6.6 Third-Party Payment

6.6.1 Psychoanalysis and the German Health Insurance System

Nearly all patients consulting a psychoanalyst in the Federal Republic of Germany (FRG) have medical insurance. Over 90% of the population are members of compulsory insurance programs. Persons earning more than about DM 50 000 (ca. $20 000) annually are no longer compelled by law to insure themselves against illness, but are free to do so voluntarily. At the time of the initial interview, most patients have no clear idea of whether, or to what extent, their insurance company will agree to cover the costs. Only the cautious few who plan long-term and have been considering the possibility of a psychoanalysis for some time have inquired in advance and have a realistic payment plan. Those who are members of the various public health insurance organizations have mostly been officially referred by their family doctors and assume this means they will not have to pay. They know that they have the basic right to treatment free of charge by the doctor of their choice, but the majority have extremely vague conceptions of psychotherapy and psychoanalysis.

Many patients do not know that psychodynamically oriented and analytic psychotherapy are recognized by the insurance companies and that the analyst is thus remunerated for his services according to a fixed scale. Their insecurity is correspondingly great, with a very broad spectrum of attendant reactions. Depressives tend to assume that analytic psychotherapy is not covered by their insurance and that they will not be able to afford the fees themselves. Others take it for granted that they will receive free treatment for their marital and other problems, even if these cannot be construed as illnesses. Patients referred to a psychoanalytic outpatient clinic ask the receptionist about payment by the insurance company. As all people with public health insurance know from previous visits to the doctor, the official referral guarantees treatment free of charge. The doctor is not entitled to charge these patients any additional fee on top of his remuneration from the insurance company.

When agreeing on the therapy, if not before, the patient should be informed of the regulations covering psychoanalysis, including payment in the context of public or private health insurance. Because the subject matter is so complex and is immediately complicated further by the subjective and unconscious meanings which the patient attaches to it, the analyst should not confine himself to giving only limited information. Above all, he must himself be acquainted with the way in which psychotherapeutic care fits into the German health insurance system. We regard it as essential to inform the reader about the current regulations, although they form only the external framework of therapy. In cases of third-party payment, it is extremely important that analyst *and* patient be fully informed about the part played by the third parties, in order to be able to grasp both the unconscious meaning of this arrangement and the interaction between inside and outside. Neglecting to provide information *and* to supply continual

interpretations brings about confusion which endangers the analytic process.

We have to familiarize the reader with the banal facts of the mode of payment and with the regulations for the use of analytic psychotherapy within the German insurance system. The less patient and analyst know about the legal framework and its historical development, the more difficult it is to analyze the many and varied unconscious meanings attached to third-party payment.

Every third-party payment, whether by the health insurance company or by the patient's family, brings problems which have both external and internal — material and psychic — aspects. We are clearly talking primarily about the situation in West Germany, but we are not addressing ourselves exclusively to the German reader. The recognition of psychoanalysis as a valid form of treatment for mental illnesses has led in many countries to a situation in which health insurance companies cover the expenses. This is reflected in the international currency of English terms such as "third-party payment" and "peer report." The arrangements for payment via health insurance, involving an application by the treating analyst and peer review by a second analyst on behalf of the insurance company, vary greatly from country to country, but we believe that some typical problems are universal and thus that readers of all nationalities can pick up some ideas on treatment technique from this section. Our knowledge of the situation in many other countries has also convinced us that Germany — a country whose history has not often been characterized by successful compromises — has arrived at a system of third-party payment for analytic therapy through health insurance which is not only effective but leaves a great degree of flexibility for the individual case. Third-party payment and the peer report system, which have proved successful in West Germany over the past decade, are now attracting interest in many other countries, and for this reason our experience merits international attention.

Critics from other countries, such as Parin (1978), Parin and Parin-Matthey (1983b), and Mannoni (1979), have not taken the trouble to examine the West German system in detail before condemning it. Lohmann (1980) — by no means a lover of institutionalized psychoanalysis — repudiated the assertion made by Mannoni (of the Lacan school) that there is a connection between socialization and payment, and described many of Mannoni's invectives as ignorant and grotesque. Ironically, Lohmann's arguments also apply to Parin's (1978) ideological prejudice against psychoanalysis as conducted in the context of the West German health insurance system. De Boor and Moersch (1978) have also advanced pertinent arguments to counter Parin's view. The discussions between representatives of the various European associations of psychoanalysis in recent years show how difficult it is to absorb information and dismantle prejudices. Groen-Prakken (1984) has summarized the debate. She stresses the undeniable advantage of patients in some countries now being able to obtain psychoanalytic treatment independent of their means, but overall this is outweighed by the fear of interference on the part of those providing the financing. "Interference," not "assistance," is the word most frequently used in these discussions. Since third-

