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MANAGED CARE IN MENTAL HEALTH: THE ETHICAL ISSUES

by Philip J. Boyle and Daniel Callahan

Prologue: Managed care in mental health, as in general health, is neither us good nor us evil us its advocates or detractors want us to believe. Critics, on the one hand, contend that managed care, as it reduces the intensity of services, jeopardizes the physician/patient relationship. Supporters counter this with evidence that managed care can broaden access to needed services, with no obvious erosion of this relationship. In this paper Philip Boyle and Daniel Callahan tackle the debate in the context of mental health care. The ethical issues are similar whether one is looking at mental or physical health; however, for mental health the population in question has unique characteristics that make the debate all the more compelling. They do not point accusatory fingers at the reimbursement system itself. “After reviewing [the problems that are unique to managed mental health care],” Boyle and Callahan write, “we believe that [it] . . . 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.”

This paper emanates from a three-year project at The Hastings Center, funded by The John D. and Catherine T. MacArthur Foundation, to examine ethical issues inherent in the distribution of resources in the health care system. Mental health is but one aspect of this project. Boyle is associate for medical ethics at The Hastings Center, a research and educational organization devoted to examination of ethical issues in medicine, biology, and the environment. He received a doctorate in theology from St. Louis University. Callahan is president of The Hastings Center, which he cofounded in 1969. He holds a doctorate in philosophy from Harvard and has written or edited thirty-one books, the most recent of which (coedited with Boyle), What Price Mental Health?, is reviewed in this issue of Health Affairs.
Abstract: Praise and blame of managed mental health care are on the rise on many fronts, including allegations that it could adversely affect quality of care, access to care, the physician/patient relationship, and informed patient choice. Given the heterogeneity among managed mental health care organizations—each with differing practices—it is difficult to sift the ethically defensible concerns from the indefensible ones. In this paper we identify and examine the different moral concerns about managed mental health care and mark which problems have been addressed or are in need of resolution. We also identify which problems are unique to managed mental health care.

The trend in health care seems unstoppable: Managed care, including attempts to manage mental health care, is on the upswing. Public reaction to this trend has been mixed, and the sentiments about managed care in the mental health sector are all the more conflicted. Those who welcome managed care in mental health—including health maintenance organizations (HMOs), vendors of managed mental health services, and employers—believe that it will benefit patients, providers, payers, and society. Skeptics believe that the trend toward managed care will limit patients’ choice of providers and treatments, reduce quality of and access to care, and disrupt the provider/patient relationship. Amid this tension, it is difficult to sift fact from fiction and ethically defensible concerns from indefensible ones.

Managed Care Proponents

Beliefs. Evidence indicates that health care and mental health/substance abuse (MH/SA) treatment costs are burdening U.S. businesses, possibly making it harder for them to compete internationally. Supporters of managed mental health care sometimes suggest that if persons now excluded from the system, or those whose health care benefits are negligible, are unable to secure access because of poor management of existing resources under the present fee-for-service system, then managing services better might mean expanded access to health and mental health services. Backers most frequently note that in general health and mental health, some services are unneeded or provided inefficiently, are marginally beneficial, and perhaps even cause further illness. They provide compelling moral reasons why managed care is preferable to fee-for-service care: It expands access to care, uses dwindling health care resources more responsibly, and cuts down on the use of unneeded services.

Background. Managed care techniques have been applied to mental health care because of unprecedented, often unwarranted expansion of mental health services in the 1980s. During this time, profit-making inpatient drug and alcohol abuse treatment programs and adolescent psychiatric programs grew exponentially. Many commentators suspected, even proved, that there was misuse—if not abuse—of intensive mental health treat-
ments, especially for children and adolescents. Many thought, moreover, that most outpatient psychiatric services were a hobby for the self-indulgent that enriched only the “worried well” and their all-too-willing therapists (the Woody Allen syndrome). To better manage the quality and cost of care and to stem the (perceived) misuse of mental health services, managing care reduced the intensity of services, for example, by limiting treatment for substance abuse and inpatient acute care in general (and long-stay inpatient care when there seemed to be little benefit to the patient).

