An open letter from Helmut Thomä, M.D., in response to Pyles' article in the last TAP (Vol. 40, No. 4), "Lessons from Germany: Single Payer No Panacea."

More about "Lessons from Germany: Single Payer No Panacea" by Bob Pyles

Helmut Thomä

Pyles' title surprised me. For decades, German psychoanalysts learned from IPA-colleagues. As a member of the first post-war generation of German analysts it took me some time to consider the possibility that something can be learned from us. His article is based on information from Ekkehard Gattig. My perspective is somewhat different. In the "The Macmillian Book of Proverbs, Maxims, & Famous Phrases" I found in the chapter "Judgment: Hear both sides" one of the oldest proverbs going back to Aeschylus (458 B.C.): "Two parties are here present, he hears but half who hears one party only".

The following points might lead to a different evaluation.

1. The German Insurance System is state-controlled, but it is not a National Health Service system (Kächele et al. 1990). About 90% of the population are in various kinds of mandatory insurances. Every employed German, who earns up to 3562,50 Euro monthly, is automatically in a mandatory insurance. If the income is higher than that amount, he is free to chose a private insurance. In mandatory insurances, the employer and the employee each pay half of the monthly rate. All mandatory insurances recompense for analytic psychotherapy under similar regulations. About 8 Million are privately insured. Of those, 2 Million are federal employees or employees of the 16 German states. All of them and their families get additional governmental support in case of illness. To give one example: in all 11 states of the Federal Republic of Germany (FRG) before the

reunion all teachers – from grammar school to university – were and still are governmental employees. In psychoanalytic clinics and in private practice[1] teachers are regularly regarded as well suited for the classical setting (before qualification, candidates are not entitled to treat privately ensured patients). For a 50-minute psychoanalytic session, the fee up to 92,50 Euro is fully reimbursed by a private insurance plus the governmental support. To compare: the fee paid by mandatory insurances varies between 60 and 75 Euro per session.

2. Pyles does not mention the very important peer-review system. Peer reviewers have a mediating function between the application of the treating analyst and the insurances, be they mandatory or private. When I was one of them, about 50 medically trained analysts were reviewers who had to confirm that the applied treatment was "necessary, appropriate, and sufficiently promising as to outcome" (Pyles, p. 30) Only if a report is very insufficient, a reviewer can refuse his consent. Either by correspondence with the reviewer or by appeal to a superior peer reviewer usually an improved version is written and passes the review. The contingents approved by the peer reviewer up to the flexible limit of 300 sessions vary between 160, 80 and 60 sessions.
3. Candidates of all German psychoanalytic training institutes were fully integrated into the system provided by the mandatory insurances only. Thus, for many years, candidates of all 53 German psychoanalytic institutes were paid by the mandatory insurances. 17 of those institutes are so-called "free institutes" of the "Deutsche Gesellschaft für Psychoanalyse, Psychotherapie Psychosomatik und Tiefenpsychologie" (DGPT, German Association for Psychoanalysis, Psychotherapy, Psychosomatics and Depthpsychology). Presently, about 1850 candidates are in training. The majority of those, namely 950, are trained under the

[1] Please notice that psychoanalysts in private practice mostly treat patients who are members of mandatory insurances.

premises of the DGPT. 450 candidates are trained in the 13 institutes of the DPV ("Deutsche Psychoanalytische Vereinigung" – "German Psychoanalytical Association") and another 450 in the 17 institutes DPG ("Deutsche Psychoanalytische Gesellschaft" – "German Psychoanalytical Society"). Only the DPV-training regulations request four sessions a week for training analysis and for the treatment of two control-cases.

4. The conflict between the DPV and the insurances, with the peer-reviewers in between, had its basis in the obligatory application of DPV-candidates. According to the training regulations they regularly applied for a four-times-a-week, open-ended analysis. In a lengthy German paper (Thomä 1994) I described the details and the background of this controversy. Gattig (1996) did not even mention this paper in his publication, which was the main source of information for Pyles.

