CORRESPONDENCE

Use of Health Care Services by People With Mental Illness: Secondary Data From Three Statutory Health Insurers and the German Statutory Pension Insurance Scheme

by Prof. Dr. med. Wolfgang Gaebel, Sandra Kowitz, M. A., Prof. Dr. med. Jürgen Fritze, PD Dr. med. Jürgen Zielasek in volume 47/2013

Waiting Times Are too Long

The authors say that even severe depression is treated primarily by general practitioners and discuss, in addition to a specific lack of trained personnel, an unsatisfactory referral rate to specialists. For GPs in the outer areas of small towns, appointments for patients are rarely available with less than three months' waiting time, even if a personal request is made (for example, on 20 November 2013, the earliest appointment was for mid-March 2014). We provide patients requiring psychotherapy with the details of therapists within a distance of 30 km. We mostly receive these details back a few days later, with the frustrating news that the waiting time is 9 months and more—the problem is certainly not one of hesitant referrals.

DOI: 10.3238/arztebl.2014.0271a

REFERENCES

1. Gaebel W, Kowitz S, Fritze J, Zielasek J: Use of health care services by people with mental illness—secondary data from three statutory health insurers and the German statutory pension insurance scheme. Dtsch Arztebl Int 2013; 110: 799–808.

Stefan Amerschläger
Im Stift 14
58730 Fröndenberg

Conflict of interest statement
The author declares that no conflict of interest exists.

Diagnoses as "Currency"

It would be good if the mass of data that the healthcare purchasers are creating could be used for more than just billing purposes.

In practice, healthcare services are legitimized through diagnoses. Longer consultations that exceed the restrictions imposed by flat rates can be bailed only by using "psycho-codes". For this reason, "psycho-diagnoses" have to be used. Many patients in the practices are stressed but by no means ill in the psychopathological sense. Often they don't even know that they have had a psychological diagnosis and are therefore a long way from seeking psychotherapy.

During the study period, doctors were instructed to code their diagnoses exceptionally thoroughly, in preparation for the structural compensation for morbidity risk. Diagnoses are "currency," not only for doctors, but also for the statutory health insurers. In this sense, diagnoses are very far removed from their original purpose—that is, describing the suffering of patients.

Did you use only those diagnoses that were coded as confirmed, or also those that were coded "for the exclusion of" or "suspected"? We try to code "confirmed" ("G") diagnoses as sparingly as possible, so as not to stigmatize patients inappropriately. We do not know whether this makes a difference.

Your evaluation throws a light on the indefensible situation in the context of diagnosis. I wish that doctors were allowed to provide thorough advice, without a strategic allocation of a diagnosis. Diagnoses should be coded only once they have been confirmed without doubt. Until such time it should be enough for the paying bodies if doctors document "a need for consultation."

DOI: 10.3238/arztebl.2014.0271b

REFERENCES

1. Gaebel W, Kowitz S, Fritze J, Zielasek J: Use of health care services by people with mental illness—secondary data from three statutory health insurers and the German statutory pension insurance scheme. Dtsch Arztebl Int 2013; 110: 799–808.

Dr. med. Maria J. Beckermann
Frauenärztin, Psychotherapie
Berlin
M.J.Beckermann@t-online.de

Conflict of interest statement
The author declares that no conflict of interest exists.

In Reply:

Amerschläger points out that interdisciplinary treatment in mental disorders is difficult primarily because of a lack of therapeutic resources. Several studies have shown long waiting times for treatment in specialist care (1, 2). The Central Federal Association of Statutory Health Insurance Funds presented a position paper on reforming psychotherapy in November 2013, which, among others, includes measures to shorten waiting times for treatment (3). In Mecklenburg-Western Pomerania and Saarland, an approach of "urgent referral" has become established, which enables GPs to refer patients to specialist medical care within a few days.

Beckermann criticizes the fact that data collected for billing purposes do not tell us anything about the "true" prevalence of mental disorders. In our article we consistently used the term "prevalence of use" of outpatient, inpatient, and rehabilitational care.

