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Ethical Issues In Policy Advocacy
by Mark Schlesinger

The literature on managed care is predominantly a mix of diverse opinions and statistical reports on service use and costs. There is all too little discussion of the ends toward which the health care system being managed ought to be directed. A paper that is sensitive to ethical concerns comes as a welcome relief. It highlights important questions about the appropriate criteria for allocating scarce resources, concerns about justice in the decision-making processes that allocate those resources, and a sensitivity to the implications of managed care that extend beyond the narrow dyadic relationship between patient and provider.

Despite these virtues, I am distressed by the basic message conveyed by Philip Boyle and Daniel Callahan. I am not troubled by their advocacy of managed care. A good case can be made for managed mental health care, at least in some forms and certain circumstances. I am concerned because their paper seems to inappropriately conflate policy advocacy with policy analysis, masking a predisposition toward resource-conserving reforms in the guise of logical argument and empirical documentation. As an economist, I do not presume to instruct two ethicists in the appropriate norms of ethical argumentation, but I nonetheless am struck by the ways in which their analysis seems inappropriately skewed in favor of their preferred conclusions. As a policy analyst, I hold to the fundamental principle that policy analysis (as opposed to policy making itself) ought to be as consistent as possible with the available evidence. Boyle and Callahan fail this test in two ways. Their paper overlooks the vast majority of empirical research on managed mental health care. In addition, they selectively use the absence of evidence to justify positions they support and undermine those they oppose. Ethical standards for policy analysis are important in their own right. In my assessment, their paper repeatedly violate those norms.

The Argument

Boyle and Callahan have a clear and important goal: to make the case that mental health care can be “managed” in an ethical manner and to develop some criteria for determining whether particular managed care practices meet these standards. The authors identify and develop some important and plausible principles: (1) a continuum of obligations, suggesting that the most intensive care go to those with the most severe but treatable needs; (2) limits on acceptable contractual arrangements between plans and providers, discouraging powerful financial incentives or “coercive” practice guidelines; (3) constraints on the amount of information that plans collect about enrollees and the uses to which plans put that information; (4) requirements that plans provide an adequate amount of information to their enrollees; and (5) expectations that plans allow greater participation in decision making, exemplified by the creation of “representative consumer/provider panels.”

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They also effectively critique a variety of less plausible claims, the sort that often appear in editorials written by clinicians in professional journals.

This analysis is effectively, if briefly, developed. The argument begins to falter, though, when Boyle and Callahan attempt to demonstrate that managed mental health care now meets these standards. Part of the problem rests in their use of evidence, which I discuss further. The logic of the analysis is also flawed in that it oversimplifies morally relevant distinctions, it misleadingly portrays the “problem” requiring resolution, and it holds managed and unmanaged care to different standards of performance.

Whatever one’s preferred standards of justice or equity, it seems universally agreed that a consistent ethical analysis ought to treat like people or situations alike, while distinguishing among those people or circumstances that are different in morally relevant ways. It thus is puzzling when the authors announce that they will “talk simply of managed mental health care,” since widely available evidence suggests that certain forms of managed care plans more reliably address mental health needs for outcomes that are “morally relevant” by the authors’ own standards. This simplification is even more perplexing in light of the authors’ recognition that access to care for the mentally ill is sensitive to the forms that managed care can take and that certain payment arrangements raise troubling “ethical concerns.” The overly simplified description also blinds the boundaries of what constitutes managed care. The authors consistently compare “managed care” to “fee-for-service care.” But the latter refers to a method of provider payment and says nothing about the organization or regulation of services. These muddled comparisons raise serious doubts about the authors’ assessment of managed care in any of its forms.