### Managed Care Opponents

**Beliefs.** Reductions in the intensity of service engender in opponents of managed care a range of generic complaints, but especially the charge that managed care harms the quality of, and access to, care and the provider/patient relationship. They cite cases in which managed care techniques applied to mental health care have had disastrous results. These techniques include rejecting elective outpatient care and inpatient days, increasing copayments for outpatient visits, establishing gatekeepers, using nonpsychiatrists for mental health care other than medication management, and requiring specialized utilization review. Often overlooked, the new attempts to manage mental health care sometimes simply continue practices found in fee-for-service medicine, but there is renewed ethical concern about the means managed care uses to limit intensity of service.

**Background.** The fears of managed mental health care adversaries are not unfounded. Mental health services have long been the neglected step-child of health services, and the increased management of mental health services often rides on the long-standing discriminatory policies against covering mental illness. Historically, mental health services have not received the same public or corporate support as have physical health services. Private and public funding often limits mental health coverage and provides fewer benefits than those allowed for physical illnesses of the same scope and intensity. Traditional insurance plans and HMOs customarily restrict mental health benefits more stringently than they do medical care benefits, by setting caps on numbers of hospital days or outpatient visits, or by imposing annual or lifetime dollar limits.

As is generally acknowledged by researchers but not the public, the causes of this unequal treatment arise in part from deep-seated convictions, if not biases. Service scandals and widely publicized crimes committed by homeless persons with mental illness fuel discrimination. In combination, these beliefs have conspired to minimize treatment and funding for mentally ill persons. Unlike those with a physical illness, persons with mental illness are often perceived to be the cause of their own problems and, for
that reason, to be less entitled to generous benefits. People with mental illness are typecast as severely and persistently ill, while in actuality many suffer only infrequent, mild episodes; people who use outpatient mental health services typically use fewer than ten visits a year. The nature of mental illness is often conceived as a dichotomy between mind and body, which tends to minimize the physical suffering and disability associated with mental illness. Even within the mental health field, some wish to distinguish biological from nonbiological mental disorders to give priority to the former in hopes of gaining access to (higher) medical benefits.

A long-standing complication for mental health advocates is a relative lack of proof of the effectiveness of mental health treatments. Remedies for the severe and persistently ill are perceived to be almost futile, and relief for the worried well is thought to be discretionary; care is typically thought to be lengthy and expensive. While these contentions are somewhat overstated, in the absence of convincing research it is often difficult to distinguish established interventions from the latest fad. The lack of agreement regarding effectiveness gives rise to conflict even among mental health advocates. They argue, for example, about the value of psychotherapy as compared with more medically oriented services, the appropriateness of involuntary or other hospitalization, and the effectiveness of family-based or group interventions. The lack of good data on treatment expenditures and costs increases the disagreement over effectiveness.

### Rhetoric Or Reality?

Ethical analysis in this situation is difficult, given the varied understandings of managed care and managed mental health care. Managed care is a catch-all term that is popularly associated with entities such as group and staff-model HMOs, individual practice associations (IPAs), and preferred provider organizations (PPOs). Many organizations might be characterized broadly as managed care because they adopt certain techniques, such as assuring cost and quality of care, assuming risk, and offering comprehensive services within a budget. This broad characterization includes organizations not traditionally perceived to use managed care structures, such as some Medicaid programs and state mental health departments, which are in the early stages of more aggressively managing care. Some kinds of managed mental health care are more difficult to identify than others. For example, HMOs that have fully integrated and comprehensive mental health services have a claim to the name of managed mental health care. However, other providers of mental health care that do not provide comprehensive services—such as vendors of mental health services to HMOs, employers, and states—are also considered by many to manage
mental health services. These structural differences complicate an ethical analysis. Allegations may apply to some but not to all entities that manage mental health services. For example, not all plans capitate benefits, and those that do cause a host of ethical concerns. Many managed mental health care vendors offer whatever product purchasers of these services want, and the ethical problems might only become apparent if and when HMOs or purchasers limit services.