Furthermore, Beckermann points out that healthcare services are legitimized by diagnoses. This is correct in as far as only the existence of a diagnosis will trigger reimbursement by the statutory health insurance funds. Whether longer consultations are billed as "psycho

codes", as she explains, seems questionable in our opinion—medical advice is included in the catalogue of services provided by statutory health insurance physicians. We cannot follow Beckermann's assertion that diagnoses become "currency." The "currencies" are, depending on the healthcare area, diagnosis-related groups, flat rates, and fee tariffs—supported by diagnoses, but the amount that is reimbursed is not determined by a diagnosis alone. With regard to the question of which types of diagnoses were included in our study: we included only those diagnoses that were coded as confirmed ("G"). The question of stigmatization as a result of a diagnosis of a mental disorder is certainly a problem—we do not think, however, that it is appropriate to circumvent putting patients at a perceived or actual disadvantage by means of blurred diagnoses or diagnoses that avoid the issue, because this can also result in the withholding of necessary services. Sielk and colleagues found for depression, for example, that psychological stress is often identified and treated in general practices without a corresponding diagnosis being made (4). We cannot follow in such poignancy Beckermann's claim, that the situation around diagnoses is "indefensible." New studies of the quality of diagnoses would be needed to confirm such a claim. The fact that, as Beckermann reminds us, diagnoses should be coded only once sufficient certainty has been reached is undisputed—for this reason, suspected diagnoses are explicitly coded "V" in Germany. Both letters to the editor point to several serious deficits in healthcare services for people with mental disorders. But they also underline the importance of health services research with routine data—the quality of which is in need of further improvement.

DOI: 10.3238/arztebl.2014.0271c

REFERENCES

1. Bundespsychotherapeutenkammer. BPtK-Studie zu Wartezeiten in der ambulanten psychotherapeutischen Versorgung. Berlin, 2011. www.bptk.de/fileadmin/user_upload/Publikationen/BPtK-Studien/belastung_moderne_arbeitswelt/Wartezeiten_in_der_Psychotherapie/20110622_BPtK-Studie_Langfassung_Wartezeiten-in-der-Psychotherapie.pdf (last accessed on 27 February 2014)
2. Kruse J, Herzog W: Zwischenbericht zum Gutachten „Zur ambulanten psychosomatischen/psychotherapeutischen Versorgung in der kassenärztlichen Versorgung in Deutschland – Formen der Versorgung und ihre Effizienz". Gießen, 2012. http://s255669059.online.de/pdf/Gutachten_Psychosomatik_Zwischenbericht.pdf (last accessed on 30 January 2014).
3. GKV Spitzenverband. Reform des Angebots an ambulanter Psychotherapie – Vorschläge der gesetzlichen Krankenkassen (Positionspapier). Berlin, 2013. www.gkv-spitzenverband.de/media/dokumente/presse/publikationen/Positionspapier_GKV-SV_Ambulante_Psychotherapie.pdf (last accessed 31 January 2014).
4. Sielk M, Altiner A, Janssen B, Becker N, de Pilars MP, Abholz HH: Prävalenz und Diagnostik depressiver Störungen in der Allgemeinarztpraxis. Ein kritischer Vergleich zwischen PHQ-D und hausärztlicher Einschätzung. Psychiatr Prax 2009; 36: 169–74.
5. Gaebel W, Kowitz S, Fritze J, Zielasek J; Use of health care services by people with mental illness—secondary data from three statutory health insurers and the German statutory pension insurance scheme. Dtsch Arztebl Int 2013; 110: 799–808.

On behalf of the authors:
Prof. Dr. med. Wolfgang Gaebel
Klinik und Poliklinik für Psychiatrie und Psychotherapie
Medizinische Fakultät, Heinrich-Heine-Universität Düsseldorf
LVR-Klinikum Düsseldorf
wolfgang.gaebel@uni-duesseldorf.de

Conflict of interest statement
Prof. Gaebel is a faculty member of the Lundbeck International Neuroscience Foundation (Scientific Advisory Board). He has received reimbursement of travel expenses from the DGPPN, the AQUA-Institut, and the Federal Working Group of Psychiatric Hospital Operators (Bundesarbeitsgemeinschaft der Träger psychiatrischer Krankenhäuser). He has received event sponsorship (symposium support) from Lilly, Servier, and Janssen Cilag.