   By the application of candidates for a high frequency, open-ended analysis, the peer-reviewers were exposed to a fundamental problem, which they tolerated for many years. All people involved knew, of course, that the candidates had to apply for a high-frequency analytic therapy due to the training regulations of the DPV. Reports had to be made up to fit into a system, which set a limit at 300 sessions. This limit is flexible. To continue analytic treatment beyond this limit was and is possible, if the applicant, be he a candidate or a qualified analyst, submits a convincing report to the peer-reviewer with regard to the criteria summarized under point two. There are many seriously ill patients needing more than 300 sessions to improve reliably. An unknown number of analytic therapies of candidates were paid beyond the regular limit. Still, Gattig's statement (1996) is correct: there are financial considerations involved. At the same time the peer reviewer had to face the problem of the dose-effect-ratio in relation to the time needed for structural changes. Experts in the group of peer-reviewers argued for instance: If the contingent of financed sessions

is limited, what is more effective: to have a very high dose, e.g. five times a week, or a lower dose, allowing a longer period of time. A more fundamental question refers to the meaning of a rigid setting. Candidates are obliged to follow training regulations and have to convince their patients, that a four-times-per-week analysis is absolutely necessary to optimize process and outcome. If a patient reduces the number of sessions from four to three before or after the 300-sesion-border, candidates lose this case as a recognized training case. For example: If a candidate wrote a qualifying paper for associate membership by presenting a qualitatively sufficient case report about a patient, who had reduced the numbers of sessions from four to three per week, it was rejected purely on quantitative grounds. It seems to me that this training regulation is incompatible with the psychoanalytic spirit.

5. Pyles mentions the manual "The Indication for High-frequency Analytic Psychotherapy within the Public Health Insurance System" (Danckwardt and Gattig 1996). That manual does not contain convincing data to arrive at a valid indication at the beginning of an analysis. The impressive follow-up study of the DPV by Leuzinger-Bohleber et al. (2002) chose not to investigate possible differences between three and four times a week analytic therapies. Similarly, Döll-Hentschker et al. (2006) investigated the selection of the setting of 150 patients. 29 patients received a high frequent treatment (four times a week), 20 patients three times weekly, 40 two times weekly, 48 one treatment a week. The authors, to their disappointment, could not find consistent diagnostic differences in association with the frequency of sessions. They describe five models, which seem to regulate the choice of frequency in psychoanalytic practice.
6. Now to the contest between DPV and the mandatory insurances. By the end of 1990 and after many years, the tolerance-threshold of the peer-

reviewers was surpassed and as mediators they tried to find a solution. In January 1991, the peer-reviewers suggested a reasonable compromise based on clinical and research evaluation suggesting that the guidelines should secure a higher frequency than three sessions at least in certain phases of an analytic psychotherapy. The membership of the DPV unanimously rejected any variation of the high-frequent technique at a business meeting in May 1991. Lore Schacht (1991), as president of the DPV, summarized this decision: without a stable frame from the beginning to the end of an analysis a successful therapy of seriously ill patients would be at stake. Without calling peer-reviewers by name, diverting opinions were declared as subjective. Indeed, there is a deep-seated controversy expressed in the terminology. Readers might wonder, why the term analytic psychotherapy is used and not just the word psychoanalysis. The deeper reason for this is the idea, shared by many IPA psychoanalysts, to keep true and strict psychoanalysis outside of any connection with insurances. They have the illusion, that by avoiding the word psychoanalysis in connection with third party payment or any external reality they remain the only owners of Freud's legacy. However, the idea of just analyzing without defining any goal is a widespread self-deception, as Sandler and Dreher (1996) pointed out. It seems to me that its most extreme form is the Neo-Kleinianism as expressed in a paper by Bott Spillius (1996). In my critical paper on this controversy (Thomä 1994) I spoke about the "Kleinianische Wende". Without mentioning the source of this quotation, Gattig mentions the words which are now showing up in Pyles' paper as "Kleinian turning point" (p. 30). The context is remarkable as well as the transformation process from Thomä's to Gattig's and to Pyles' papers. Already Gattig mentioned "psychoanalytic experts", who belonged to various psychoanalytic psychotherapeutic societies and their different theoretical positions. He