While recognizing that these differences can affect the ethical analysis, we nonetheless talk simply here of managed mental health care. Our contention is that managed care is inevitable, but this need be no more morally troubling than the present fee-for-service mental health system. If anything, attempts to manage care are or could be less morally doubtful. Complaints about managed mental health care have been identified (if not overstated by its critics), and, where necessary, practices have been adjusted, although some problems could still be addressed more adequately.” Equally important, there are some complaints not generally found in managed care, but unique to managed mental health care, that must not be overlooked, The nature of mental illness, decision-making problems for persons with mental illness, and the services necessary to treat persons with mental illness create special ethical and public policy challenges.

### Specific Criticisms

Allegations about ethical issues in managed mental health care often entail several overlapping claims, some of which apply to managed care in general. Our intent here is to disentangle these claims and show that some (though not all) have features that are easier to respond to than the critics of managed mental health care suppose.

One generic concern about managed care that underlies almost all of the widely publicized complaints is the practice of limiting or denying services. Supporters of managed services believe that working within a budget with fiscal and clinical accountability is potentially the greatest virtue and moral defense of managed care—the key to good and affordable care. Of course, budgets, by definition, limit the use of services. But managed mental health care is hardly the only system that limits services. The fee-for-service system also does so. Managed mental health care, however, raises awareness that limits or denials affect not only those previously affected—the poor and those with catastrophic needs—but also middle- and upper-class purchasers who previously could get whatever they wanted, whether or not it was medically necessary or appropriate.

The public concern that new limits are being set needs to be addressed straightforwardly. Is it ever defensible to limit or deny care? Those uneasy
with limits or denials believe that the practice is either unnecessary or unjustifiable, although this uneasiness is sometimes absent in discussions about how fee-for-service medicine limits or denies care. Nonetheless, there is the pragmatic realization within managed care, if not in society as a whole, that there is no “artesian well” of health care resources. In fact, there is justifiable doubt that the health care system can ever offer everyone everything they need or want, given legitimate competing demands for our financial resources from such areas as public safety, education, and defense, and the public’s increasing unwillingness to pay more in taxes for these public services. Let us turn to some more specific criticisms.

Criticism one: Managed mental health care could adversely affect quality of care. Significant criticism is based on the assertion that the means of containing or cutting costs in managed mental health care will necessarily have an adverse effect on quality of care. Several kinds of evidence underlie this criticism. Critics argue that quality of care could be harmed because managed care uses less costly providers and treatments and a lower intensity or quantity of services. Quality also could be harmed, critics say, by the use of nonpsychiatric mental health gatekeepers who, they allege, are often unaware of, or insufficiently trained or unconcerned about, the effect of their decisions on treatment quality. Finally, critics claim that heavy reliance on outcomes data and practice guidelines—subordinate to the effort to manage mental health services—could be premature; it has not yet been established that using them improves quality.

Assuming that there is an obligation to protect quality of care, what kind and level of service is necessary to produce acceptable quality? The short answer is that there is no agreed-upon kind or level of care. Preliminary research evidence suggests that quality of care in fee-for-service mental health care is similar to that in managed mental health care. One study finds no consistent evidence that enrolling chronically mentally ill Medicaid patients in prepaid managed care causes any harm, at least in the short run. Bolstering this study is some general evidence on quality of care. A March 1993 US. General Accounting Office (GAO) study of six states, for example, concluded that states that have turned to Medicaid managed care provide the same quality as fee-for-service health care provides. Yet even with this preliminary evidence, there remains doubt about how to define and measure quality of care in managed systems.

When quality of care is framed as a factual issue, it unfortunately eclipses the more significant normative issues: What level of quality do we have a social or moral obligation to provide? In the face of uncertainty about quality, how and where should the health care system set the standards and limits? The short answer to these questions is: When there is little evidence about quality, it is commonly justifiable to provide more services, but not
necessarily the most expensive services, to those persons who are the sickest. Several moral considerations establish this moral presumption.

Quality of care is often mistakenly connected with quantity of care. Contrary to popular opinion, more services do not necessarily mean better outcomes. More services may actually increase the potential for undesirable medical, psychological, and social consequences. Lower intensity or quantity might mean better quality. This justification for fewer services grows stronger in the absence of a good definition of quality.