Blanket discussions of the mentally ill are equally problematic. Boyle and Callahan count as morally relevant the distinction between persons with more or less severe conditions, but they apparently fail to see any relevant differences between chronic and acute conditions, publicly and privately insured patients, or substance abusers versus persons with other conditions. The importance of the first two distinctions seems to follow from the authors’ own principle of “not to further disadvantage the already disadvantaged.” All three distinctions have been shown in the literature to be associated with morally relevant differences in the outcomes associated with managed care. Masking these differences loses much of the ethical and policy content of this issue.

Throughout the paper the authors appear more concerned with furthering a particular conclusion than with providing a balanced assessment of the relevant arguments. This is initially evident when they introduce managed mental health care. They suggest that its advocates see managed care as a remedy for problems in the contemporary mental health care system. They characterize the arguments of its critics as asking if the cure is worse than the disease. For the rest of the paper, Boyle and Callahan subject concerns with the “cure” to careful scrutiny. But they never do the same in their portrayal of the “disease;” arguments about the failings of the existing system are taken as given, with minimal supporting documentation. Readers are expected to accept that the costs of mental illness are “possibly” threatening international competitiveness, that these costs are so out of control that they require compromises in continuity of care, that opponents of managed care question whether it is “ever defensible to limit or deny care,” and that most users of outpatient mental health care services are no sicker than Woody Allen (now that’s reassuring). In the interest of space, I consider only the first and last of these claims.

Is it the case that mental health/substance abuse (MH/SA) treatment costs are burdening U.S. businesses? Since most economists believe that higher health benefit costs are almost fully offset by lower wages, these costs probably create no competitive disadvantage at all. But one can assess the validity of this argument without recourse to economic analyses. Since MH/SA costs average 10 percent of all health costs, and health benefits as a whole average less than 10 percent of employee
compensation, even if these costs were entirely borne by employers and fully translated into higher prices, this represents less than 1 percent of the price of a typical product—hardly a major burden.4

What of the claim that “Many thought that most outpatient psychiatric services were a hobby for the self-indulgent?” It will undoubtedly surprise the four to five million Americans with serious mental illness (schizophrenia, major depression, or bipolar disorder) that they are simply cases of the “Woody Allen syndrome,” neurotically self-indulgent from having spent too much time in New York City.5 This will certainly prove a revelation to psychiatric epidemiologists.

These claims are specious, yet they are cited by the authors with little circumspection and thus given a veneer of respectability. One can certainly find real problems with unmanaged mental health care. There is considerable historical evidence of high rates of inappropriate treatment for MH/SA problems.6 But this provides a more compelling rationale for utilization review, including prior authorization, than it does for the panoply of physician gatekeepers, restrictions on outpatient treatment, and required courses of medication that are evident in many managed care plans, particularly in health maintenance organizations (HMOs). In short, by failing to diagnose the disease more accurately, the authors undermine the confidence that readers might have had in their assessment of the cure.

The third problem in the analysis stems from the authors’ failure to hold managed and unmanaged mental health care to a consistent standard. Boyle and Callahan observe, quite accurately, that many of the early charges made against managed care plans unfairly compared them with an idealized mental health care system of “Marcus Welby-type doctor/patient relationships” and “Cadillac care no matter the cost.” No managed care plan could match these ideals, any more than could unmanaged services.

But this paper simply reverses the bias. The claims of those concerned about managed mental health care are represented with rigid, universal statements that can be refuted with a single counterexample. In contrast, the claims of the proponents of managed care are extensively qualified, crafted to emphasize the potential that managed care might have. There is nothing wrong with highlighting potential benefits of managed care, as opposed to its actual performance. But this should be done explicitly. And it is simply inappropriate to compare the potential of one system (various forms of managed care) with the actual performance of another (the treatment of mental illness or substance abuse in the absence of external management), for precisely the same reasons that it was wrong in the past to compare the performance of one system with the idealized description of another.

To make an effective case for the potential of managed mental health care, the authors must demonstrate that there are institutionalized mechanisms that improve its performance over time and that make it possible to realize that potential. They make this claim “[c]omplaints about managed mental health care have been identified . . . and, where necessary, practices have been adjusted,” although they acknowledge that “some problems could still be addressed more adequately.” When it comes to specifics, the claim looks less convincing.

