Prologue: As insurance comes under the scrutiny of health care reformers, differences in the treatment of general medical care and mental health care emerge. In this essay psychiatrists Steven Sharfstein and Anne Stoline offer a road map for policymakers through the various components of psychiatric care—both medical and nonmedical—and put forth their proposals for reforming the insurance of such care. As Sharfstein explained, “The crisis in psychiatric care and its financing requires a rethinking of old assumptions and a reinventing of methods of payment based on new needs and new realities.” The analysis presented here “will assist legislators in developing a rational policy for the financing of psychiatric treatment and supportive services for the mentally ill,” write the authors. Sharfstein is president, medical director, and chief executive officer of the Sheppard and Enoch Pratt Hospital, a private, nonprofit psychiatric hospital in Baltimore, Maryland, and clinical professor of psychiatry at the University of Maryland. Trained as a psychiatrist at the Massachusetts Medical Center, he also holds a master’s degree in public administration from Harvard University. Sharfstein’s strong interest in and analysis of mental health care financing have led to six books and over a hundred articles. He is well versed in the financing issues of both the public and private sectors, having examined public financing during thirteen years in the U.S. Public Health Service, and private financing and managed care issues during the past decade in the private sector. Stoline is staff psychiatrist at Springfield Hospital Center, a state psychiatric hospital in Sykesville, Maryland. She completed her psychiatric residency at The Johns Hopkins University in June. While in medical school at Hopkins she wrote, with Jonathan Weiner, the widely acclaimed book, The New Medical Marketplace: A Physician’s Guide to the Health Care Revolution, whose second edition is due out next spring.
Health insurance has become the primary means of financing psychiatric care, leading insured Americans to expect that the costs incurred in treating mental illness will be covered. In fact, this is often not the case—health insurance currently fails to pay for long-term catastrophic expenses, hardly ever pays for cost-effective preventive services, and minimizes coverage of acute care by use of managed care contracts. These conditions are of major concern to insured Americans, particularly in this era of escalating costs and growing doubts about the value and quality of care provided. Access to and payment for psychiatric care are even greater problems for the millions of Americans who lack health insurance. Many Americans—a significant percentage of whom are children—are therefore without private insurance and must resort to public-sector programs for care.

These circumstances have created the impetus for comprehensive reform of health care financing. Since psychiatric treatment differs in several important ways from general medical care, health care system reforms create a number of unique issues for the mental health sector. The need for essential, yet nonmedical, services by the mentally ill complicates development of mental health policy. The current system inadequately reimburses providers for such services. Here we describe the role these treatments serve in comprehensive psychiatric treatment.

Understanding the demands of today's mental health system for medical care as well as nonmedical, rehabilitative, and social control requirements will assist legislators in developing a rational policy for the financing of psychiatric treatment and supportive services for the mentally ill. Reform based on this approach could improve treatment outcomes for this vulnerable, neglected population.

**Evolution Of Mental Health Insurance**

When health insurance was introduced in the United States in the 1930s, hospitalization for mental illness was not covered. The primary reason for this exclusion was that for almost one hundred years most psychiatric care had been delivered in a public, state-financed system. In addition, psychiatric treatment options were limited, and supportive care was the mainstay of services for those with major mental disorders. Private insurers were concerned about the high costs of providing this supportive care to the persistently ill and the potential financial burdens of shifting these costs from the public tax-supported system.

In the 1950s, as general hospitals incorporated psychiatric units, coverage for psychiatric services—especially the acute hospital treatment of mental illness—began to be included regularly in benefit packages.
Expansion of mental health benefits continued through the late 1960s, into the 1970s and 1980s. As psychiatric benefits were liberalized, treatment of psychiatric conditions with psychotherapy and psychoanalysis became more common.

This expansion of private policy benefits led to a trend toward privatization, as care that was once publicly funded was transferred to the private sector. Despite these trends toward improved coverage, insurance for treatment of mental illness and substance abuse has always been more limited, unavailable, and uncertain than benefits for general medical care have been.

Expenditures for the health care system as a whole increased sharply during these expansionary years. A few factors, however, were unique to the mental health sector. In particular, the treatment costs of substance abuse and adolescent inpatients increased in the late 1980s in proportion to the expansion of for-profit private psychiatric hospital units and private substance abuse programs. Provider supply was also a factor in psychiatric treatment cost increases; as private insurance benefit packages were liberalized and state mental health mandates were implemented, more providers were encouraged to enter the system. State independent practice statutes also facilitated the establishment of non-physician mental health care providers. The supply of independent mental health care providers grew markedly during this period.