Even with an elusive understanding of quality and uncertainty about how to prove it, managed care is not left without a moral rudder. It is plausible to posit a continuum of obligations.¹⁹ In the absence of good arguments to the contrary, there is less moral obligation to provide a high level of services if an illness is comparatively mild and if doing without the services is likely to have little adverse impact on a patient’s mental health. There is a greater moral obligation to provide more services if an illness is comparatively severe and if an absence of service and/or physical health might jeopardize the state of a person’s mental health. Using this line of reasoning, managed mental health care may justly offer less costly substitutions for the treatment of milder illness than can be defended for more severe illness. The kind of substitution (nonpsychiatrists instead of psychiatrists), who makes the decisions about substitution (gatekeeper or reviewer), and the basis of the substitution (science-based practice guidelines) must be morally evaluated in light of this continuum.

**Criticism two: Managed mental health care could limit access.** The trend to managed mental health care has been based in part on the assertion (and some empirical evidence) that it enhances access to care and that patients are more likely to obtain services in a timely and appropriate manner than under financially restrictive, traditional fee-for-service care. In mental health this belief is bolstered by documented underuse of services, especially of outpatient mental health services; that is, many persons with mental illness do not seek care.²⁰ Despite the hope that managed mental health care will promote access, critics charge that larger patient copayments and other means of managing care (also found in fee-for-service) will simply contribute to further underuse of services.

Whether managed mental health care does and should limit access has not been definitively established. The GAO study concluded that there was greater patient satisfaction with managed care than with fee-for-service care and that there was equal or improved access with managed care.²¹ Many managed mental health care vendors have studies that show increased utilization by eligible populations at lower cost. In any case, it is too early to judge how attempts to manage mental health services have affected access to care; there is insufficient evidence from which to draw strong
Moreover, when the conclusions are drawn, they will need to be specific to differing care systems, vendors, benefits, and populations. Even if the evidence suggested that managed mental health care limits access, the question of whether it ought to do so would still need to be addressed. There is nothing inherently wrong with limiting care if there are strong social or therapeutic reasons to do so. Limiting care is justifiable if, for example, there is a need to triage, if the service causes harm, if the service is simply not available, or if there is broad agreement that the service is the moral equivalent of purely elective cosmetic enhancement. On the other hand, a purely arbitrary limitation of needed access in the pursuit of financial gain is morally indefensible. Selecting only “best-risk” patients or denying patients access merely on the basis of an expensive disease condition—as insurers and some purchasers have repeatedly done through nonparity for mental health services—is clearly objectionable.

Limiting access should arguably be understood on a continuum similar to quality of care, and for the same reason: not to further disadvantage the already disadvantaged. Mental health activists are split over whether priority access should be given to those who are worst off. A case can be made that preference but not absolute priority should be given to persons who are worst off because of illness, and that when access must be limited, the moral presumption for access should be more generous to the worst cases than to those with less severe and persistent illness. High-quality managed mental health care organizations already organize their protocols and care referrals in this way and, in fact, spend much time and money to properly judge severity of symptoms and failure of previous treatments.

Criticism three: Managed mental health care could adversely affect the provider/patient relationship. Critics of managed mental health care contend that (1) therapists will have incentives to do less; (2) therapists will be required to disclose confidential information to managed mental health care organizations to obtain approvals for treatment; and (3) continuity of care will be disrupted—especially when gatekeepers direct patients to preferred health professionals. Allegedly, patients will be persuaded to switch exclusively to providers credentialed by managed mental health care organizations and will be directed to psychiatrists only when they need prescription drugs or when their conditions warrant hospitalization. We address each of these issues in turn.

Physicians and other therapists, it is said, will have incentives to do less for patients, which could disrupt the provider/patient relationship. There is little evidence that this problem exists, although a perception that the problem is real is confirmed by newspaper accounts and cases such as Salley v. Du Pont, in which a family successfully sued a managed mental health care organization in 1992 for the denial of four days of inpatient care for
their daughter, who later committed suicide.\textsuperscript{26} However poignant these isolated accounts, a case can be made that it is not, in principle, wrong to give less care and that less care does not necessarily mean worse care.