especially referred to "some influential peer-reviewers" who are members of the IPA. Pyles' language is less diplomatic and expresses Gattig's opinion undisguised: "The problem became even more serious when so-called analysts of other groups, and even some traditionally trained IPA analysts, joined in the government's argument" (Pyles p. 30). These statements are embarrassing for peer-reviewers, I among them. They are regarded either as incompetent "so-called analysts" (Pyles p. 30) or traitors. In my experience, not one peer-reviewer succumbed to governmental arguments, although money and politics are involved. Nor is it justified to regard the compromise of the peer-reviewers as discrediting or even slandering of psychoanalysis as Gattig is putting it (Gattig 1996 p. 10). Pyles quotes a statement by the Federal Committee of Medical Doctors and Health Insurances: "Analytic psychotherapy as a long term therapy with a frequency of four or more hours per week cannot be applied in accordance with psychotherapy guidelines, because no scientific proofs exist of any specific indication for it or of its greater therapeutic efficacy. (Pyles 2006, p. 30). This statement has to be read in the context of a permanent higher frequency than three times a week without taking into account the relation between therapeutic process and outcome in a given time-span under financial considerations.

7. What about the vicissitudes of that contest? The compromise offered by the peer-reviewers was later officially recognized by the insurances but again sharply rebuffed by the DPV. Now a lawsuit was pending. The legal advisor of the DPV, Holger Schildt, warned the membership and refused to act as lawyer, if the DPV would bring the case to the judge. On the basis of research findings, I was pretty sure that we would lose the case and the damage would be devastating for psychoanalysis in Germany.
8. Some colleagues, I among them, became diplomatically active. Board-members of the DGPT mediated meetings of analysts of the DPV, the

DPG and representatives of medical corporations. After some meetings, we arrived at a settlement quite similar to the compromise offered by the peer-reviewer before the contest started years ago. It is somehow ironic to call this compromise, first proposed by the peer-reviewer, sharply dismissed by the DPV, a kind of a victory. Obviously, psychoanalytic organizations have to learn to find compromises. The American Psychoanalytic Association had found a conflict-solution known as the lawsuit (Wallerstein 2002, Welch and Stockhamer 2003, Simons 2003). Contemporary psychoanalysis is worldwide confronted with third party payment. The experiences in Germany demonstrate that true analysis is possible, if treating analysts and peer-reviewers collaborate. Thomä and Kächele (2006) have discussed the problems very thoroughly. We refer to the propositions of Marill (1993) in the paper "The advent of the third-party payer". It is a pity that Pyles does not emphasize the historically essential aspect of the "Lessons From Germany": it is the fulfillment of Freud's prediction that one day psychoanalytic therapy will be available for everybody independent of the patient's financial means. In the English Version of the Ulm Textbook Thomä and Kächele stated: "Patients from all strata of society, rich or poor, can now have psychoanalytic treatment at the expense of the insurance system, which in turn is funded by the regular contributions of the insured population. Freud's prediction (1919 a) has thus been fulfilled." (1987 p. 43).

9. Now, 15 years later, the psychotherapeutic scene has changed. In Germany, there is now a law, which created a third health profession: the psychological psychotherapists (besides physicians and nonmedical practitioners colloquially called quacks). The far-reaching consequences of that law go beyond this paper. Psychoanalysis has now to win even more important contests.

