

Medicine Around the World

The Role of Primary Care Practitioners in Psychosocial Care in Germany

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Editor's Note: Medical practice in Germany functions at a high level and everyone is provided coverage. One notable difference from the US is the major role that psychosomatics has in everyday primary care. At a time when one sees euphemisms here such as "Comprehensive Clinic," in Germany the title "Psychosomatic Clinic" is widespread, not only in signage, but in practice. How 'psychosomatic' became equated with 'imaginary' in the minds of American patients is unclear, but it is a significant disadvantage. Two experienced German physicians here describe a major difference between the actual operation of primary care in Germany and in the US. The cost implications of this difference are of significant interest when one reflects that costs here are higher and coverage less.

—Vincent J Felitti, MD

therapist after the GP's consultation. They rated the Impairment Score (IS)¹² and gave a diagnosis according to DSM-III-R classification. Patients did self-ratings by questionnaires (for example SCL-90-R) and answered questions about their subjective illness theory. Over a third of the patients fulfilled relevant DSM-III-R criteria and showed considerable impairment with IS >4, fulfilling the formal criteria for a psychogenic disorder. By means of SCL-90-R, 31.7% were classified as psychogenically ill. There was no sex difference in the frequency of psychogenic disorders. By contrast, the GPs had a conversation with only 11.5% of their patients related to psychosomatic basic care; only 3.3% were referred to psychotherapy. These numbers were higher with psychogenically ill patients who themselves assumed a psychic cause of their illness. These very measurements acknowledge the importance of psychosomatic medicine in Germany, and the GPs' accepted role of psychosomatic basic care as part of their diagnostics and therapy.¹³

Although the majority of patients with psychologic disorders are seen in primary care where the diagnosis of the GP decisively influences the subsequent treatment, agreement between the physician and the researchers on mental health was

Introduction

Several epidemiologic studies in Germany have shown that about 25% of the general population suffer from psychogenic disorders that fulfill the criteria of a case that needs treatment.^{1,2} These figures are comparable to data from the National Comorbidity Study (NCS)³ in the US or the Edmonton Study⁴ in Canada. Many of these patients are seen by general practitioners (GPs).

The treatment of psychogenic disorders in Germany is mainly done by GPs. Physicians, especially GPs, have a major screening function in the care of patients suffering from psychologic disorders.⁵ Zintl-Wiegand and Cooper⁶ point out that it was the studies of Michael Balint and his co-workers⁷ as well as the distribution of Balint groups in general medicine that played an impor-

tant role so that the influence of psychodynamic concepts was ultimately greater in the group of GPs than in other medical disciplines.⁸ The diagnosis and therapy of somatoform disorders are often difficult and unsatisfactory for the attending physician. Multiple diagnostic tests, ineffective treatment, and time absent from work create high costs for the social security system.⁹ It is obvious with this group of patients that GPs have responsibility in terms of screening, filtering, prevention, and treatment. Glaesmer and Deter¹⁰ showed how costs can be reduced with psychosomatic basic care offered by GPs.

Tress et al¹¹ investigated the frequency of psychogenic disorders in the offices of 18 GPs. Five hundred seventy-two patients were examined and diagnosed by a psycho-

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modest.¹⁴ GPs identified 51.4% of the patients with psychologic disorders, but adjustment disorders were often ignored by GPs. They prescribed psychotherapy for only 3.3% of their patients, these usually being patients with somatoform disorders who had significant impairment. A path analysis showed that psychotherapists' ratings agree much more with patients' self assessment than do GP ratings.¹⁴

Psychosocial Disorders are Very Often Overlooked in Primary Care

In a following study Kruse et al⁵ investigated the reasons *why* GPs overlook so many psychogenic symptoms in their patients. In this study (physician-patient consultations of 120 patients with psychologic disorders in 16 primary care practices) physicians identified 60.8% of the psychologic disorders. There was a significant association between physician's identification of psychologic disorders and the severity of the disorder, the number of complaints reported during consultation and the pattern of physician-patient interaction. The study shows that the interactional process during primary care consultation is very important, and is associated with physicians' identification of psychologic disorders.⁵

Depression in Primary Care Practice

Jacobi et al¹⁵ focused on patients with depression. They examined the prevalence of depressive syndromes among unselected primary care patients as well as physicians' recognition and treatment rates. This nationwide German study included a total of 20,421 patients seeing their primary care physicians (n = 633) on the study's target day (4/15/1999). The findings confirm the high preva-

lence of depressive syndromes in primary care settings (11.3%) and underline the particular challenge posed by a high proportion of patients near the diagnosis threshold. Although recognition rates among more severe major depressive patients (59%), as well as treatments prescribed, appear to be more favorable than in previous studies, the situation in less severe cases, and the high proportion of physicians' definite depression diagnoses in patients who do not fulfill the diagnostic criteria, still raise significant concerns.¹⁶

Current Research Topics in Germany

In a cooperation of GPs and psychosomatic clinicians, Heidelberg University carries out and evaluates a curriculum called "FUNKTIONAL," which will help GPs to recognize and treat somatoform complaints as early as possible. The study aims at optimizing diagnostics and treatment and at increasing the patients' satisfaction and quality of life by special training of GPs. The aim is to record systematically short- and mid-term effects of the intervention, on patients and physicians. The curriculum has been implemented and is being evaluated in a randomized controlled trial.^{17,18}

In a systematic review of nine studies that took place between 1966 and 2003, Fritzsche et al¹⁹ found that psychosocial interventions by German GPs are effective but that there is need for improvement because clinical effects were usually limited and of short duration. Studies with specific therapeutic approaches in specific disorders showed the best results. They conclude that further conceptual development is necessary of structured psychosocial interventions that can be applied in the general practice for common emotional disorders.