If doing less is morally defensible, then complaints about the impact of managed mental health care on the provider/patient relationship are not based legitimately on the fact that care is limited, but rather on the manner in which mental health care is managed. Rational persuasion of physicians, as compared with more coercive means of limiting care, has the least effect on the traditional provider/patient relationship. Providers have ordinarily, if sometimes slowly, been willing to change their behavior if research provided evidence for the superiority of an alternative practice. More subtle means of changing providers’ behavior can call into question traditional notions of professional autonomy and discretion but can have other disadvantages, such as exacerbating therapists’ potential conflicts of interest. Offering providers financial inducement to provide less care—such as end-of-year bonuses or pay increases—potentially places their personal financial gain ahead of the patient’s best interest, which traditionally has been assumed to be therapists’ primary obligation. Or, more coercively still, HMOs or those that purchase mental health services could mandate very restrictive practice guidelines from which providers must not deviate, lest they lose their patients and/or their jobs.

These concerns are remediable, and important correctives have been suggested, such as disclosing incentives to patients, limiting disincentives, and basing financial incentives on quality of care or adherence to best practices. We must not forget, however, that until managed care appeared, therapists had (and still have) a considerable financial incentive to provide service to maximize their personal incomes. Whether the patient’s best interest is always served when this is the case is highly doubtful.\textsuperscript{27}

Managed mental health care is also alleged to disrupt the provider/patient relationship because it requires health care professionals to disclose an increasing amount of otherwise confidential information to obtain certification of treatment. The problem of the limits of confidentiality is not unique to managed mental health care, although disclosure of mental illness is arguably worse than disclosure of general health information because of the risk of greater stigmatization. More positively, there are well-recognized exceptions to the general confidentiality rule, based on the view that society has a compelling reason to have access to confidential information under limited circumstances.\textsuperscript{28} Valid social and medical reasons exist why clinical reviewers for mental health care must have access to privileged information, including obligations to protect patients from treatments that might have iatrogenic effects, to be good stewards of limited resources, and to seek treatment that is guided by the patient’s condition.
rather than by arbitrary benefit entitlements. In this view, managed mental health care should be seen as part of the confidential relationship. Managed and fee-for-service care alike must contend with the practical realization that, like it or not, private information will eventually be known by many. What is morally relevant is not whether managed mental health care plans need to know (they do), but rather how they will use and protect this information. Thus, the moral obligation of managed mental health care is to ensure that all of those who have legitimate reason to work with the information use only the information necessary to accomplish their work and that they protect its dissemination.

A final criticism is that the provider/patient relationship is adversely affected by a disruption in the continuity of care. Sometimes long-standing relationships are altered because managed mental health care directs patients away from the providers patients have chosen. It is certainly undesirable to disrupt a carefully established, therapeutic relationship, but when does this disruption become an ethical problem? Some believe that the initial therapeutic bond is always necessary and is perhaps the only effective treatment for mental illness. In this view, disrupting the bond for any reason undercuts effective treatment. Many do not hold this view, however, and, in fact, hospitalized patients often do not see their initial therapist during hospitalization or after release. Traditionally, mental health counseling has often involved a disrupted sequence of care. Again, we ask: When some forms of disruption of the initial bond are necessary to contain costs, to assure better access, and to obtain more appropriate treatment, what should the moral presumptions then be? If some forms of limitation and disruption are defensible, then it seems more legitimate to disrupt the bonds for persons who are minimally ill and less legitimate for those whose conditions are serious and for whom disruption may have adverse consequences.

Criticism four: Managed mental health care could adversely affect informed patient choice. There is a growing concern among providers and some patients that managed mental health care could insufficiently promote informed decision making, both at the point of enrollment (for example, about the scope and limit of benefits) and at the point of service (for example, that a service not offered by the plan is available elsewhere). Both of these claims are difficult to evaluate because of the heterogeneity among managed mental health care plans and the lack of published evidence about staff practices in informing patients of limitations or potential denials of services. No norm exists for how much information needs to be provided at enrollment or at the point of service, and there is only preliminary development and testing of what information needs to be provided to enrollees and/or their providers and whether they are satisfied. Most of the
larger managed mental health care vendors/plans and large employers conduct confidential patient and provider satisfaction surveys that ask about these issues, but this information is not available to the public.

