Introduction

William M. Glazer, M.D., and Jerrold F. Rosenbaum, M.D.

Like many other areas of medicine, psychiatry currently faces the challenge of ensuring optimal care and enhancing quality of life for patients while working within the financial constraints introduced by trying to balance competing needs among different sectors of the population. This challenge is particularly salient in the treatment of depression in a managed care setting. As an issue that demands simultaneous consideration from clinical, economic, social, and ethical perspectives, this topic raises difficult questions with regard to deciding the psychiatrist's role as provider and allocator, determining who should assume the burden of risk, and balancing efficacy and effectiveness of different treatments, to name just a few. Admittedly, the topic is complex and often controversial, in terms of both the questions it generates and the answers posed in response. Nonetheless, it has been our intention to elucidate, in the form of a debate, some of the difficulties facing psychiatrists as we move into the challenging, yet inevitable, era of managed care. In an attempt to provide a heuristic framework, we have agreed to represent extreme positions, though the sides taken by each of us do not necessarily represent our individual opinions. It is our hope that the issues addressed by the participants of this symposium and contained in this supplement help to clarify some of the complexities facing psychiatrists treating depression and other forms of mental illness in a managed care environment, to provide substantive options for clinical practice and treatment, and to engender further discussions, which will contribute to making the best informed decisions regarding quality patient care.

Managed Care Versus Managed Money

William M. Glazer, M.D., and Jerrold F. Rosenbaum, M.D.

What are the Basic Arguments for and Against Managed Care?

Dr. Rosenbaum: The theory behind managed care sounds reasonable. Who can quibble with the proposal to ensure quality of care within the bounds of available resources? Unfortunately, the reality of the idea, the actual practice, is problematic. Under the practice of managed care, the reasons for rising costs of mental health care, as well as the need for and value of these services, are largely unexamined; instead, charges are merely denied or capped. Increased costs may reflect more accurate reporting, better diagnosis and detection, changing demographics, or increased prevalence of the disorder.

One of the most evident outcomes of managed care is the transfer of hundreds of millions of dollars from the health care system to for-profit organizations and to individual entrepreneurs. These organizations and entrepreneurs are not "managing care"—they are managing money to line their own pockets. In fact, in many cases, 11% to 18% of the mental health care premium gets diverted to mental health carve-out companies for their expenses, their stockholders, and their executives. Wall Street expects growth, which means increasing profits, but there are few options to grow profits in this business now other than to drain compensation from physicians. The expertise of many of these companies is not in improving the value of care delivered but rather in obstructing payments and shifting dollars from health care providers.

The success of most managed care operations is not reflected in documented improvement of direct mental health services. Instead, the innovation of the health care entrepreneurs has been the devising of a two-part tactic: (1) to create so many obstacles that patients have difficulty accessing their benefits, and (2) to make psychiatrists spend countless unpaid hours authorizing and obtaining reimbursement for services, usually from nonexpert "case managers." Thus, many patients never get services. In the event that patients do receive the care they need, clinicians frequently are unpaid for time and services delivered because the insurance companies disallow charges after the

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fact. Patients are then told by the insurance companies that they do not have to pay as a result of technicalities in credentialing and authorization, and doctors are forced into giving free care.

Dr. Glazer: Capitation, a solution to the problems of managed care, is a reimbursement methodology designed to attain a balance between cost and quality of care. A certain amount per member per month is paid for a specific set of preestablished services.[1] Consider this contract: A psychiatric group practice gets $10 million over the next year to take care of 10,000 people. The group can keep the surplus if the whole budget is not spent but loses the profit if treatment costs exceed that capitated amount. Practitioners in that group will think very differently about how they deliver services than will practitioners who receive a fee-for-service rate for their work.

There is good and bad managed care. No form of reimbursement works if the focus is only on costs. Managed care and capitation are growing rapidly. A number of states have implemented capitation-like reimbursement strategies. The Bazelon Center report (1996) indicates that 13 states have been approved to utilize a full-risk approach: Arizona, California, Colorado, Delaware, Hawaii (for adults only), Iowa, Kentucky, Nebraska, North Carolina, Oregon, Tennessee, Utah, and Vermont.[2]

Why Should Providers and Patients Participate in a System of Capitated Health Care?