For example, Boyle and Callahan acknowledge that “many managed mental health care plans initially kept secret their decision protocols and criteria for network mental health services,” creating the potential for arbitrary and unjust denials of care, but they state that this all changed in 1991.

What actually happened in 1991 was that a few of the larger employers began to request that the plans reveal the protocols to their benefit consultants, and a handful of states required that the review criteria be made public.7 This made some information about utilization review more available, but it hardly eliminated the potential for arbitrary decision making, as the authors misleadingly conclude by stating that “[s]ome of the more obvious criticisms about arbitrary plans have been resolved.” On the other side of the coin, Boyle and Callahan acknowledge that plans that pay providers through capitation “cause a host of ethical concerns.” They then ignore this issue for the rest of the
paper. By so doing, they fail to give notice that the decentralized forms of HMOs that rely most heavily on capitation are also the fastest-growing part of the industry, so that these ethically problematic practices are increasingly becoming the mainstream of prepaid managed care.

A balanced assessment of managed mental health care thus requires a more finely differentiated analysis of managed care and mental illness, as well as a more straightforward description of plan performance. Policy analyses ought to educate, not draw unwary readers down a path whose direction is apparent only to the authors.

**The Evidence**

Effective policy analyses also depend on a complete and accurate summary of contemporary evidence relating to the problem at hand. Boyle and Callahan fall short of this standard, as evidenced by their failure to effectively review the empirical literature on managed mental health care as well as their inaccurate claims about contemporary managed mental health care practices.

The first of these failings casts the gravest doubts on the authors’ claims to have carefully assessed the performance of managed care. Two recently published papers have reviewed the impact of managed care on enrollees with mental illness. These papers identified roughly thirty empirical studies of managed mental health care produced in the past fifteen years and ten earlier papers that had reviewed previous empirical literature on this topic. (This does not include various editorials or anecdotal reports in the clinical journals.) Boyle and Callahan cite only one of these empirical studies and two of the older review articles.

These omissions are problematic for several reasons. First, the authors discount some criticisms of managed care, most notably those associated with patient/provider relationships, on the grounds that “there is little evidence that this problem exists.” Although it is true that there has been little empirical research on the nature of the patient/provider relationship under managed mental health care, one of the most consistently repeated findings in twenty-five years of research on HMOs has been that the quality of patient/provider communication is lower in prepaid settings than under unmanaged fee-for-service arrangements, particularly in solo practice settings. Although we do not know how this translates to patients with mental illness, recent findings from the Medical Outcomes Study (which included a substantial number of patients with depression) suggest a similar pattern: 67 percent of respondents in solo fee-for-service practices rated the quality of physician explanations excellent, compared with 50 percent in HMOs and 46 percent in multispecialty prepaid group practices.

A second problem relates to the quality of the evidence that the authors do cite. On the critical question of the comparative quality of managed mental health care, the authors conclude that based on preliminary research evidence, “quality of care in fee-for-service mental health care is similar to that in managed mental health care.” They base this conclusion on three studies: one that followed patients for a year before the demonstration project was discontinued, the second a report in a trade publication, and the third a study of managed Medicaid programs that had nothing at all to do with mental health care. They ignore research such as the Medical Outcomes Study, which demonstrated somewhat worse outcomes for enrollees with depression in HMOs than for those in other insurance arrangements.