Regardless of the lack of evidence about the extent and effect of informing enrollees whose capacity to understand may be limited, moral concern is justified. The first claim, that enrollees are not well enough informed prior to enrollment, is a debatable concern. A few employers offer only one plan to employees/enrollees; this is perceived as coercive and lacking the requisites for informed consent. A significant number of employers offer a selection of plans, however. Even if enrollees do have a choice, they frequently do not understand how their chosen plan limits or provides access to care and what the health consequences of the limits will be. This confusion can occur particularly among employees who lack education or have a shaky command of language. Managed mental health care creates a unique problem in this respect because there is a prevalent belief among employees that mental illness is a disease of “other persons,” even though there is ample evidence of the prevalence of mental illness in the general population. A person with mental illness who is in denial of his or her condition might not be able to understand that managed mental health care or fee-for-service care limits services that they may need.

Compared with managed care, managed mental health care also has some unique problems of informed consent at the point of service. Some persons with psychological disorders have impaired judgment, and their ability to exercise preferences for treatment has long been questioned. Problems with informed consent are not, of course, limited to persons with mental illness or to managed mental health care. But since impaired judgment is more likely in persons with mental disorders, there is moral reason to be extremely cautious in the structuring of informed consent in managed care settings. To the extent that managed mental health care shifts the responsibility for care to enrollees, there will be greater concern about the ability of some persons with mental disorders or their families to exercise that responsibility. Because there has been little public debate about whether, how, and to what extent to inform enrollees about limitations of access or services, managed mental health care must experiment continuously with different models for providing this information effectively. Many 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.

Criticisms five: Benefit design within managed mental health care could be capricious and unfair. Some managed mental health care or-
ganizations have been criticized for coverage policy and benefit design. Although the practice has changed, until 1991 many managed mental health care plans initially kept secret their decision protocols and criteria for network mental health services, on the grounds that these criteria were proprietary. Some of the more obvious criticisms about arbitrary plans have been resolved. For example, managed care organizations are making available the criteria used in decision making and network selection and have put into place well-structured benefit appeals processes.

Even after most managed mental health care plans made their protocols and network criteria public, however, critics charged that mental health benefits had been arbitrarily targeted and reduced by vendors. In fact, most vendors simply administer employer-dictated benefits. In any event, there remains no parity between mental health and general health benefits in most public or corporate benefit plans, whether managed or unmanaged. Employers (and even unions) generally establish these benefits-with or without good consultation and logic-and they pick vendors to administer them. Some high-quality vendors refuse to work for employers whose designs are too constricted or arbitrary. But some vendors administer whatever they can to earn a living. From a moral perspective, the issue of arbitrary nonparity between mental and general health benefits is well explored; no morally principled reason exists to treat persons with mental illness with less care than persons with so-called physical illnesses receive.

This problem is manifested less obviously in the designing of benefits that give greater preference to biologically based mental illnesses. This move is evident usually only in corporate plans that typically provide benefit packages designed solely on a medical model. However, not all mental health problems fit this model. The etiology of a disease is less important than the fact that a person suffers from that disease. Likewise, it is less important whether the intervention for an illness involves a medical treatment or social services, or both. Nonmedical treatments, such as intensive case management, congregate housing, or job training, can be as helpful as or even more effective than medical treatments, as some state mental health offices have discovered.

This leads us to wonder, however, whether managed mental health plans have the resources and protocols to offer such nonmedical treatments. Some observers perceive private providers of managed mental health services to be effective in collecting and analyzing data but less efficient in integrating medical, nonmedical, and social services—a strength of some notable public health systems such as New York’s. Private managed mental health care needs to examine carefully, and integrate where possible, these strengths (and many have begun to do so, to obtain managed mental health service Medicaid contracts). Also, many private employee assistance
programs (EAPs), now integrated with managed mental health services vendors, have always provided nonmedical and social services, although they have not been systematic in their protocols and data collection.