Dr. Glazer: There are a number of potential advantages to capitation. First, the clinician's income is certain. Under capitation, the physician knows the amount of reimbursement he or she will receive over a specific time period; it may not be clear how hard they will have to work for it, but they can count on it. Second, capitation should bring an end to utilization reviewers as we have known them. Utilization review is a transitional process[3] that will evolve into self-contained health care systems in which physicians are empowered and given an incentive to deliver high quality care as efficiently as possible. Third, capitation will encourage health care providers to be creative in incorporating the principles of efficiency into their practice. For example, they will participate in integrated systems of care that provide comprehensive services to patients. Under the fee-for-service model, little incentive to organize services led everyone to operate independently, and the result was a fragmented nonsystem. Such an approach may have been adequate for patients with limited illnesses but was inadequate for those with chronic conditions, who were in need of different levels of service at different times of their life.

Psychiatric services should be capitated because of rising costs, particularly in seriously mentally ill populations. Services for seriously mentally ill populations have been fragmented; mental health services are separate from general health services, social services, housing, and rehabilitation, and the coordination between the hospital and the community is poor. As a consequence of this fragmentation, services are not easily accessible and care lacks continuity. Capitation promotes coordination of these services because such coordination leads to efficiency. Such an outcome would improve the health of today's seriously mentally ill population.

Successful capitation programs have been implemented. In Rochester, New York, reports have shown that capitation can lead to coordination of services and efficiency.[4–7] In the Rochester program, capitated services led to fewer hospitalizations, more community support, and better case management in comparison to the usual fee-for-service method. Admittedly, this model reduced hospitalization more than it improved functioning or symptomatology. In another recent study, Chandler et al.[8] compared the usual form of reimbursement with a capitated PACT model[9] used by two California integrated services agencies (ISAs). The authors reported that after 12 months of services, patients using both of the ISAs were more likely to remain in treatment, were less likely to use psychiatric hospital care, and were more likely to work for pay than patients in systems with the usual fee-for-service format. The authors await the 36-month results to examine outcome differences in other socially and clinically important domains.

Dr. Rosenbaum: Capitation resolves some of the problems of managed care, but it also creates insidious new problems. First, it is not true that providers know what they will earn; rather, they know the limits of what they might earn. Second, a patient's choice of a mental health provider possibly becomes more limited, and a patient's freedom to be a full participant in deciding the best match between his or her difficulty and the treatment is potentially severely constricted by the primary care physician's financial incentives not to refer. Physician incentives also run counter to informing patients fully about their options when they become sick. For instance, physicians are "gagged" by clauses such as: Physician shall agree not to take any action or make any communication which undermines the confidence of enrollees, potential enrollees, their employers, their unions, or the public in [the HMO] or the quality of [the HMO's] coverage and Physician shall keep the proprietary information [payment rates, utilization review procedures, etc.] and this Agreement strictly confidential.[10]

Dr. Glazer: There are few data to support (or refute) the assumption that capitation means constricted choice, although the risk is obvious. The Rochester program did "de-capitate" by attending to the seriously mentally ill population at the expense of the less severely ill persons, but it seems to be something that can be addressed and remedied over time. If capitated health plans result in a healthy consumerism, this concern is diminished. There are indications that we are seeing greater scrutiny of health plans by patients/consumers or purchasers such as

employers. For example, an article in the financial magazine *Barron's*[11] reported that while the index of HMO stocks showed a sharp rise in 1995, some of them were beginning to falter due to poor quality ratings. Employers like GTE, Xerox, and IBM are dropping HMOs that don't make their grade. Bruce Davidson demonstrated how concerned employers at Digital assessed mental health services.[12] Such scrutiny will foster competition and, as a consequence, continuous improvement in the quality of services.

Capitated reimbursement methods, like fee-for-service methods, will be effective only if the correct outcomes are measured. Leff et al.[13] delineated these outcomes as access, adequacy, and appropriateness. Without attention to such indicators, no reimbursement methodology will protect patient choice.

Does Capitation Pose Ethical Concerns?

Dr. Rosenbaum: Yes. Capitation absolutely poses ethical concerns because the alignment of incentives creates troubling dilemmas and distorts the doctor-patient relationship. Under capitation, the primary care doctor lacks incentive to refer to a psychiatrist unless she or he believes that failure to refer will lead to greater costs rather than to diminished quality of life or suffering for the patient. Thus, for the patient at risk for hospitalization if treatment is inadequate, the incentive for timely referral is clear. But if the patient simply suffers, can't take care of the family, or is at risk for losing a job, the outcome is at best financially neutral for the decision maker. At present, only about one quarter of patients with major depression and anxiety disorders receive treatment. With respect to the incentive for increased detection, capitation runs counter to all the efforts that the field has been making to extend treatment to the majority who are underdiagnosed and untreated because capitation establishes a financial disincentive to detect treatable psychiatric disorders. In short, we introduce a demoralizing ethical dilemma to the physician when he or she is forced to choose between financial loss on the one hand and suboptimal patient care or illness detection on the other.