The authors’ failure to adequately review the empirical literature is nowhere so apparent as in their central claim about the quality of managed care. They argue convincingly that one must have some ethical norms for determining how to allocate scarce medical resources and posit a “continuum of obligations” that would distribute the most resources where illness is most severe and care potentially most effective. What the authors fail to ask is whether prevailing practices in the managed mental health care industry in fact meet these standards. Even a casual review of the empirical literature raises serious doubts. For the past twenty years HMOs have routinely excluded any coverage of
chronic mental illness, a practice that remains common today.) Does this distribute resources toward the most severely ill? Many HMOs rely on primary care gatekeepers to authorize access to mental health services.\textsuperscript{14} But the Medical Outcomes Study, along with other research, has documented that primary care providers are often ill trained to effectively diagnose mental illness, making it impossible to reliably direct resources to those with the most severe needs.\textsuperscript{15}

While the paper’s inadequate review of past research casts the most doubt on its conclusions, the authors’ tendency to assert knowledge about industry practices or other aspects of mental health treatment is perhaps the most perplexing feature of the paper. Let me illustrate with a final example.

Boyle and Callahan conclude their discussion of informed patient choice by stating that “[m]any managed mental health care plans [and employers] . . . already have spent a great deal of time and money making clinicians available to enrollees on a toll-free telephone line twenty-four hours a day, sending extensive written and video communication kits, and providing expert trainers for employee meetings on newly managed mental health care benefits.” Sounds quite impressive. While I cannot fully assess this claim, I do have some relevant data from a survey of the utilization review industry conducted in the winter of 1993-1994.\textsuperscript{16} Utilization review organizations were asked about their patient education practices. As shown in Exhibit 1, some review organizations do actively educate patients. However, (1) mental health specialty firms are less likely to do so than their general medical counterparts are, and (2) there is no evidence of the extensive distribution of communication kits or training classes, on which managed mental health firms are purportedly spending so much time and money.

### Conclusion

Effective policy analysis of a topic this complex is no simple task. Boyle and Callahan make some important contributions to our thinking about managed mental health care by elucidating some of the ethical issues and potential standards by which one might sensibly judge plan performance. Had they stopped there, they would have had a cogent (albeit short) addition to the literature. But they need not have stopped there. As the authors suggest, the ethical issues associated with managed mental health care go beyond the patient/provider relationship and extend into areas only hinted at in this paper, including: (1) the just provision of health and other benefits through the workplace; (2) the appropriate demands to place on professional service providers, in terms of their autonomy, authority, and responsibilities to patients or society; and (3) the equitable allocation of societal resources to meet the health needs.

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**Exhibit 1**

**Frequency Of Various Patient Education Practices, By Type Of Review Organization, 1993**

<table>
<thead>
<tr>
<th>Form of patient/enrollee education</th>
<th>Percent of all medical and surgical UROs providing</th>
<th>Percent of all mental health specialty UROs providing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct mailing of educational material</td>
<td>56.8%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Videos or instruction manuals</td>
<td>12.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Classes for patients/enrollees</td>
<td>10.2</td>
<td>6.7</td>
</tr>
<tr>
<td>Patient advisory telephone number</td>
<td>50.0</td>
<td>46.7</td>
</tr>
<tr>
<td>No educational materials or programs</td>
<td>13.6</td>
<td>20.0</td>
</tr>
</tbody>
</table>

*Source: Unpublished data collected by the author.*

*Note: UROs are utilization review organizations.*
of dependent populations, relative to their needs for housing, financial benefits, or other support services. These are questions of far broader scope than managed care or mental illness per se, yet each is distinctly shaped by the nature of the managed care process for mental health services.

The diversity of these related questions suggests another unexplored issue: Boyle and Callahan tried to determine whether managed care was more or less ethical than some alternative institutional arrangement. Given the multiplicity of ethical standards by which both philosophers and the public assess medical care, this may simply not be the right question; it certainly isn’t the only ethically important question. One might instead have asked how effectively managed care responds to the diversity of ethical norms that different people or groups seek to impose on the U.S. health care system, or the varied norms by which Americans judge different types of health care needs. Precisely because mental health issues cross beyond traditional medical domains, they are more likely to be judged by a variety of ethical standards. Indeed, perhaps the most intriguing potential for a managed care system involves its ability to develop a decentralized, heterogeneous response to moral pluralism. How to ensure that a system of managed care, as opposed to individual plans, performs in a reasonably ethical manner is thus a critical challenge for future work.