Insurers in both the public and private sectors have attempted numerous strategies to control costs. As a result, whereas the expansions of the 1970s and 1980s reflected some success in achieving reimbursement parity for the mental health sector, reversal of this trend began in the mid-1980s. Public-sector programs and many major employers with generous benefits implemented managed care approaches, increased cost sharing, and reduced benefits as their major attempts to contain costs. Recent studies underscore this retrenchment.

Private-sector cost control efforts have served to shift the financial burden back to the public sector. As public-sector budgets for mental health care shrink, the holes in this safety net are widening. It is estimated that thirty-five million Americans have no health insurance, and the number underinsured for psychiatric care is even greater.

Components Of Psychiatric Care

Development of mental health policy is complicated by the essential nonmedical services needed by the severely mentally ill, some of which are inadequately reimbursed in the current system. In a 1976 paper Boris Astrachan and coauthors discussed the potential impact of national
health insurance on the tasks and practice of psychiatry. They elaborated the four major tasks included in comprehensive psychiatric care. Here we discuss each of these tasks and their financing in the current health care system.

**Medical tasks.** Medical tasks under psychiatric care include ambulatory differential diagnosis, evaluation, and treatment, as well as acute inpatient care. Diagnostic and management services included in consultation/liaison psychiatry also fall in this category. These tasks apply to acute psychiatric conditions, as well as to exacerbations of chronic illness, and are usually performed or coordinated by physicians.

Insurance typically pays for these medical tasks on a fee-for-service or capitated basis. Insurance coverage of acute care services creates financial incentives for both patients and providers to maximize treatment of mental illness with these methods as far as their insurance coverage allows. However, many Americans are underinsured for these services. Because today's plans usually include significant cost sharing, enrollees face potential financial hardship even in typical benefit plans. When insurance benefit limits are reached and major psychiatric conditions persist or recur, patients are usually transferred to the state system unless they or their families pay out of pocket for continued care in the private system, or unless the private facility continues to provide treatment without reimbursement.

The following case example illustrates the course of events following the onset of a catastrophic psychiatric illness, given inadequate financing of medical tasks.

**Case One: Acute Catastrophic Illness.** M.D. is a thirty-five-year-old married female lawyer who is currently facing financial catastrophe due to a serious mental disorder. Eighteen months ago she experienced her first psychotic episode. After a week of sleeplessness while working feverishly on an important case, she became emotionally explosive in court during opening arguments. An outpouring of rambling, sometimes obscene arguments led to an interruption in the court proceeding, a motion for mistrial, and her being escorted from the courtroom. Psychiatric evaluation later in the day confirmed the diagnosis of an acute manic state (there was a history of bipolar illness in two close relatives), and hospitalization was arranged in a local general hospital psychiatric unit.

After medical and neurologic diagnostic evaluation, the patient was started on lithium bicarbonate and low-dose neuroleptic. On her thirteenth hospital day she was discharged with follow-up care arranged through a private psychiatrist in the community. Her health insurance policy contained “inside limits” of thirty inpatient days and twenty outpatient visits per year. The copayment on inpatient care was 80 percent; on outpatient visits, 50 percent.

Over the next several months she became more stable medically and was seen every other week because of her lapsed outpatient coverage. Although she had a stable lithium level, she began to develop severe side effects six months after treatment began, including severe skin problems and abnormal renal function tests. Discontinuation of lithium was necessary, and she began taking carbemazepine, which is more costly. Unfortunately, one month later
she experienced a second manic episode and had to be rehospitalized. Other medication strategies were considered, including calcium channel blockers and low-dose neuroleptic. Her thinking and ability to concentrate became impaired. She developed symptoms of depression and began taking an antidepressant. Discharged within two weeks, she had only two days of insurance coverage remaining.

She was unable to continue working, left her job, and lost her insurance. Her husband tried to get her included on his insurance but found that prior illness exclusions required a one-year waiting period. A third episode of severe mania, followed rapidly by a severe depression, led to a costly two-month hospitalization at a local psychiatric facility. Her husband took out a second loan on their home, but with her fourth episode the family faced financial ruin with psychiatric treatment costs approaching $20,000 per month. Consideration was being given for transfer to the state hospital.

This patient suffered several acute episodes of psychosis in rapid succession. It is impossible to predict the future course of her illness—the frequency and intensity of her symptoms may wane, worsen, or continue in this pattern. Once insurance benefits are exhausted, her family faces potential financial ruin in paying for necessary medical tasks without the income she formerly earned.