Dr. Glazer: Any form of reimbursement for medical services poses ethical concerns. But under capitation models, clinicians are motivated to help prevent disease from occurring, because this will reduce utilization by ensuring the good health of a population. Under fee-for-service programs, clinicians will not think about prevention unless it is covered in the patient's benefits, and it is rarely covered.

Many people see ethical problems in the administrative costs and profits gained by managed care delivery systems. In fact, some states developing Medicaid capitation programs are beginning to define limits to these finances. Caps should prevent unnecessarily high administrative costs or abuses, although administrative costs under managed care are higher than they are traditionally in the public sector. The Bazelon report[2] indicated that several states have dictated limits on administrative costs: Arizona (8%), California (15%), Kentucky (10% in Year 1, then 8%), Oregon (6%), Utah (variable), Delaware (undefined as of this writing), and Iowa (undefined as of this writing). Profits in HMOs and other organized delivery systems have also been the focus of regulatory concern. The Bazelon Center report indicates that only a handful of states address the issue of profits: Hawaii has imposed a combined limit on administrative costs and profits of 10% to 12%; Massachusetts requires a defined amount of reinvestment before profit is taken; Oregon has set a 5% limit on profit; and Tennessee is about to define this issue as well. The Bazelon report indicated that the more financial risk the provider assumed, the greater the potential for ethical concerns. The report advocates "soft capitation," which sets a basic cap rate per enrollee but allows risk sharing for expected additional costs at a defined level. This reduces the incentive to shift patients into the public safety net.

Under Capitation, Will the Threshold for Medical Necessity Be Compromised?

Dr. Rosenbaum: Yes. The threshold for "medical necessity" will be set by the level of funding under capitation, not by therapeutic opportunities. We lack, unfortunately, a universally applied definition of medical necessity and, consequently, the threshold is left open to a great deal of interpretation. As Mariner states, "Given the difficulty of defining medically necessary care, whoever has the authority to make decisions about what is covered by the comprehensive benefit package will control the care most patients receive."[14] As a result, the threshold for medical necessity under managed care, capitated or not, will be set by those who stand to lose financially from a low threshold. Services, by consequence, will be limited and/or of questionable quality because undertreatment, particularly in situations where the risk of excessive medical utilization or hospitalization is low, will be rewarded. The danger is, says Mariner, "Physicians whose incomes were limited under contracts with insurers might abuse their authority, misrepresenting medically necessary care as unnecessary to the patient in order to avoid incurring costs. In other words, they might do precisely what patients fear that health plans will do: deny patients care for their own financial gain."

Dr. Glazer: Psychiatry, like most medical specialties, needs clear, structured operational definitions of medical necessity.[3] Had such guidelines been created 20 years ago, fee-for-service reimbursement would probably be alive and well today. Such guidelines need to correlate levels of service utilization with patient behavior, function, and resources. Clinicians need a "gold standard" to ground their decision-making process; otherwise they are weakened by an extreme variability in decision-making from provider to provider and community to community. Such variabili-

ty underlies the perception that psychiatric services are unpredictable, impossible to measure, and at risk for inflation. With clear guidelines in place, capitation in and of itself will not compromise the threshold for medical necessity. Rather, with operationalized guidelines in place, the threshold for medical necessity can be set scientifically, not politically or economically.

Dr. Rosenbaum: Guidelines are yesterday's medicine; they are too simple for the complexity of our work. They are old recipes; we do not need cookbooks.

Is Patient Care Better Under Fee-for-Service or Capitation?

Dr. Rosenbaum: Much of our efforts in clinical research have been focused on the majority of patients who fail to completely recover with initial adequate treatment. Patients who have treatment-resistant depression or residual symptoms of panic disorder and agoraphobia, or who are stabilized but chronically mentally ill, all benefit from persistent efforts to optimize therapeutic response. Changing treatment, augmenting treatment, combining treatment, adding targeted psychotherapies, and utilizing psychosocial interventions all offer incremental benefit for the majority of patients who continue to be symptomatic despite treatment. Capitation, on the other hand, encourages being satisfied with improvement sufficient to limit cost but not to maximize quality of life or to minimize suffering. As a case in point, a medical outcomes study[15] demonstrated that depressed patients of psychiatrists participating in prepaid services did not fare as well as those depressed patients under fee-for-service care.