Instead, the authors clearly felt the need to go beyond a conceptual treatment of ethics. In attempting to legitimize the principle of constrained resource allocation, they wound up defending an array of institutions and practices that have emerged within the managed care industry. The first goal was both sensible and timely; the second was far more questionable, vastly complicated by the breadth and diversity of the managed care enterprise. And by striving for simple, policy-relevant conclusions for a policy-oriented audience, they left themselves in an untenable position. A compelling case simply could not be made with the evidence they mustered. More careful review of the literature could generate more evidence but not more convincing proof. Nor could supplementing the evidence with additional assertions or cleverly cast arguments make the case sound.

Although I conclude that Boyle and Callahan end in an untenable position, I find both their initial position and their preferred principles for change quite appealing. There is no reason to think that one cannot formulate a fully ethical model (or models) for managed mental health care and develop supportive public policies. There is, however, also no reason to think that these should be simple-minded policies, such as making the world safe for some generic version of managed care that enrolls some archetypical person with mental illness. Public policy can deal with managed care in a more differentiated manner. Indeed, it must. There is little reason to believe that either market forces or professional norms are sufficient to encourage the evolution of the forms of managed care that will in fact promote an equitable allocation of care to the mentally ill. If anything, trends in our relatively unregulated current system suggest exactly the opposite. By more carefully and completely acknowledging the ways in which contemporary managed care practices fall short of the ideal, it should be possible to develop remedial policies that ensure that future performance is in closer accord with the needs of both persons with mental illness and the society in which they live. Masking these shortcomings does more to raise ethical questions than it does to answer them.

NOTES


2. Following some papers in the literature, Boyle and Callahan may have intended to distinguish network-based managed care (plans that have defined groups of providers) from other forms of insurance. See, for example, R.H. Miller and H.S. Luft, “Diversity and Transition in Health Insurance Plans,” Health Affairs (Winter 1991): 37-47. Since both forms of insurance can incorporate various types of managed care, for the authors’ purposes this dis-
tinction is just as muddled as the one to which they refer.


4. One could be a bit more sophisticated in this calculation. Since employers in other countries are also paying for health care costs, typically through taxes financing national health insurance plans, the only real effect on the competitive position of U.S. manufacturers involves the extent to which MH/SA treatment costs in this country exceed those costs in other countries. Even if one assumes that the highest rates of inappropriate care reported in the literature (roughly 40 percent of all hospitalizations) occur only in the United States and are translated completely into higher product prices, they could account for at most 0.25 percent of the cost of even the most labor-intensive products.


15. L. Eisenberg, “Treating Depression and Anxiety in the Primary Care Setting,” Health Affairs (Fall 1992): 149-156.

16. For a more complete discussion of the survey and an application to a different set of questions about managed care, see M. Schlesinger et al., “Charity and Community: The Role of Nonprofit Ownership in a Managed Health Care System,” Journal of Health Politics, Policy and Law (forthcoming).


18. The notions of multiple standards of justice, linked to different social domains, was developed at length in the early 1980s, at a philosophical level by Michael Walzer, Spheres of Justice (New York: Basic Books, 1983) and in empirical terms by Jennifer Hochschild, What's Fair! American Beliefs about Distributive Justice (Cambridge: Harvard University Press, 1981). Perhaps the clearest distinctions involve the norms of justice that most Americans apply within the family versus those generally applied to market transactions or those related to “basic needs.” Since MH/SA problems have important ramifications in all three of these domains, they will inevitably tap into complex and sometimes conflicting norms of equity. See also the discussion by James Sabin and Norman Daniels cited in the Boyle/Callahan paper (Note 38).