With such cost control methods as benefit reductions and managed care controls, health insurance as a means of paying for medically necessary treatment of mental disorders and substance abuse is inadequate, inefficient, and deteriorating, as this example shows. Too few Americans have minimally adequate coverage for more than one or two acute episodes of psychiatric illness.6

When patients have exhausted insurance benefits, the short length-of-stay in state hospitals represents stop-gap treatment. This is an example of private-sector cost control methods increasing the burden on the public sector at a time when strained budgets are reducing appropriations to state facilities.

Epidemiologic studies indicate that the course of major psychiatric illnesses typically includes many more than one or two acute episodes of psychiatric illness.7 Given the prevalence of these conditions in the general population (1 percent for schizophrenia, 0.5 percent for manic-depressive illness), more families face the prospects of financial catastrophe with the development of an acute mental illness. Improved funding for this type of care is needed, with the goals of stabilizing patients after exacerbations of illness and increasing the length of time between episodes of illness.

Reparative tasks. Reparative tasks aim to rehabilitate patients with impairments and disability. These needs begin while patients are acutely ill and continue into the recovery period. They are a particularly important component of the treatment plan for patients who remain severely and persistently ill, such as those with manic-depressive illness or schizophrenia. Reparative tasks include day care, assistance with household management skills, other types of community outreach, “Meals on
Wheels,” transportation, special education, vocational counseling and training, shopping assistance, protective services, and recreational activities. The following case illustrates the personal and societal effects of one patient’s lack of access to reparative services.

Case Two: Chronic Mental Illness. C.S. is a thirty-years-old single man. He had his first psychotic episode at age twenty-two, just after graduating from college and taking his first job. He was an honor student in high school and an excellent athlete. Thus, this psychotic episode took everyone by surprise. It was preceded by three to four months of social withdrawal and the persistent belief that the television was talking to him. After he was hospitalized in a private psychiatric hospital for three months, his benefits ran out. After three more months of inpatient treatment he was stable enough to be discharged from the hospital, but his family’s middle-class resources were exhausted.

Follow-up care in a community mental health center was inadequate. He drifted in and out of state hospitals over the next several years. With state budget cuts, it was impossible to integrate him fully into a community-based system. C.S. was estranged from his family because of continued suspicions he held toward them. Over a year ago he became homeless. While he lived on the street, delusions, auditory hallucinations, periodic raving, skin sores, and a chronic cough marked his precarious existence. He remains untreated. At this point C.S. needs shelter, a source of regular meals, medical care, and a structured day program. With improvement in his condition, he could begin vocational rehabilitation with the goal of resuming some type of work.

Reparative services are cost-effective and help to reduce hospital readmission rates. They also optimize a patient’s potential for return to productive activity after the onset of severe psychiatric illness. Although some insurance policies cover outpatient, day hospital, and psychosocial rehabilitation programs, many Americans are without any coverage for such reparative services. Some patients and their families can pay for these services out of pocket, but most are unable to afford them, particularly after paying for the costs of acute care. Lack of financing for long-term support and rehabilitation of the chronically mentally ill is a public health disaster.

Humanistic tasks. Humanistic tasks foster personal growth and development, primarily through psychotherapy. While supportive psychotherapy is an element of the medical management of major psychiatric conditions, people without illnesses may also seek psychotherapy for problems of human misery. In fact, the boundaries defining mental health and mental illness have blurred in recent years, so that it seems the range of human misery has been redefined as a medical or mental health problem. Mental health professionals are now consulted about problems formerly handled within families, religious organizations, or other societal channels. For example, teenage antisocial behavior, marital difficulties, and loneliness have all been redefined as problems in need of treatment, when previously they were perceived simply as the results of personal choice or misfortune. The following case illustrates...
the financial costs and personal benefits deriving from a course of therapy sought with a desire for personal growth and more satisfaction from relationships.

**Case Three: Human Misery.** I.P. is a forty-year-old, twice-married, divorced woman with chronic low self-esteem, periodic temper tantrums, labile affect, history of mild depression, and recurrent disrupted interpersonal relationships. The intense difficulties in her love life led her to seek psychotherapy three times a week with a licensed clinical social worker.