Primary care providers are often poorly prepared to diagnose mental illness and are therefore unable to direct resources reliably to those who need them. Borus et al.[16] found that HMO primary care doctors failed to diagnose mental disorders in almost two thirds of their patients with these disorders. Although confident in their assessments, these providers correctly identified only 1 of the 7 depressions, 3 of the 18 anxiety disorders, and 0 of the 4 alcohol and drug abuse disorders presented to them. Given that these disorders are among the most prevalent specific mental disorders in primary medical care practice, the results of this study cast doubt upon the quality of care patients could receive under capitated care. Thus, individual patient outcome under fee-for-service will remain superior to patient outcome under capitation.

Dr. Glazer: Rationing is inevitable in the United States. The people of this country cannot afford to pay for all potential services—whether they are served by commercial or public insurance structures. This reality has been ignored, and the result has been de facto rationing without any overall plan. Rationing can be accomplished in a reasonable fashion under any reimbursement methodology—fee-for-service or capitation. Capitation methodologies help to articulate thresholds clearly because capitation defines allocation in terms of the population that receives the care. In fee-for-service systems, the population served is not as clearly defined, making it difficult to prioritize services reasonably. Over the next decade or two, U.S. society will determine what gets rationed. Physicians need to help articulate the stakes, but society ultimately will vote on the matter. The state of Oregon has demonstrated leadership in this regard by prioritizing funding by diagnostic category in a defined Medicaid population. Psychiatrists need to convince the public that a population of patients will contain a predictable number of persons with mental illnesses and that it is worthwhile to cover improvements in quality of life that can be achieved via psychiatric intervention. Under the capitation method, we are at a greater advantage to be able to define terms so that society can choose. For example, if we have a population of 100,000 Medicaid recipients, we can estimate that 10% (10,000) will have a psychiatric diagnosis. Of those, a percentage will have severe and persistent mental illnesses, while the rest will have intermittent, less severe forms. If there are defined resources to care for this population, we can prioritize allocation; e.g., the seriously mentally ill population gets 70% while the less severely ill gets 30%. Such a proposal is easily understood and can be voted on publicly. In the meantime, rationing should occur only after clear guidelines are approved.[17]

Will Capitation Put Care Providers at Increased Risk of Vulnerability to Difficult, Abusive Patients?

Dr. Rosenbaum: Yes. Capitation leaves the care providers vulnerable to patients who are difficult, abusive, or noncompliant. We care providers are financially responsible for our patients, and the patient's responsibility to be a financial partner in his or her care is diminished under capitation. You can't terminate your patient. Individual practitioners are shackled to the patient, assuming financial risk and responsibility, at times unfairly and without recourse.

Dr. Glazer: No. If psychiatric practice remains status quo except for capitated reimbursement, there is real risk that clinicians could be left vulnerable to abusive patients. Before capitation, clinicians were rarely "stuck" with the patient. Under capitated reimbursement, a clinical practice is committed to serve all needs of a defined population. In the past, difficult-to-treat patients could be eluded by referral, termination, or other forms of avoidance. Under capitation, the stakes change.

But take the example of a 34-year-old married woman with a history of severe borderline personality disorder and juvenile-onset diabetes. Last year, she utilized $64,567 in claims to her HMO for services related to her diabetic condition and depression. She did not follow her treatment plans for these conditions and made several suicide attempts that required hospitalizations. The clinicians in this staff model HMO went to great efforts to create a

case management model plan for her—a case manager, who was a psychiatric social worker, helped coordinate her services with a diabetologist, a psychiatrist, and visiting nurses. The coordination efforts were excellent, yet the patient simply refused to follow her insulin regimen and acted out her dysphoric feelings with self-destructive behaviors. Finally, feeling that they had reached the "end of the line," the treatment team decided to offer the following arrangement. The case manager, speaking for the team, pointed out to the patient that she had submitted over $64,000 in claims, much of which could have been avoided if she had followed the recommendations of the treatment team. They extended this challenge: if the patient was willing to adhere to the treatment plan, the HMO was willing to share 10% of the savings, i.e., reduction in claims, with the patient. The patient agreed, and claims for the subsequent year dropped to $37,543.

This case demonstrates how capitated methods promote thinking "out of the box." Of course, ethical and legal considerations for this type of risk sharing with the patient need to be developed. For example, it seems fair that a portion of the savings in this case should be shared with the HMO members who are compliant with their treatment. Also, it seems inevitable that managed care organizations will set limits on the degree of noncompliance that will be tolerated.