Broadening The Ethical Analysis Of Managed Care
by Richard C. Surles

Philip Boyle and Daniel Callahan provide an excellent summary of the array of current ethical challenges encountered in the application of managed care to the treatment of mental illness. They systematically analyze each of the major issues within the contexts of both unmanaged and managed mental health care. They argue that current moral analysis has centered too narrowly upon aspects of the therapist/patient relationship, such as questions of patients’ access to and interactions with therapists. Thus, the current debate has produced an examination of issues at precisely the wrong level.

But Boyle and Callahan do not take the debate to the next level—the interface of
the organization managing care and the enrollees in the behavioral health care program, which is an entirely different and potentially more enlightening discussion of ethical and moral behavior. Ethical analysis could then focus more on considerations such as informed consumer choice of health care plans and the responsibility that managers of those plans have in responding to requests for assistance. Discussion of contractual obligations between plans and therapists also could be considered, as could the moral issue of viewing care delivery more as a cost allocation process than an open-ended obligation.

Managed behavioral health care is a specialized technological innovation composed of sets of carefully planned protocols, which blend advanced information technology with clinical decision-making systems. It is also the most practical milieu in which to explore the relationship between the care delivery system and the patients who are served. Under managed behavioral health care, the initial assessment of a patient’s request for care should lead to a referral, based on clinical criteria addressing the patient’s needs, to a therapist within a comprehensive provider network. In addition, the managers of behavioral health care organizations should be continuously updating their technologies and should create incentives to lower the risk of adverse treatment outcomes for persons in their specialized plans. The examination and monitoring of these evolving managed behavioral health care techniques are crucial in assessing operational ethics in the delivery of care.

One could go even further with the logic suggested by Boyle and Callahan and raise moral questions about whether the present preoccupation with a technical innovation has precluded in-depth policy discussions on a national strategy for mental health care reform. In effect, the national debate regarding the use of managed or unmanaged care avoids the even more volatile debate over universal coverage and financial responsibility for health care coverage. By shifting to a confrontation on the merits of the techniques for managing available financial resources, strategies involving single-payer systems, employer mandates, and uncompensated care are left for another period in our history. Thus, the debate over the morality of managed care fills the moral vacuum resulting from the absence of concerted efforts to achieve national health care reform. Combined with a thesis that managed behavioral health care may force unplanned or unwanted changes in the health care environment, it becomes apparent that this technical innovation may now be a tail that helps to wag the body politic.

Considering the various interests at work within the health care arena would be a good first step in understanding and addressing concerns about how private action affects the delivery of mental health care in the absence of comprehensive public policy. One could seek to clarify the objectives of those who advocate managed care. Clearly, managed care organizations have an interest: the growth of a new industry and the creation of profitable organizations in the business of managing care delivery. Similarly, mental health care providers have an interest in maintaining a patient flow that is sufficient to sustain their practices and are rightfully concerned that managed behavioral health care could limit referrals and reduce their incomes.

Boyle and Callahan suggest in their overall analysis that the policy and implementation of managed care need not be considered a creation of an immoral force. Instead, they state that “we believe that managed mental health care need not be judged any more inequitable than the present mental health fee-for-service system and, if anything, can be judged potentially more equitable and accountable.”

Continuing to focus the debate at a lower level of analysis, especially in the area of mental health treatment, leaves out significant questions about the care and treatment of mental illness. By focusing on the management of care, we may overlook an erosion of mental health services and resources within the larger health care system. Probably the greatest potential risk would be stalled progress in mental illness treatment methods. Our new understanding of managed behavioral health care approaches
could be overshadowed by the debate on managed versus unmanaged health care systems. Contentions about the merits of technical innovations over more time-honored behavioral health care financing techniques may preempt serious review of the importance of mental health services system design within the overall health care field.