party payment can be provided by various agencies — insurance companies, the state, or a national health service — there are different contractual partners in different countries; in the western world, however, one can assume that democratic governments and insurance companies which exist to serve the common good, are not interested in invading the private sphere and will respect the statutory and professional ethical provisions on confidentiality. The important thing is thus to find solutions which on the one hand guarantee the rights of the individual, and on the other are compatible with the statutory responsibilities of the insurance companies. The current international debate on third-party payment reminds us vividly of the controversies preceding the introduction of the present system in West Germany. Thanks to the efforts of certain doctors, including some analysts, it was possible to establish a set of agreements between the *Kassenärztliche Bundesvereinigung* (KBV; the national corporate organization of physicians regulating matters of public health and the payment of medical care) and the health insurance companies. These contain lucid guidelines that exclude manipulative interference and make analytic psychotherapy available to the insured to an extent which was previously unthinkable. Up to the 1960s, following the example set at the Berlin Psychoanalytic Institute (1920-1933), psychoanalysts had treated quite a few of their patients on a low-fee basis out of a sense of social responsibility (de Boor and Künzler 1963).

We will first discuss the external framework of the system of third-party payment by the public health insurance companies. The insured patient makes no direct payment; the analyst receives his fee via his branch of the KBV. However, the patient does have a substantial monetary interest in this transaction, since he pays a fair proportion of his earnings to his health insurance company as cover for general health care, including the eventuality of an illness whose costs would be too great for the average individual to pay alone. A typical person insured with one of these public companies pays about DM 5000 (approximately $2000) annually. There are no further charges at time of use. It should be emphasized that the patient's right of legal redress is directed not at the state but at the health insurance company, an arrangement dating back to insurance regulations implemented by Bismarck. The West German social insurance system is supervised by the state, but it is not a national health service in the sense of, for example, the system in the United Kingdom.

The patient knows how much is deducted from his salary or wages as his health insurance contribution, and he can calculate how much he has paid in over the years and how often he has availed himself of services. He has a free choice of doctor. Just as the public health insurance companies together form a corporate entity, nearly all doctors are members of the KBV.

The fees for doctors' services are negotiated between these two corporate organizations. Expressed simply, this means the following: The insurance companies have a duty of payment toward the regional physicians' organizations, which together comprise the KBV. The physicians, in return,

have a duty to provide medical care for the members of the public insurance companies, i.e., for over 90% of the population. The regional sections of the KBV represent the interests of the doctors in the financial negotiations with the insurance companies. Obviously, the agreements on the fee rates for medical services involve compromises in which political factors play a part and the general economic situation must be considered. And indeed, in many respects, the specific regulations covering psychodynamically oriented and analytic psychotherapy, including the guidelines on payment, represent such a compromise.

Most analysts are reluctant to concern themselves with the topic of payment by insurance, and naturally, the less one goes into them the more complicated they seem. The latent presence of the third party financing the treatment is seen as a source of interference in the ideally purely dyadic psychoanalytic process. It is thus no wonder that nostalgia for the good old days, when settling the fees was a purely private matter, grows with third-party financing.

The advantages of the old system are, however, exaggerated. The true state of affairs can be seen by looking at the situation in countries where analytic psychotherapy is still not covered by health insurance. As far as psychoanalytic care is concerned, the good old days were only good for a very small proportion of the mentally ill. For the majority they were very bad old days. And in countries where the health insurance companies contribute nothing or not enough to the costs of psychoanalytic treatment, it is still true today that only the well-off can afford an analysis. The same conditions prevail which Freud bemoaned in his famous speech in Budapest at the end of the First World War: broad strata of the population suffer from severe neuroses without anything being done about it. At the same time, he predicted, "at some time or other the conscience of society will awake and remind it that the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery" (Freud 1919a, p. 167).

In some western countries Freud's prediction has been at least partially fulfilled, and third-party payment, as shown by the controversies of recent decades, has become a hotly debated aspect of treatment technique. Surprising, though, is that third-party payment has only now become a problem- the severely ill, married women, adolescents, and children without inherited wealth or a high income were always reliant on third parties. The biggest such group, and the most dependent on third parties for payment, are children and adolescents. In this section, as in this book in general, we restrict ourselves to the treatment of adults, but at this juncture we would like to stress the great importance of the fact that analytic psychotherapy of children and adolescents is included in the agreements between West German health insurance companies and doctors' organizations. Provision of the necessary funds ensures the treatment of financially dependent children. The early treatment of crises typical for particular phases of development and of neurotic manifestations was made possible by the inclusion of psychodynamically oriented and analytic

psychotherapy in the medical treatment covered by health insurance. It is plain that the treatment of infantile neuroses at the time they arise is of tremendous psychosocial significance.