With stable employment as a research analyst for a large consulting firm, she has good insurance coverage consisting of 80 percent coverage of the first fifty visits for outpatient psychotherapy and 50 percent coverage thereafter. With a fee of $80 per session, the insurance company has paid $8,000–$10,000 per year for her treatment. Therapy has been ongoing for the past three years. She has achieved some improvement in her interpersonal functioning and more satisfaction from life. There is no anticipated termination date. With the availability of good insurance coverage, this patient has made some important personal improvements. Nevertheless, the financial cost has been high.

Coverage for humanistic tasks—that is, psychotherapy—in the current system is varied. Public-sector programs provide partial reimbursement for these services. Private plans and managed care organizations such as health maintenance organizations (HMOs) vary in coverage of psychotherapy; some provide none, others have no limits. Most have cost-sharing provisions.

The boundary question, which has always plagued the mental health sector, became particularly cogent as many more professionals entered the private practice of individual, group, and family psychotherapy, and more hospitals and practitioners engaged in advertising and marketing to fill beds. Insurers worry that as the definition of mental illness expands, their expenditures will increase. The rising costs of adolescent inpatient care during the 1980s, due in part to this development, reinforced their concerns. (It is important to emphasize that this reflects society’s changing demands on the mental health system, not simply changes within the mental health system itself.)

If patients assumed more responsibility for this type of mental health care, funds that paid for such care could be shifted to cover catastrophic expenses and reparative tasks. Without minimizing the value of these services, it could nevertheless be argued that current insurance coverage for the psychotherapy of human misery diverts excessive resources to a few well-functioning individuals.

**Social controls.** Some psychiatric conditions motivate behavior that puts other members of society at risk for physical or psychological harm. The principal examples of this type of condition are substance abuse and some of the sexual disorders. Psychiatric tasks with goals of social control are required for psychiatric patients with socially deviant behavior.
These tasks overlap with legal enforcement. In many cases the control is more important than the treatment, because society’s desire for protection from this type of behavior exceeds the desire of affected individuals to seek treatment. The following example illustrates both the social risk from, and the low personal motivation to seek treatment for, such a condition.

Case Four: Psychiatric Conditions Involving Criminality. D.P. is a forty-year-old white man, never married, with a diagnosis of homosexual pedophilia. He has a long history of inappropriate touching of young boys in his neighborhood, finally culminating in an arrest after one of his victims reported the behavior to his parents. While he was awaiting trial on multiple charges of sexual abuse of these minors, D.P.’s lawyer referred him for psychiatric care. The patient, facing almost certain prison time if he refused consultation, agreed to the evaluation.

Treatment for his paraphilia included an inpatient admission with long-term follow-up in group and individual psychotherapy. He received depo-Provera injections to help reduce his libido and inappropriate sexual urges. Given his stellar cooperation with psychiatric treatment, the patient was given probation, contingent on ongoing treatment of his sexual disorder. D.P. had been employed in a large company with general insurance benefits, which paid for his individual and group psychotherapy. The patient paid for his medication out of pocket. After his visit limits were exhausted, the patient paid for this treatment out of pocket as well.

In this case the patient could afford treatment not covered by private insurance. He was also motivated to remain compliant with care because the alternative was a prison sentence. However, there are many people afflicted with such conditions who are unable to afford psychiatric treatment or who require external control such as legal charges to force them into treatment.

Although they make up just a small portion of the overall epidemiology of mental disorder and disability, these headline-grabbing issues are essentially neglected by the current financing system. Their coverage is patchy; in some instances, patients are responsible for treatment costs. Some insurance plans cover psychotherapy and inpatient costs. At this time, social programs do not directly allocate funds for these psychiatric services. However, society sustains high indirect costs when such services are neglected.

In our assessment, health insurance has failed individuals who experience a several mental disorder and their families. Coverage for acute treatment is inadequate, far less than what is available for general medical treatments of patients with serious physical illness. Coverage for chronic, catastrophic mental illness is nonexistent, exacerbating the public health crisis of severe mental illness in the community. Allocation of resources to treatment for individuals with higher social functioning (who can nevertheless benefit from psychotherapy) complicates
the establishment of priorities within cost constraints. Financing the care of patients with mental disorders who create social control problems is not even addressed in the current system. Policy changes, as we outline below, are necessary to remedy these failures in financing psychiatric care and to make access to comprehensive psychiatric services a societal priority.

Reform Options

Financing of medical tasks. The current health insurance system is designed to cover acute medical services. However, it fails to provide adequately for the acute medical needs of the severely ill psychiatric patient. Benefit reductions, including limits on outpatient visits and inpatient days, and high coinsurance and deductibles create barriers to the medical tasks of psychiatric care. Simultaneously, some plans may overdedicate resources to psychotherapy benefits. Social control tasks are covered incidentally for some patients. Rehabilitative tasks are covered through such benefits as inpatient occupational therapy reimbursement, but a comprehensive approach to reparative tasks is lacking in the current system.