A fundamental issue missing from the current technological debate is the fact that millions of people have little or no access to mental health services because they simply lack adequate insurance coverage for mental health treatment. Discriminatory limitations on mental health benefits within comprehensive health care plans remain the status quo. Moreover, the historic financial contributions of state and some local governments for supplemental coverage also could be lost unless these resources are blended into comprehensive plans for behavioral care. As pressure for overall health care cost containment increases, mental health benefits could be an early casualty. Although managed care could be a convenient method to trim costs and yield savings to support underfinanced health plans, greater leadership and support are needed at the public policy level.

Restricting the ethical and moral debate to technological considerations can be seen as a means of avoiding the more difficult issues. For example, as for the needs of persons with more severe forms of mental illness, the current emphasis on Medicaid managed care has largely ignored the issues of poverty, disability, and the need for ancillary supports beyond what is customary in health care. The nature of a long-term mental illness makes employment difficult, and a high percentage of Americans on Social Security Disability income are there as a result of mental illness. Moreover, Medicaid eligibility rules and benefits vary dramatically from state to state, and many persons experience rapid changes in their eligibility status. Among those with severe mental illness, the combination of poverty and the complexity of Medicaid eligibility are a constant threat to maintaining both health and mental health coverage.

The ethical and moral debate should not be dominated by what are essentially details of the emerging technology of managed care. The debate also should find a place for substantially improving the understanding of the course and treatment of major mental illness, including the linkage and financing of ambulatory services such as supported living and social casework. In addition, a framework needs to be created to recognize the historic roles states have played in either providing or financing mental health services. Further, shifting the legal and financial responsibility for treatment and coordination of mental health to prepaid plans for persons fortunate enough to have coverage must be analyzed in terms of the long-term consequences for those who have either no coverage or a grossly inadequate benefit.

Boyle and Callahan are correct to point out that we may be having the wrong debate. There is a serious risk that if excessive attention is focused on managed care, mental health services in the United States could become even more irrationally financed, and even greater numbers of persons could lose access to care. Given the very nature of severe mental illness, failure to intelligently address treatment and delivery system needs could create a short-term decline in behavioral health care costs, but certainly an escalation of both health and social services costs would follow as untreated illness eventually creates even greater needs.

Managed care could be an excellent strategy for assuring appropriate access as well as medical coordination and responsible treatment, especially for persons with severe forms of mental illness. However, underfunding of mental health care within prepaid health plans could totally undermine a beneficial innovation. So could ignoring the health and social public policy questions that must be answered in order to adequately coordinate the relationships among basic income, health status, and quality of life.
Organized Psychiatry And Managed Care: Quality Improvement Or Holy War?
by James E. Sabin

The front lines of mental health practice are sharply divided over whether to wage a scorched-earth, take-no-survivors holy war against the “great Satan” of managed care or to pursue a quality improvement strategy of making managed care better.

The 1995 campaign for the presidency of the American Psychiatric Association displayed this struggle with unusual clarity. The winning candidate (with a 51 percent margin) described managed care systems as greed-driven sharks that “ravage health care for profit” and argued that psychiatrists “must never accept them . . . we must fight them with all our resources.”

The losing candidate criticized many aspects of managed care practice but concluded that “managed care is here to stay” and urged psychiatrists to “fight mangled care, but also creatively adapt. . . so that we manage care with our patients and move on to the next phase [possibly a single-payer system].”

A profession torn between holy war and quality improvement is in a very poor position to influence the rapidly evolving mental health care system. Philip Boyle and Daniel Callahan offer a path out of this paralysis. Here and in other writings they establish that since even the extensive resources the United States allocates to health care will not allow every person to receive every potentially beneficial intervention, an ethical health care system must be managed (that is, priorities must be set), whether as an American-style managed competition model, a Canadian-style single-payer program, or some other way.

If Boyle and Callahan are correct—and I believe that they are—in arguing that a managed system of mental health care potentially offers better quality, access, and equity than the combination of fee-for-service and public-sector care that has prevailed since World War II, debate about the concept of managed care per se must be seen as misguided. Their analysis invites us to shift attention from the question of whether to manage care to the important policy questions about how to manage care well.