The complications which can arise from dependence on a spouse, other relatives, or wealthy acquaintances, even if they are required by law to provide financial support, are discussed in Sect. 6.6.2. Other problems of treatment technique can arise when financially independent patients pay out of their own pockets with money they have not earned themselves. Freud's Wolf Man is a good example. Originally very rich, he was impoverished by the Russian Revolution; nevertheless, Freud continued his treatment free of charge and even indirectly supported him. It is our belief that most patients, and thus also their analysts, were always dependent on direct or indirect financing by third parties.

For obvious reasons the self-payment by the minority was idealized. Those who genuinely finance their own therapy avoid many complications that inevitably accompany financial dependence on a third party. Therefore the ideal (interminable) analytic process was conceived of as one with a patient whose success in professional life demonstrated good — though neurotically limited — ego functions and who was in a position to remunerate the analyst adequately from his own resources. Even the financially independent patient nowadays usually claims, as a matter of course, the (partial) third-party payment to which he is entitled. The problems which occur in the psychoanalytic treatment of the rich and powerful are, as is made plain by Cremerius et al. (1979), much greater than the idealization of the self-payer would indicate. Even the very wealthy almost always have private health insurance, and expect — realistically — that their application for at least partial payment of the costs, accompanied by a report from the analyst, will be successful. The medical treatment of civil servants is subsidized to the extent of approximately 60%.

About 50 years after Freud's Budapest address (1919a), neuroses were at last recognized as diseases by West German public insurance companies. Far too little attention has been paid to the fact that the road leading to broad application of psychoanalysis was paved by the work in the 1920s at the outpatient clinic of the Berlin Psychoanalytic Institute, where poor patients were treated for very low fees, which did not even cover costs and were paid to the clinic, not to the therapist. The Institute, the first of its kind in the world, was thus kept going not only by the generosity of its benefactor, Max Eitingon, but also by the idealism of its members and trainees, who gave much of their time free of charge. The clinic was not very large, but the treatment of a relatively small number of patients sufficed to allay one anxiety which Freud had expressed in the Budapest address. Although he believed that the most important and effective elements of strict, disinterested psychoanalysis would be adopted in psychotherapy for the masses, he feared that "the pure gold of analysis" would have to be freely alloyed with "the copper of direct suggestion" (1919a, p. 168). Hypnosis and even an integration of psychic and material support would have a place in this future broad-based psychotherapy.

Freud's clear distinction between strict, disinterested psychoanalysis and the mass application of the method, expressed in his metaphor by the stark contrast between the pure gold of analysis and the copper of suggestion, has made a lasting impression right down to the present day. This makes it all the more important to repeat the finding of the report on 10 years work at the Berlin Psychoanalytic Institute (Rado et al. 1930): that the broad — though by no means mass — application of psychoanalysis did not lead to a relapse into simple suggestion. Freud's foreword for this report (1930b) underlined the threefold importance of the Institute as a center for teaching, research, and treatment. Simmel (1930, p. 11) stressed that the *outpatient* treatment of working-class and insured patients differed in no way from that of well-off, selfpaying patients.

In 1946, amid the ruins of postwar Berlin, Kemper and Schultz-Hencke broke new ground by founding the Central Institute for Psychogenic Illnesses, which was financially sponsored by the local insurance society, the later General Communal Health Insurance *(Allgemeine Ortskrankenkasse).* Baumeyer (1971) and Dräger (1971) rightly emphasize the great social significance of this pioneering advance: "This was the first step in the recognition of neurosis as illness by a German public institution. For the first time one of the institutions in the social insurance system paid the costs of psychoanalysis and other psychotherapeutic treatment" (Dräger 1971, p.267). For the first time, insured patients were able to receive psychodynamically oriented therapy at no direct cost, and this on a far greater scale than in the outpatient clinic at the old Berlin Psychoanalytic Institute. Great credit is due to Dührssen (1962) for her pioneering analysis of the follow-up of 1004 patients who had received analytic psychotherapy at the Central Institute, in which she showed the effectiveness and efficiency of the treatment.