Does Capitation Encourage "Dumping" by Primary Care Physicians on Psychiatrists?

Dr. Rosenbaum: Yes. For cost-cutting, mental health is an easy target, and subcapitation for mental health in a system dominated by actuaries and nonpsychiatric physicians will be inadequate. Further, subcapitation encourages the dumping of responsibility for expensive patients from one provider group to another (e.g., from primary care doctors to psychiatrists).

Dr. Glazer: Carefully planned systems of care can generate incredibly efficient systems via well integrated relationships between psychiatrists and primary care physicians.

Are Providers at the Whim of Actuaries?

Dr. Rosenbaum: Yes. Capitation rates that were developed from actuarial projections of costs may not be realistic, making it difficult for providers to successfully give quality care to patients within the caps and also putting providers at serious financial risk. This may be especially true for subgroups of patients with serious mental illness.[18] Furthermore, capitation does not take into account the possibility of major shifts in illness incidence in the population that may be outside of a physician's control. Economic adversity, for example, may be a risk factor for mental illness. Should the rate of anxiety, depression, or family and marital dysfunction increase at a time of economic downturn, the financial burden would fall on the physician/psychiatrist. Actuaries do not assume that the population needs more care than is currently being provided.

Dr. Glazer: There are safeguards for providers who assume financial risk via capitated contracts. First, the larger the risk pool, the less the risk, because "outlier" high-cost cases can be absorbed. The lowest number of persons in a single population that psychiatric clinicians should consider capitating is probably somewhere between 50,000 to 100,000. Second, it is possible to adjust for risk on the basis of such factors as age, sex, and occupation. Third, in capitated systems, an emphasis is placed on prevention so that catastrophes seldom happen. Fourth, incentives can be built into the system, e.g., withholdings and bonuses—units of payment at the end of the year dependent on performance measures. The key to success with such incentives is the measurement of the quality of care that is generated—not just of the costs.

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Role of Medication in Managed Care for Depression

William M. Glazer, M.D., and Jerrold F. Rosenbaum, M.D.

Would You Compare Efficacy With Effectiveness in Terms of Managed Care?

Dr. Glazer: A basic tenet of managed care says that if two treatments have the same outcome, use the less expensive treatment. Since controlled studies demonstrate that tricyclic antidepressants (TCAs) are as efficacious as the serotonin reuptake inhibitors, it is logical to conclude that the former class should be selected before the latter.

Dr. Rosenbaum: The distortions in health care introduced by managed care programs are nowhere more apparent than in the formularies. Those who oversee the pharmacy budget typically base decisions about pharmacotherapy only on cost (and for some, personal bonuses) and argue against newer agents, which are more costly on a per-tablet basis than older generic agents. The cost claim, however, is disingenuously based on equivalent efficacy data in Phase 3 clinical trials. Large Phase 3 industry trials are hardly representative of the effectiveness of treatments in nonresearch clinical populations, most of whom are excluded from clinical trials. Also, the efficacy of older agents in those clinical trials does not reflect the realities of clinical practice. For example, patients are rarely given the doses of TCAs that are achieved in research trials, where protocols drive patients to efficacious doses. It is noteworthy that these doses are rarely obtained clinically by primary care physicians.

Besides the questionable validity of findings from the Phase 3 trials, the use of older antidepressants introduces other problems. First, the risks of toxicity and death from overdose are greater. Second, the side-effect burden, which may include orthostatic hypotension, tachycardia, delayed cardiac conduction, seizures, blurred vision, and dry mouth, is greater for the older agents. Thus, the risk for initial treatment failure, resulting from poor compliance, is increased when the older antidepressants are used. Also, the likelihood of dropping out of continuation and maintenance treatment is higher for the use of older antidepressants as compared to the newer agents.[1] Consider just the anticholinergic burden alone: if there were a disease called "Muscarinia" which was associated with dry mouth, blurry vision, cognitive dysfunction, constipation, tooth decay (to say nothing of such other TCA-associated symptoms as sedation and weight gain), would your insurance plan pay for it to be diagnosed and treated? If so, why are they so willing to give it to you?