Considering the large number of patients with emotional disorders in primary care, Fritzsche et al. conclude that these efforts will undoubtedly be worthwhile.¹⁹

Overall, there are many efforts to train GPs to be qualified for psychosomatic basic care. They are trained to reflect on the physician-patient relationship, for example in Balint groups. If psychosomatic basic care is not enough for the patient, there are two branches of the Psychotherapy Service Delivery System in Germany: the inpatient and the outpatient system.

The Inpatient System

Historically, the development of the inpatient system in Germany began with local experimentation by Georg Groddeck in Baden-Baden in the year 1900²⁰ and by Ernst Simmel in Berlin in the 1920s. It is an interesting fact that after World War II inpatient psychotherapy was considered acceptable for insurance coverage long before outpatient psychotherapy became eligible.²¹ This inpatient trend has been increasing since the 1970s, when those hospitals established for the treatment of chronic somatic diseases (such as tuberculosis) were forced to find a new patient base. Psychosomatic medicine turned out to be a comparatively inexpensive treatment modality and therefore was financially attractive to owners of rehabilitation institutions. There are specific indications and guidelines for inpatient treatment.²²

The Outpatient System

The present system of funding psychotherapy allows for regimens that are detailed in the guidelines.^{23,24} Funding is easier for short-term psychotherapy than for long-term treatment. So, short-term psychotherapy is often indicated for

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patients in an acute crisis, with a defined and limited focus, or to test motivation for a long-term psychotherapy. For long-term treatment, peer review is required at each phase to confirm that further treatment is medically needed.²¹

Health Insurance in Germany

In Germany, the health insurance system ensures that necessary outpatient and inpatient medical treatment is available at the time of need for individuals from all strata of society, regardless of their financial situation. With few exceptions, the patient pays no more than his or her regular insurance premium (approximately 14% of income). These regulations powerfully shape the nature of the psychotherapy service delivery system.²¹

The system of providing psychotherapy is regulated by agreements between the health insurance companies and the national corporate organization of physicians: *Kassenärztliche Bundesvereinigung* (KBV), which regulates matters of public health and oversees payment of medical care.

Patients have a choice of physicians. Just as the public health insurance companies together form a corporate entity, nearly all physicians (and psychotherapists) are members of the *Kassenärztliche Vereinigung* (KV). Fees for psychotherapists' services, as for physicians' services, are negotiated between these two corporate organizations and are very often compromises. The German system of third-party payment is explicit about the fact that the patient makes no direct payment; instead the therapist writes a detailed report to request that the health insurance company cover the cost of treatment. Peer reviewers examine the claim and, if approved,

the therapist is compensated via the local branches of the KBV.

The German social insurance system is supervised by the state, but it is not a national health service. 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 Chancellor Bismarck (1815-1898) at the end of the 19th century.

The Guidelines (Psychotherapie-Richtlinien)

To direct the practitioner and to ensure quality of care, clinical guidelines (called *Psychotherapie-Richtlinien*) are continuously monitored by the KBV, which makes its judgments on the basis of input from peer reviewers elected from the field. There are specific clinical indications for psychodynamic therapy and psychoanalytic therapy as well as for behavior therapy. The guidelines specify that psychotherapy provided by health insurance is restricted to those illnesses whose course can be influenced for the better. Thus, the patient officially requests insurance coverage, and the psychotherapist is called upon to provide the peer reviewer with evidence suggesting that the intended therapy has the potential to alleviate, improve, or cure the neurotic or psychosomatic disease in question.²¹ The directives for psychotherapy, which were established in 1967 for the compulsory national health insurance system, had a strong influence on the subsequent development of psychotherapy in Germany and the general framework of the directives for psychotherapy in the decades following.²⁵

Whether therapy is extended or not depends on the assessment of the peer reviewer. On the basis of the guidelines, the peer reviewer deter-

mines treatment duration: Analytic psychotherapy should, as a rule, achieve a satisfactory result in 160 sessions—in special cases, up to 240 sessions. Further extension to 300 sessions is possible under exceptional circumstances, which must be supported by detailed arguments. Even 300 sessions do not constitute an absolute limit in the event that valid, convincing evidence of need is presented. In the unlikely event that therapist and peer reviewer do not agree, a patient may go to court and, in some cases, successfully claim more sessions.

The Triad of Necessity, Effectiveness, and Economy

Health insurance companies are obliged to cover costs when the symptoms constitute an illness and when the *triad of necessity, effectiveness, and economy* is also satisfied. German psychotherapists, whether medical physicians or psychologists, must keep these criteria in mind, both in diagnosis and in treatment. Psychodynamic therapy and psychoanalytic therapy are not covered by public health insurance if they do not have the potential to bring about cure or amelioration of a disease, or to lead to medical rehabilitation. This regulation also disallows interventions intended exclusively for professional growth and development, social adjustment, child-rearing guidance, and other similar measures.²¹

General practice in Germany has had a strong involvement with psychosomatic medicine after World War II, in part due to the influence of the innovative Hungarian psychoanalyst, Michael Balint. According to the severity of the psychosocial disorder, patients are seen by specially qualified GPs, in an outpatient setting by psychotherapists (medical physi-

cians or psychologists), or can be sent to a psychosomatic hospital. Insurance covers both inpatient and outpatient treatment for psychologic disorders, to a much greater degree than in the US. This has been affordable, perhaps because of cost shifting into a less expensive realm of medical diagnosis and treatment. ❖

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