Baumeyer (1971) correctly stressed that the work of the Central Institute for Psychogenic Illnesses made a significant contribution to overcoming the resistance of the social insurance system to psychodynamic treatment: "The Central Institute for Psychogenic Illnesses provided the German Society for Psychotherapy and Depth Psychology with many of the arguments which after long and weary years of negotiations finally led to success" (i.e., to recognition of psychoanalysis by the health insurance companies) (p.231).

The recognition of neuroses as illnesses was a precondition for the inclusion of the so-called standard psychotherapy in the program of the major health insurance companies in 1967, followed by the other public organizations in 1971 (Haarstrick 1976; Faber 1981). Some limitations were imposed by the obligations of the public and private health companies. The health insurance system exists to enable the necessary outpatient or inpatient medical treatment at the time of need for people from all strata of society, regardless of their financial situation. Apart from a few special circumstances, the patient pays no more than his regular insurance premium (approximately 14% of his income). The legal constraints thus do not permit the health insurance companies to demand from

the patient any direct contribution toward the costs of analytic therapy. Whether this will change in view of the explosive growth in the cost of providing health care remains to be seen. In passing, we would like to state that a socially just regulation of the degree to which each patient should bear the costs directly would entail practical problems that could be exceedingly difficult to solve. For the time being, at least, the present legal framework will remain in force, and psychotherapy will continue to be available free of charge to members of public health insurance organizations whose illnesses fit the existing guidelines. It is to these guidelines that we now turn our attention.

In the latest version (March 1984) of the guidelines for the use of psychodynamically oriented and analytic psychotherapy, the methods of the two forms of therapy are defined and the indications for them laid down. The most important passages are as follows:

Psychodynamically oriented and analytic psychotherapy, as defined herein, are types of etiologically oriented psychotherapy in which the unconscious psychodynamics of neurotic disturbances with psychic and/or somatic manifestations is made the object of treatment. Techniques of psychotherapy which are not in accordance with the following descriptions of psychodynamically oriented and analytic psychotherapy will not be funded.
a) *Psychodynamically oriented psychotherapy* includes forms of therapy which treat currently active neurotic conflicts but strive for a concentration of the therapeutic process by means of restriction of the aims of treatment, use of a conflict-oriented procedure, and limitation of regressive tendencies.
b) *Analytic psychotherapy* includes the forms of therapy which treat not only the symptoms of the neurosis, but also the neurotic conflict material and the patient's underlying neurotic structure, in the course of which the therapeutic process is set in motion and continued with the help of the analysis of transference and resistance, involving the exploitation of regressive processes.

Psychodynamically oriented psychotherapy encompasses the short-term focal therapies and the dynamic psychotherapies which expose and work on conflicts. These short therapies, which originated from the psychodynamic derivatives from psychoanalysis, have proved their worth (Malan 1976; Luborsky 1984; Strupp and Binder 1984). Kernberg's (1984) expressive psychotherapy, based on the Menninger Foundation's follow-up study (Kernberg et al. 1972; Wallerstein 1986), is the equivalent of what is known in Germany as the psychodynamically oriented, conflict-revealing techniques of treatment.

The definition of the method of *analytic psychotherapy* fully incorporates the factors Freud regarded as the cornerstones of psychoanalysis, i.e., resistance, transference, and the therapeutic use of regression.

The application of the two forms of therapy in the framework of the health insurance system is restricted in principle to illnesses whose course can be influenced for the better. The therapist must satisfy the analyst acting as peer reviewer that the intended therapy has the potential to alleviate, improve, or cure the neurotic or psychosomatic disease in question. In the application form (from which we quote below), a conditional prognosis has to be stated and supported. The conditions which give the symptoms the status of an illness and the factors maintaining the symptoms must be set out. The decisive factor as regards prognosis is constituted by the *conditions for change* which the two parties, patient and analyst, must bring about. The analyst must in each individual case

assess what he and the patient can achieve after he has aroused the patient's hopes by accepting him for therapy and taking on the responsibilities involved. In the situation we are concerned with here he must explain the prognostic criteria to a fellow analyst acting as peer reviewer, i.e., specify why he expects an improvement to occur.
In the above-mentioned guidelines the indications for the two forms of therapy are laid down as follows:

1. Psychoreactive psychic disturbances (e.g., anxiety neuroses, phobias, neurotic depression)
2. Conversion neuroses, organ neuroses
3. Autonomic functional disturbances with established psychic etiology
4. Psychic disturbances consequent on emotional deficiencies in early childhood; exceptionally, psychic disturbances related to physical injuries in early childhood or to malformations
5. Psychic disturbances resulting from severe chronic illness, as long as they offer a basis for the application of psychodynamically oriented or analytic psychotherapy (e g., chronic rheumatic conditions, particular forms of psychosis)
6. Psychic disturbances due to extreme situations which evoke grave personality disturbances (e.g., a long prison sentence, severe psychic trauma)

The indications are further defined by a list of circumstances under which the health insurance organizations will *not* cover the costs of psychotherapy:

Psychodynamically oriented and analytic psychotherapy are not covered by public health insurance if they do not have the potential to bring about cure or amelioration of a disease or lead to medical rehabilitation. This applies especially to measures intended exclusively for professional or social adjustment, to child-rearing guidance, and other similar measures.