Unfortunately, the problem of the relation of DPV-training regulations and the situation of candidates in the insurance system is pretty much the same. Candidates give the requested fourth session of the Eitingon-Model in most of the training institutes usually free of charge. There seems to be a kind of a grey area. Pyles' statement that patients nowadays and under the new law "retain the right to pay privately for additional weekly sessions" (Pyles 2006, p. 34) is contradictory to what I observe. Instead of putting the question of the learning and teaching of the best possible psychoanalytic competence at the center of the training, quantitative data are still overrated. I would like to share Erlich's hope that "the IPA will stop debating frequencies and concentrate on the pertinent models" (Erlich 2006 p. 11/12). In my judgment (Thomä 2006), the acceptance of three training models within the IPA – the Eitingon, the French, and the Uruguayan model – could lead to "The coming changes in psychoanalytic education" (Kernberg 2006) if the serious shortcomings of each model are overcome.

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Unter der Rubrik „Politics Public Policy" veröffentlichte Robert Pyles in The American Psychoanalyst (THE AMERICAN PSYCHOANALYST, Volume 40, No. 4, Fall/Winter 2006), dem vierteljährlich erscheinenden News Magazine der American Psychoanalytic Association, den folgenden Artikel. Da der American Psychoanalyst nur von wenigen deutschen Kollegen gelesen wird, habe ich den Artikel abgeschrieben, um meine Stellungnahme verständlich zu machen. Leider sah ich mich gezwungen, nochmals auf die unselige Frequenzdiskussion einzugehen. Die nunmehrige Annerkennung von drei Ausbildungsmodellen durch die IPA beendet die Probleme allerdings nur scheinbar.
Helmut Thomä.

(p. 30)

Lessons from Germany: Single Payer No Panacea

Bob Pyles

Sometimes, our country leads the world in ways that we wish it didn't. For some 20 years, health-care practitioners, particularly psychoanalysts and psychodynamic psychotherapists, here have been struggling with increasing threats to our patients and our profession in the form of intrusive third-party payers, increasing government regulation, and threats from lesser-trained therapists purporting to be psychoanalysts. Interestingly, Europe and Latin America have both begun to come under the same kind of pressure. Country after country is reporting increasing difficulties with these same challenges.

While we do not have a single-payer system in this country, many have argued that this would save our badly broken health-care system. Single-payer is the system of choice in a number of countries in Latin America and Europe. In this system, the government, rather than private companies, is the primary payer (as

with Medicare). Germany is one such country and we can learn a great deal from their experience. What has happened in Germany is an object lesson in both the benefits and hazards posed to psychoanalysis when the government is the main health-care supplier and payer.

I am greatly indebted to Ekkehard Gattig of the German Psychoanalytical Association for supplying much of the information that follows.

Bob Pyles, M.D., is chair of the Committee on Government Relations and Insurance and a past president of the ApsaA.

It is clear from his report that when the government controls the delivery of health care, the problem of corporate entities maximizing their profit margin by continually reducing the cost and amount of health care delivered is avoided. However, inevitably, the government begins to do the same thing, and begins to behave precisely like HMOs behave in this country. The government starts to cut costs by reducing the amount of health care that is delivered.

PSYCHOTHERAPY GUIDELINES

In Germany 90 percent of the citizens are insured under public health insurance schemes. Since 1967, Germany has had legislative guidelines for psychotherapy, which detail the kind and extent of psychotherapeutic services which may be offered. Psychoanalysis is included under the rubric of "psychotherapy" for purposes of management by the government. In order to embark upon treatment, a psychotherapist or psychoanalyst has to submit an application and an extensive report to prove that the proposed treatment is medically necessary (yes, they have that, too) and that the treatment is "necessary, appropriate, and sufficiently promising as to outcome."

Initially, the government insurance would only reimburse for symptom relief and not for a treatment aimed at relieving unconscious conflict or creating

structural character change. However, the German Psychoanalytical Society argued that structural change was indeed a legitimate goal, and from 1976 on this was included within the scope of treatment guidelines.

Treatment could only be done, however, by medical doctors and qualified psychologists. The total number of sessions was limited o 300 for analytic psychotherapy. The assumption was that a proper analytic therapy would be finished within that number, and the patient was assumed to be cured either before or when that number had been reached. Apparently, the German regulators operate in the same way as the U.S. Congress, i.e., "in a data-free environment."