By rendering explicit each type of psychiatric service and then prioritizing them, the potential exists to improve financing of each area. Similarly, policymakers likely will find it necessary to clarify the distinction between severe, disabling mental illness and less disabling conditions. In this paper we place human misery problems in the latter category. A shift of resources within insurance plans, whether public-sector programs such as Medicare and Medicaid or private insurance plans, could remedy these imbalances.

We recommend the following mental health insurance reforms: (1) Increase cost sharing for psychotherapy for problems of human misery, while leaving it a part of the current health insurance benefit structure; (2) make explicit those treatments whose primary goal is social control and remove them from health insurance reimbursement; and (3) separate rehabilitative services from acute medical treatments and reimburse them under a separate benefit.

The model benefit plan described by Richard Frank, Howard Goldman, and Thomas McGuire elsewhere in this volume of Health Affairs provides a workable plan for financing the medical tasks of psychiatry. The model benefit plan would be used primarily to finance the acute medical services component of psychiatric care. It would cover catastrophic costs, with cost-sharing provisions to deter unnecessary use. Although designed for private-sector insurance plans, this plan could be
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adopted in the public sector as part of Medicare or Medicaid or as part of a universal health insurance program.

In this type of reform, policymakers would face such issues as reimbursement of nonphysician providers and the potential need for copayments and benefit limits. Global budgeting, with explicit priorities and limits on different types of acute medical treatment and psychotherapy, could be used to make these determinations.

More fundamental reform, such as a universal health insurance system, would be necessary to ameliorate the failures of the current insurance market resulting from adverse selection, cost shifting, and financial barriers to private insurance. We discuss specific issues relating to this type of reform elsewhere.8

Financing of care beyond health insurance. While adoption of a plan such as the model benefit proposal would improve financing of acute medical services, key aspects of psychiatric care would remain underfinanced. Indeed, insurance should not be asked to do the job of all social policy. Limiting its goals would help to dispel the myth that increased coverage would lead to more care. Financing of nonhealth-related psychiatric tasks should be treated differently from general health conditions under health insurance.

Major mental illnesses typically have a relapsing and remitting, if not downhill, course. Although one cannot predict when patients diagnosed with these conditions will get sick, it can be predicted that they will. For patients with severe and persistent mental illnesses such as schizophrenia, the reparative tasks are key. These include rehabilitation programs, residential living arrangements with varying degrees of supervision and support, and other types of community outreach. These cost-effective services should have priority equal to the treatment of acute psychotic symptoms. A new public-sector entitlement is necessary to finance these reparative tasks.

Patients diagnosed with the major psychiatric illnesses would qualify for this benefit package. Reform would require a plan for diagnosis based on standardized criteria such as those found in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). It also likely would require a measure of functional status. The difficulties inherent in assessing both diagnosis and level of functioning are well recognized, yet they need not prevent an attempt to determine this patient pool.

In 1978 David Mechanic outlined major issues in the design of mental health benefits under national health insurance.9 In his paper he touted the potential advantages of a capitation system to encourage mental health organizations to seek the most efficient mix of therapeutic and
rehabilitative programs along a continuum of care. Several managed care plans attempt to provide some of these incentives, but with so many payers and so few patients in any given program, it is difficult for an organization to be responsive and to develop the necessary economies of scale to become financially sustainable over the long term.

Capitated approaches also may be quite appropriate for long-term catastrophic illness. A longitudinal perspective is essential for the development of sensible policy to finance care and move from a simplistic model of paying for acute treatment. Such a system could be responsive to the basic need to plan for services over the long term with enough flexibility to respond to the intermittent and changing needs of individuals with severe mental illness. This new public-sector entitlement could be implemented by either the public or the private sector.

A system of prospective capitation would set rates based on health status or risk. Termed “risk-adjusted capitation,” it is based on the patient’s past use of services, current health status, and level of disability. Issues for this type of reform include determination of the types of organization eligible to receive funds, how rates would be set, and how competition would be regulated or encouraged within a given market area. Proxies for procedures also would be required, and the diversity represented by nonphysician therapists again adds complexity to such a system.