In the area of rehabilitation the following points have to be observed:

If indicated exclusively as a means to medical rehabilitation, psychodynamically oriented or analytic psychotherapy can only be applied under the condition that psychodynamic factors play an essential part in the psychic disturbance or in its effects and that with the help or psychodynamically oriented or analytic psychotherapy the patient can be integrated, if at all possible long term, into the working situation or into society.

The use of psychodynamically oriented and analytic psychotherapy is thus limited in a variety of ways. The range of application is defined in terms of method and nosologic orientation (indications), but at the same time is very adaptive. Each individual patient's motivation and adaptability must be assessed with regard to the possibility or probability of treatment being successful. Here we run up against the triad of necessity, effectiveness, and economy which governs a doctor's diagnostic and therapeutic action in Germany; he is obliged to review his chosen therapy and to justify it, in terms of the triad, to the insurance company.

The treating analyst argues the case for his therapy plan in an application in which the patient's personal data are encoded. This application is checked for form and content by an independent peer reviewer, also an analyst, who has to judge whether the above-mentioned preconditions (type of illness, indications) are fulfilled. The reviewer thus has no personal influence on the treatment

process or the way treatment is conducted, but his very function means that he may have a significant effect on the patient's transference, especially at the time of applications for extension of therapy. The fact can then no longer be overlooked that the analytic dyad is in this sense a triad including a latent third party.

Complications inevitably ensue if analyst and analysand forget that they are in many respects only two sides of a triangle. The less the role of the peer reviewer in the therapy is clarified and interpreted, the better he serves as a projection screen. One cannot behave as if the reviewer were not there; whether therapy is extended or not depends on his assessment. In making his decision, he has to heed what the guidelines have to say on the subject of treatment duration: "Analytic psychotherapy should as a rule achieve a satisfactory result in 160 sessions, in special cases up to 240 sessions." Extension to 300 sessions is possible in exceptional circumstances, but must be supported by detailed arguments. Even 300 sessions is no absolute limit, and in the discussion of applications for extension we will present the conditions which have to be met in order for treatment to be continued within the guidelines. The compromise in the guidelines on psychodynamically oriented and analytic psychotherapy obviously has many different aspects. Our positive evaluation of this compromise will become still clearer in Sect. 6.6.2, in which we examine the consequences of the contractual agreements on the psychoanalytic process.

At this point, however, we would like to draw attention to an aspect of professional politics. The introduction of analytic psychotherapy as a form of treatment covered by the public health insurance system means that appropriately qualified doctors can be authorized to provide the specific psychotherapeutic services set out in the guidelines. It is thus unusual for doctors who offer psychoanalysis to be fully active in other areas (general practice or specialities). Their contract with the KBV — their authorization — is limited to psychoanalysis and psychodynamically oriented psychotherapy. Also involved in providing psychoanalytic care to the members of the public health insurance organizations are nonmedical psychoanalysts, who, after completion of a course of academic study (nowadays a degree in psychology is a prerequisite), spend several years in psychoanalytic training at an accredited institution. It is misleading to describe these nonmedical analysts as lay analysts. Sixty years ago, the prosecution of Reik, himself a psychologist trained as a psychoanalyst, on a charge of quackery led Freud to publish *The Question of Lay Analysis* (1926 e). The charge against Reik was dropped, but nonmedical psychoanalysts were not licensed to practice within the Austrian health insurance system (Leupold-Löwenthal 1984). The incorporation of nonmedical analysts into the network of services covered by health insurance in West Germany is exemplary in the history of psychoanalysis.

A consequence of the recognition of neuroses as diseases was that the psychoanalytic treatment goal had to be guided by the medical concept of illness. The health insurance companies are obliged to take over the costs only

when the symptoms constitute an illness and the triad of necessity, effectiveness, and economy is also satisfied. Both in diagnosis and in treatment, the West German doctor must have these criteria in mind. He must also remember that neuroses are on a continuum with characterologically determined disturbances, which are not covered by health insurance, and that a smooth transition from one to other may occur.