in the absence of competing incentives for personal financial gain, health care professionals may not always make decisions that are consonant with patient preferences. The principle that medical decisions must ultimately be based in the informed judgment of the patient– or if the patient is incompetent to judge his or her own best interests, by someone who represents those interests exclusively– explicitly recognizes that the arbiter of the best choice for each patient must be that patient or the patient's representative, not the provider.

Resource allocation decisions often affect service delivery to large populations or subpopulations of patients, not just to specific individuals. Decisions that concern the discontinuation or expansion of special programs such as outreach programs to the homeless, assertive community treatment programs, or psychosocial rehabilitation programs affect many patients and communities. These decisions are best made by teams of relevant stakeholders, including professional experts, consumers, and members of the local community. The Kantian injunction to serve each patient's needs cannot stand by itself, but must be guided and supplemented by a consensus derived from the community of concerned citizens.

**Maximization of benefit and minimization of cost.** We live in a world of scarce resources. In addition, there are few universally accepted psychiatric treatment indications and no universally accepted treatment protocols that fully specify necessary and sufficient treatments for each of the many situations encountered in clinical practice.

As a result, the principle that medical decisions should be guided exclusively by each patient's best interests– even if the decisions are based on a consensus of stakeholders as described above– cannot be realized. Resources are inevitably inadequate to finance every treatment that would benefit every patient. Best interests and best treatments are imprecisely specified. Thus blindly providing all possible services to patients selected on a first-come, first-served basis would be neither efficient, as some services would yield limited benefit, nor fair, as this strategy would eventually penalize the person next in line after the last person to receive all the services he or she needed.

As vividly demonstrated over the past 30 years of health care policy debate, we must take resource constraints into consideration in planning how the health care system will work. We are thereby brought to the principle of maximizing cost-effectiveness– of giving priority to programs that maximize the amount of improvement in health-related quality of life per dollar expended.

This cost-effectiveness perspective derives historically from the utilitarianism (17) of Bentham and Mill, a philosophical tradition quite different from that of Kant. In utilitarianism, societal decisions are to be guided by the goal of achieving the great-

# A Note About the Papers on Care of the Least Well Off in Mental Health Services

Robert A. Rosenheck, M.D.

As health care resources grow tighter, mental health program managers and policy makers in both the public and the private sectors must increasingly make decisions setting priorities for service delivery. On March 27, 1998, the special committee on treatment of seriously mentally ill veterans of the undersecretary for health of the Department of Veterans Affairs, together with the VA's Connecticut-Massachusetts Mental Illness Education Research and Clinical Center, sponsored a conference on the obligation to the least well off in setting mental health service priorities. The conference, which took place at the Cannon Office Building of the U.S. House of Representatives in Washington, D.C., was held in honor of Paul Errera, M.D., director of VA's Mental Health and Behavioral Science Service from 1985 to 1994, and Thomas Horvath, M.D., current director of the Strategic Health Group for Mental Health at VA headquarters, who have provided strong leadership in recognizing the nation's responsibility to veterans disabled by mental illness.

A consensus statement developed by the conference presenters, which was reproduced in the October 1998 issue of *Psychiatric Services* (pages 1273–1274,1290), had as one of its foundations the tenet that "civilized societies have a deep and irrevocable obligation to people with serious mental illness." One of its conclusions was that "as VA and other health care systems undergo momentous changes in their operation, political leaders and health care administrators must be aggressive in preserving and enhancing services for this population."

This issue presents three papers from that conference that elaborate in greater detail the foundations for the consensus statement from the fields of psychiatry, ethics, economics, and public policy.

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