Social health maintenance organizations (SHMOs) have been implemented in some communities. These social insurance programs use global budgeting to control costs while providing continuity of care and a broad spectrum of services required under the reparative tasks of psychiatry. One such prospective allocation method is currently in use in Rochester, New York. The primary goal of this project is to provide community agencies with fiscal incentives and flexibility to expand outpatient treatment and residential services for the severely ill and to integrate social welfare supports effectively for this population.

Capitated financial incentives move care from the hospital to outpatient settings; from nursing homes to private homes; from single-room-occupancy hotels to supervised group residences; from costly acute care to more cost-effective, long-term, community-based treatment systems. Ultimately, this system moves from a philosophy of “cure promising” to “care providing.”

Financing of humanistic tasks. Given that psychotherapeutic treatments were in ascendance at the time that insurance companies were broadening their coverage of psychiatric services, current policies often pay well for the humanistic tasks of psychiatry. These treatments were also the mainstay of therapy for major mental illnesses, until the devel-
opment of medications relegated supportive psychotherapy to a secondary role in the therapy of these conditions. As a result of these forces, psychotherapy for issues of human misery is overfinanced in some policies, at the expense of coverage for catastrophic illness. This imbalance could be corrected by increasing cost sharing for psychotherapy as contrasted to medical management.12

Some patients receiving psychotherapy do not suffer from major mental illness and in fact often function very well. It is easy to argue that some personal financial responsibility is appropriate for these treatments. This concern could be addressed by including cost-sharing provisions in insurance coverage of psychotherapy of well-functioning individuals. The model benefit plan would support such an approach to the humanistic tasks of psychiatry, with cost sharing required of patients. This introduces the element of personal choice for seeking such services.

In a health system with resource limits, prospectively setting priorities is a way to improve equitability, in that individuals are all subject to the same limits. In this way, society’s choices regarding resource use are made explicit.

**Financing of social control tasks.** Public policy regarding the financing of mental health care should include social control issues related to deviant behavior and other forensic issues. A portion of public program budgets could be explicitly allocated for this type of psychiatric treatment. The criminal justice system also could contribute to the treatment and rehabilitative needs for this costly subgroup of the mental health system. The model benefit plan also could be included as one aspect of financing these tasks, with patients sharing some financial burden for their care.

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**Conclusion**

Fee-for-service health insurance has emerged as heavily biased toward a medical model and procedural medicine. This has led to difficulties in financing the essential nonmedical tasks of psychiatry, defining boundaries of care, developing proxies for “procedures” such as hospital days, arbitrating political battles by nonphysician mental health professionals for independent practice, and determining insurance coverage entitlement. To continue to expect the current health insurance system to finance the comprehensive needs of the severely mentally ill is to court failure.

Many aspects of psychiatric care could be paid for through some form of universal financing, which eliminates costly administrative redundancies while providing incentives for the best-trained professionals, medi-
cal and nonmedical, to care for patients most in need. Under this reformed insurance system, mental health would be treated differently than general health is treated. To best use limited health care resources, an approach is needed that bundles the payment for acute and rehabilitative care and provides for a continuum of services oriented toward the severely mentally ill. The most qualified professionals will gravitate to systems and preferred organizations with those financial incentives, in contrast to current incentives, which lead practitioners away from multidisciplinary organizations that care for the severely and chronically ill.

The current interface between the public and private sectors in mental health care is unclear. While the need would remain for public funding, given societal benefits deriving from psychiatric care, the presence of the public-sector delivery system preserves an illusion of care, where in fact appropriations are rarely tied to demand. Although the proposed reforms could be implemented in the public sector, they potentially eliminate the need for a state hospital system to deliver psychiatric services. Instead, resources could be allocated from public budgets to private sector delivery systems. With a model insurance benefit to cover the medical tasks, a capitated social benefit to cover reparative and social control tasks, patient cost sharing under an insurance model for humanistic tasks, and legal system funding for social control tasks, public-sector delivery of acute and chronic psychiatric care would become unnecessary.

Regardless of whether mental health care is provided through public or private channels, the importance of revealing the total costs of effective psychiatric treatment—including direct treatment costs and society’s indirect costs—cannot be underestimated. These reforms offer the potential for revealing total costs, by making explicit several types of care that today are financed either indirectly or not at all.

These proposals suggest the need for thorough reform of the current health insurance system to pay for necessary psychiatric care. We do not presume to have explored all of the complications and contingencies created by such fundamental reform. However, only through an honest acknowledgement of the failure of our system can we begin to redefine a policy of “parity” and move forward with a reform that creates a system more helpful to patients, their families, and society.
NOTES