Boyle and Callahan provide important initial guidance about managing care ethically. When systems allocate resources, patients with more severe and incapacitating forms of illness should receive relative priority. During the past four years I have observed this principle in action, because the Harvard Community Health Plan (HCHP), the health maintenance organization (HMO) at which I have practiced for twenty years, has followed it since 1991.

In the late 1980s HCHP reexamined its mental health benefit (twenty outpatient visits and sixty days of hospital care per year) and, anticipating Boyle and Callahan’s recommendations, decided to remove the cap on outpatient treatment for severely impaired persons. This could only be done, however, by introducing an increased copayment for relatively healthier patients after eight visits.

In light of this policy, I have had hundreds of discussions in my clinical practice of the same general form: “The good news is that you do not appear to have a condition like schizophrenia or manic depression, but the bad news is that after the eighth visit the copayment will go up to $35;” or, “The bad news is that we are dealing with a condition that is causing [these very serious symptoms], but the good news is that the copayment will not go up, no matter how often we meet.”

Four years of clinical experience clearly suggests that although patients and families who might have gotten more or paid less under a different set of priorities are disappointed, they almost universally accept the policy itself as fair.

Once the major stakeholders in managed care have accepted managed care as something that is here to stay, our task is to ensure that it is the best possible managed system, and to mobilize the resources that we have to improve the care of our patients.
mental health care accept the authors’ conclusions that the concept of managed mental health care is ethical and that more seriously impaired patients should receive relative priority in resource allocation, we will immediately have to address a number of crucial issues that Boyle and Callahan do not consider, such as coverage for patients with personality and substance-related disorders.

However bizarre or frightening the symptoms of schizophrenia or manic depression may seem to the general public, those conditions can readily be assimilated to the model of illness and collective responsibility for care through health insurance. By contrast, personality and substance-related disorders are often seen as conditions of self-indulgence or weakness of will, more appropriately subjected to moral condemnation than to insurance coverage. Many insurance companies already refuse to cover treatment for so-called Axis II conditions (personality disorders), and despite clear evidence linking alcoholism and drug use to recidivism, many prisons have eliminated substance-related treatment programs.5

It will be difficult to consider these volatile questions with Boyle and Callahan’s calm lucidity, but that is precisely what is needed. In considering coverage policies for personality and substance-related disorders, a well-managed mental health care system will distinguish three questions and address them separately and explicitly.

First, should these conditions be eligible for coverage by collective health insurance funds, whether public or employer-based? Norman Daniels and I have argued that treatment of suffering and disability caused by any defined “disorder” in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) should fall within the scope of potential insurance coverage.6 Second, are effective forms of treatment available for these conditions? A well-managed system will be hard-nosed about this kind of question, whether it applies to asthma, alcoholism, or avoidant personality disorder. There is no moral obligation for third parties to pay for ineffective treatments, or for effective forms of treatment that, for definable reasons, are unlikely to benefit a particular person.

Finally, even if a condition is eligible for coverage and an effective treatment exists, Boyle and Callahan have shown us that it is entirely proper to ask whether the condition is of high enough priority to receive coverage within the available insurance funds. When health care priorities are considered in a serious manner, as in the Oregon process, the mental health sector overall tends to fare well. Oregon included substance-related disorders and some personality disorders in the basic benefit package but ranked others below the cutoff point.7

No society is very far along the learning curve in setting explicit priorities. Boyle, Callahan, and others will need to revisit this topic many times in the years to come. However, once we accept their conclusion that managing care is a moral imperative, not a moral crime, our society will be much more able to address difficult questions of managed care policy in a humane and caring way. If we believe that making hard choices is the right thing to do, we need not stigmatize people in order to control spending. Making hard choices inevitably causes conflict and pain, but it can be done with integrity, honesty, and respect for those involved.8

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