Another problem common to any benefit design is the question, Who will decide? It has been argued that terms used to select and deselect benefits, such as medical necessity or medically effective, are ambiguous and foster individualized, if not subjective and bias-ridden, interpretations. Medical criteria used for benefit design, such as effectiveness, are imbued with unquestioned values. Medical professionals may be expert in providing medical criteria, but they are not experts in what society prefers and that decision must be left to society. The solution to overcome these biases is less agreed upon, but one suggestion is to provide all parties with a stake in the matter (patients, families, health care professionals, and the managed mental health care organization) some role in decision making. These parties must contribute to the public discussion about what is necessary and what kind of effectiveness is sought and ought to be promoted by mental health services. Effectiveness might mean that a treatment helps those persons with the most severe illness, or that it produces the highest number of cures, or that it works best for the greatest population. If any of these propositions are so, then decisions about which kind of effectiveness should be used to design eligibility and benefits should, ideally, be left to all of those whose lives are affected by the use of such criteria. The creation of representative consumer/provider panels could assist in developing more equitable and open decision processes.

Criticism six: Managed mental health care could create problems because responsibility is inappropriately shifted to management. Many complain that managed mental health care could remove decision making from physicians and give it to managers or utilization reviewers. Yet it is the individual provider who is held responsible, rarely the managers. This is nowhere more apparent than in court cases in which managers have made benefit decisions to restrict the very services that physicians believe constitutes negligence to withhold—yet physicians have been held responsible. The courts are still considering these relatively rare suits. A few cases have held management within a managed care organization liable, but a significant number of them have held negligent the therapist who does not appeal a denial, not the managed mental health care plan.

These shifts in responsibility raise at least two moral challenges for managed mental health care. The first challenge is the uneven split of power and responsibility between manager and therapist. If managed mental health care assumes some authority over treatment planning, it must bear its fair burden of responsibility. If the responsibility, however, is truly shared among the managed mental health care organization, the therapist,
and the patient or family, then the lines of shared authority should be made clearer to ensure equity in legal and clinical decision making.

The other moral challenge is that the rise of managed mental health organizations shows clearly that much of the moral debate has been misfocused. Many, if not most, early complaints about managed mental health care arose from a moral analysis that assumed an idealized set of moral practices rooted in traditional patterns of medicine (such as Marcus Welby-type doctor/patient relationships, unlimited choices for all patients, and Cadillac care no matter the cost). The primary focus here was the individual patient and physician. This focus completely neglected the social fabric in which these individuals were embedded: issues of broader access to care or of standards for reasonable care.

The most common moral analysis of unmanaged and managed mental health care has engaged the issues at precisely the wrong level. When the bulk of criticism focuses on the dyadic relation between therapist and patient, few ethical problems are unresolvable. From another perspective—the managed mental health care organization and patients—a different set of concerns and analyses occurs. If, for example, the moral problems occur at a different level of responsibility—at the interaction between a mental health services manager and all eligible enrollees in a plan—then moral analysis that focuses only on the values conflicts of doctor and patient misses the most salient ethical features of managed mental health services.

Conclusion

The problems that confront managed mental health care diverge very little from those of managed care in general. For the most part, the moral problems of managed mental health care are resolvable, with the exception of a few outstanding difficulties (for example, benefit design). The problems unique to managed mental health care are those occasioned by the nature of mental illness itself, the nature of those who suffer from mental disorders, and the debate about services necessary to best treat the disorders. After reviewing these unique problems, 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. Such a judgment will require that managed mental health care organizations be explicit and expert about benefit plan design, quality and access to care, the therapist/patient relationship, and appeals processes. To the extent that managed mental health care is making, and continues to make, good-faith attempts to curb abuses, rectify ethical problems, and address treatment effectiveness issues, it should prove superior on the whole to fee-for-service medicine.
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NOTES


7. Jellinek and Nurcombe, “Two Wrongs Don’t Make a Right.”


12. Schreter et al., eds., Allies and Adversaries.


16. “Early Data Show Mixed Results for Managed Care,” Focus (June 1993): 3-5.


21. GAO, *Medicaid: States Turn to Managed Care*.


25. Jellinek and Nurcombe, “Two Wrongs Don’t Make a Right.”


33. *Managed Mental Health Database* (Stamford, Conn.: Towers Perrin, 1994).


35. Boyle and Callahan, “Minds and Hearts.”

36. Ibid.