Moreover, Sclar et al.[2] found that the administration of TCAs to depressed patients was associated with an initial, short-term savings but actually resulted in an overall increase in cost 1 year after initiation of antidepressant pharmacotherapy. The results of their study stress the importance of looking beyond procurement cost for a given medication when determining its economic value. When an HMO saves $100 per month for a drug, it may well cost the employer several hundred dollars a day in lost work or decreased productivity and cost the patient and family much more in quality of life and maintenance treatment because of noncompliance, treatment failure, and side effects. In sum, a narrow view of the cost to the formulary obscures the total cost to the health care system as well as to society. The question I ask when this issue is debated is, "Dr. Glazer, would you want your daughter first treated with a tricyclic?"

Dr. Glazer: Dr. Rosenbaum, you are ignoring a very important principle that the American health care profession has got to face. We must embrace the "allocator" role as well as the "advocate" role. It is noble for us to place all of our focus on the individual patient, but it is fairer for us to balance the needs of that individual with the needs of the group. You bring my daughter into the argument. First of all, I wouldn't want my daughter's doctor to treat her if he/she were overwhelmed with the emotions of a parent. I would want him or her to maintain a professional perspective on my daughter's well-being. Let me answer your question with a more realistic question: If your daughter and my daughter belonged to the same HMO, and it was clear that the money allocated to my daughter could not be used for another patient, like your daughter, would you want my daughter to receive a TCA or an SSRI? In any case, Dr. Rosenbaum, data are emerging that will lead to both of our daughters being treated efficiently.

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Role of Psychiatrists in Managed Care Systems

William M. Glazer, M.D., and Jerrold F. Rosenbaum, M.D.

Will Primary Care Physicians Reduce the Need for Psychiatrists?

Dr. Glazer: No. The Epidemiologic Catchment Area Study tells us that there is work for both the primary care physician and the psychiatrist. In that study, one in four Americans (60 million) were found to have had mental illness in the last year. Of those, only one (15 million) in four sought help.[1] Where are the other 75% (45 million) of patients going for care? Undoubtedly, they are appearing in emergency rooms and primary care settings where their mental illnesses are probably underrecognized and undertreated. Studies are demonstrating tremendous medical cost offset potential for appropriate psychiatric intervention. One recent randomized study by Smith et al.[2] measured the impact of psychiatric consultation by examining the impact of a consultation letter randomly sent to 51 primary care physicians treating 56 somatizing patients. Patients' physical functioning increased robustly during the year after this intervention, while the intervention reduced annual medical care charges by $289 or a 32.9% reduction in the annual median cost of medical care. This reduction was a function of decreased hospital care.

The unfortunate inefficiency that occurs in most primary care settings can be improved. What we need are models for collaboration. The Group Health Cooperative in Puget Sound has developed a model of care in which there is a structured relationship between psychiatrists and primary care physicians in the treatment of depressed primary care patients. Results from this work indicate that this collaboration improves the outcome of care.[3] It is time to develop strategies that promote financial as well as clinical cooperation between specialties like psychiatry and primary care. Competition and turf struggles among specialties have become a diversion of energy!

Dr. Rosenbaum: The presumption that the primary care physician is typically in a position to diagnose and treat psychiatric patients is a fantasy. As the number of patients that primary care physicians are responsible for increases, their already limited time with each patient will necessarily decrease. Is not the average follow-up visit with a primary care physician something like 5 to 10 minutes? Are primary care physicians now going to expand their time to offer adequate service to patients with psychiatric disorders without increased reimbursement?

Also, primary care doctors, if and when they diagnose and treat, are likely to be satisfied with improvement rather than remission. Are the models of collaboration between primary care physicians and psychiatrists convincing enough for us to believe that this partnership, with the primary care physician in control, will actually be successful? The standard by which the treatment provided to patients should be judged is whether this is the treatment you would recommend for a family member, as opposed to that which is most agreeable to your business manager. Who is going to pay for the time that the primary care physician and psychiatrist must spend to work "arm in arm"? Don't the available data indicate that primary care physicians tend not to diagnose and not to treat psychiatric disorders?[4,5]

Dr. Glazer: Dr. Rosenbaum, the operative term in your argument is *control*. Psychiatrists and primary care physicians must get beyond control issues. I will acknowledge the likelihood that such collaborations may require more time and money up front, but I will suggest that these costs may be offset by the greater efficiency. We need to develop financial models for risk sharing between the primary care physician and the psychiatrist at the beginning. Typically, managed behavioral health organizations are not integrated financially within care systems. Behavioral health care is often carved out or in but identified and treated differently than other medical specialties. Earnings and losses are rarely shared between behavioral health and general medical providers. The Smith et al. study[2] supports the vision that physical and mental health are interrelated.

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