In December of 1992,the board responsible for the regulation of psychotherapy guidelines, the Federal Committee of Medical Doctors and Health Insurances, decreed that psychoanalytic treatment of more than three sessions per week would not be covered by public health insurance. The following rationale was offered: "Analytic psychotherapy as a long-term therapy with a frequency of four or more hours per week cannot be applied in accordance with psychotherapy guidelines because no scientific proof exists of any specific indication for it or of its greater therapeutic efficacy."

While Gattig and his group suspected that this decision had been made for financial reasons, they were subjected to further arguments that high frequency psychoanalysis, and the so-called Kleinian turning-point, endangered the whole system of guideline psychotherapy by inducing a deeper regression, which caused it to systematically exceed the number of allowed sessions. The problem became even more serious when so-called analysts of other groups, and even some traditionally trained IPA analysts, joined in the government's argument. The German association was also concerned that private insurers might follow the lead of the Federal Committee.

LONELY BATTLE

The German Psychoanalytical Association found themselves, as we often have, fighting a lonely battle. They are the only group in Germany that feels strongly about "high-frequency treatment." Apparently, they are the only group that teaches or practices in this way. To further complicate this situation, the limitation on frequency was applied to the training of candidates as well, thus endangering the German association's educational system for candidates.

In their efforts to fight back, interestingly, the German association followed a similar path to that which our own Association has followed. When dealing with the regulating governmental agencies failed, they turned to a legal solution. The German association then

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focused on a two-pronged attack: (a) seeking legal clarification of the legality of exclusion of high-frequency treatment and (b) gathering scientific proof that this treatment is medically necessary, appropriate and economical.

The analysts felt strongly that the actions of the regulating committee constituted an unconscionable interference and that the "rights of a psychoanalyst could be violated" if forced to practice in accordance with the guidelines. Their opinion was confirmed by lawyers, who felt that this was a "clear violation of the basic right of every medical doctor to be free and to practice his profession."

They retained counsel and confronted the committee with their judgment that the rights of the therapists and the patients were being illegally interfered with. Faced with the possibility of a lawsuit that they might well lose, the Federal Committee backed down and re-opened talks.

In their effort to prove that the analytic method is not only necessary but

effective, and cheaper than other methods of psychotherapy, the German association prepared a manual describing the psychoanalytic method and its application to the insurance system. The manual, entitled *The Indication for High-frequency Analytic Psychotherapy within the Public Health Insurance System*, substantiates the need for high-frequency treatment by two lines of argument. The first describes the greater emotional intensity of the therapeutic relationship and the resultant handling of transference, countertransference, and resistance. The second deals with the reasons why high-frequency treatment should be included in the psychotherapy guidelines. The manual enabled the association for the first time to clearly demonstrate how psychoanalysts work. In addition, clinical data gathered from many individual papers were collated and put together in a single powerful argument.

The resultant negotiations with the public authorities have been concluded with something of a compromise but certainly a kind of victory. The assertion that psychoanalytic treatment involving four or more sessions per week is unscientific has been deleted. The new guidelines state that psychotherapy should be carried out within the frequency limits of two to three sessions a week. However, if the analyst deems it necessary, he may for a certain length of time analyze his patient for five sessions a week by filing an additional application. The public health reimbursement is capped at 300 sessions in total. The new guidelines also apply to candidates. Patients and candidates retain the right to pay privately for additional weekly sessions, and they can extend the analysis at their own expense once the 300 session cap is reached.

In summarizing their experience, Gattig ruefully notes that the term "psychoanalysis" cannot be protected and, therefore, it is inevitable that it will be misused. He underlines that the German experience illustrates the importance for analysts to present their case and exert an influence on the system to insure that psychoanalysis retains a respected place in society and a base from which we can describe our method and illustrate its advantages over other treatment

methods.