TAKING ISSUE

A Vision for Managing Care

Deinstitutionalization taught us that without efforts to manage mental health care, many providers gravitate toward treating those who are less ill, patients are often denied access to services, and coordination of care is rare. So we public-sector managers learned and took action. Slowly, over the past several decades, basic services were funded, and the range of services was expanded. Case management emerged as a strategy for securing access to care and coordinating treatment. Assertive community treatment was introduced and proved an effective method for integrating care within a single treatment team. Local mental health authorities were developed to establish single-point accountability for the provision and coordination of care. Consumers were engaged to shape the services being offered. Many problems remained, but there was a commitment and a vision.

Then came managed care. Imported from the private sector, it significantly increased the emphasis on cost-efficiency, a shift that in some ways was beneficial. Before managed care, our public-sector systems had been driven by perverse economic incentives that rewarded providers for treating fewer patients and using more costly modalities. Public-sector politics had prevented the reallocation of dollars among providers, even if compelling justification for reallocation existed.

Managed care's emphasis on costs has been much needed. But it has become an obsession, not only for managed care companies but also for state governments and providers. It has produced a scramble as individuals and organizations, fearing for their futures, attempt to demonstrate their ability to manage dollars. The formation of managed care organizations and networks and the development of contracts and capitation rates are now the primary focus.

Our public-sector vision has been sidelined, diluted, eviscerated. Rather than incorporating an emphasis on cost-efficiency into a comprehensive approach to caring for persons with severe mental illness, we have set the vision aside in favor of cutting costs. The focus on costs not only distracts us from the important task of building locally managed, integrated service systems that are responsive to consumers' needs, but it also tacitly enhances the idea that we are spending too much on behavioral health care. On the contrary, we have never had adequate resources to deliver proven treatments to all those in need.

We need to build on the strength and vision of our previous work by accepting cost-efficiency as one objective in managing care. We can embrace the idea of spending dollars more wisely while still advocating for funds to care for underserved populations. We must attend to, but not be consumed by, the need to manage dollars.—MICHAEL A. HOGE, PH.D., *associate professor of psychology (in psychiatry), and* EZRA E. H. GRIFFITH, M.D., *professor of psychiatry, Yale University School of Medicine*

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