews should be outcome oriented, consider unintended as well as intended outcomes, and utilize comprehensive objective data when subjective data within the group differ. Multidisciplinary review can be an accountability process, a continuing education process, and a clinical research process. National health insurance should utilize this opportunity.

The effectiveness and efficiency of the Kaiser Permanente health care system is related to the emphasis that is placed on meaningful program evaluation and health system research. National health insurance should incorporate an appropriately designed and utilized system of

evaluation and monitoring. Without a meaningful program of research the role and value of psychological services within the Kaiser Permanente system would never have been discovered and refined. The interest of Congress, the executive branch, consumers, and taxpayers coincide in the need for a mechanism to assure appropriate high-quality service for the lowest reasonable price. Well-designed and appropriately utilized evaluation programs should be the core of vital cost-contained and quality assurance measures in national health insurance. NHI must provide for the best currently available treatment, yet it must be designed to facilitate innovation and incorporate change. This can best be accomplished by a system that emphasizes a range of alternative services, providers, and modes of delivery, assesses their intended and unintended outcomes in a comparative manner, and uses the feedback to produce appropriate change in the system itself. It is rare that a federal program is initiated with appropriate and comprehensive evaluation components designed as an integral aspect of the program, but national health insurance will be costly and ineffective if it does not include such a mechanism.

An evaluation/accountability/research component must be an integral part of any national health insurance structure. First, such an evaluation unit must be relatively autonomous. Second, the director of the evaluation unit must have an influential position within the health system and the ability to help modify the system. Third, the major directors of the evaluation unit must be broadly representative—no one profession, intervention strategy, or priority should dominate it. Fourth, the priorities and goals of the national health insurance system must be prospectively articulated. Fifth, the goals of the system must be stated in measurable clinical and behavioral outcome terms. Sixth, such program evaluation, health services research, and clinical research must be a continuous process. Seventh, the results must be publicly discussed and, when appropriate, the health system must be changed. A properly designed and funded evaluation component would pay off in dollars and cents by only continuing the funding of those services that are demonstrably effective and are provided in a cost-efficient manner.

SUMMARY

The experiences of Kaiser Permanente demonstrate that, when all barriers to physical health care are removed, the system becomes overloaded with 60% or more of physician visits by patients manifesting somatized emotional distress. When psychotherapy is properly provided within a comprehensive health system, the costs of providing the benefit are more than offset by the savings in medical utilization. The experience of over two decades at Kaiser Permanente indicates that it is not the provision of a psychotherapy benefit that can bankrupt a national health system. Rather, the failure to provide psychological care and/or the failure to appropriately provide it would bankrupt the system. National health insurance must include mental health benefits if the system is to operate on an efficient and effective basis. A system of constant research, innovation, and program evaluation is critical to meeting the health and mental health needs of all Americans.

Paratrooper Psychotherapy

I was a paratrooper in the 82nd Airborne in World War II, and I had made about 13 or 14 jumps behind enemy lines by the time the war was over. One interesting thing about paratroopers was that after about the third or fourth jump, they would get skittish, and when they landed, they would forget all they knew, and get themselves killed or wounded. I was one of several people sent back to the United States to work with the best psychologists and psychiatrists in the country to try to figure out what we could do to help these young men survive.

A training program was established on Long Island, and the best professionals in the country came to work with us—William Menninger, Frieda Fromm-Reichman, Karen Horney, and Patrick Mullahy. I remember Dr. Fromm-Reichman's saying, "It is not the length of the therapy which makes for change. It is the depth." This stuck with me, and I confronted this issue again at Kaiser Permanente. As a result of this training, my job during the war was to help the paratroopers keep their cool when they jumped into enemy territory. This "coaching" seemed to help these young men survive. So this might be called Paratrooper Psychotherapy, just in case someone wants to note yet another psychotherapy method.

I learned that some people could get better very quickly, or at least improve their behavior and functioning to a significant degree, with even a very brief intervention. I accepted this as legitimate, because I had seen it work effectively in helping paratroopers make their jumps.

On one of my last jumps, I was shot, and I lay bleeding in the snow for three days. Someone came by and said of my seemingly lifeless body, "Hey, I think this guy is alive!" I yelled out, "You're damn right I'm alive!" I was shipped back to get medical care and was in the hospital recuperating from my shattered knee and abdominal wounds, when I heard that the 82nd Airborne was going for another jump, and that the plan was to free Buchenwald con-

centration camp. No way was I going to miss this! I used my officer's rank to leave the hospital, and became one of the American liberators of Buchenwald. I was probably the only paratrooper to make a jump with a cane during World War II. I wouldn't have missed that for the world.