

Obligation to the Least Well Off in Setting Mental Health Service Priorities: A Consensus Statement

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Introduction by the column editor

Any health care system that provides care to individuals in the context of a budget for a population must establish priorities for allocating resources. Establishing priorities is ultimately a process of questioning our values; it is, in other words, a process of ethics. A severe weakness of the U.S. market-based system is that to date it lacks any guiding ethical vision (1). In this column, Robert Rosenheck, M.D., and his colleagues report on an important effort by the

Department of Veterans Affairs to articulate an ethical vision for a VA resource allocation policy. Future columns will present other efforts in the managed care arena to make ethical considerations an active force in shaping policy and practice.

The Veterans Health Administration of the Department of Veterans Affairs, like other private and public health care systems attempting to manage care more effectively, is placing increased emphasis on reduc-

ing hospital use and shifting from specialty care to primary care services. These shifts are intended to broaden access to health care services for as many persons as possible, given the limited funds available for these services. This task confronts providers, health care system managers, and policy makers with many difficult resource allocation decisions.

One of the most important decisions is whether to preserve or enhance specialized, often costly, community-based programs for those with the most severe mental health problems or to shift resources to programs for larger numbers of less severely ill patients. (Specialized, community-based programs sponsored by VA include assertive community treatment, homeless outreach, specialized clinics for treatment of post-traumatic stress disorder, and work therapy programs.) Even when cost-effectiveness studies have demonstrated the value of intensive programs for severely ill patients, health system managers are often reluctant to commit limited funds to these expensive programs that in many cases yield health care benefits only over extended periods of time and have less visible short-term benefits.

Although well-developed methods for evaluating the cost-effectiveness

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of programs exist, virtually no scientific information is available comparing the cost-effectiveness of intensive programs for the most severely ill patients with that of programs for patients with less severe problems. Without evidence to inform difficult decisions about resource allocation, the simple goal of minimizing costs tends to displace support for intensive programs for severely ill patients.

Even if comparative cost-effectiveness data were available for the full range of health and mental health care programs, the most compelling reason for maintaining specialized programs for the least well off may not be their cost-effectiveness. Rather, it may be that these programs represent part of the fulfillment of a societal obligation to provide for those with the most severe problems.

As VA managers and clinicians have struggled with these difficult decisions, we have discovered colleagues elsewhere who are confronting equally challenging questions. For example, what values should guide us in setting mental health and general health priorities? What is the role in such decision making of cost-effectiveness assessment, considerations of justice or fairness, or what the Founding Fathers regarded as a self-evident human right to life, liberty, and the pursuit of happiness? If an intervention for people with severe illnesses is equally effective, but more costly, than an intervention for those who are better off to begin with, are there grounds for putting a special priority on care for the less well off despite the greater cost?

To address such questions the VA Under Secretary for Health's Special Committee on the Treatment of Veterans with Serious Mental Illness and the VA Connecticut–Massachusetts Mental Illness Research Education and Clinical Center convened an interdisciplinary conference of national experts from the fields of psychiatry, philosophy, sociology, and public health to examine the role of the obligation to the least well off in setting mental health service priorities. The conference, which honored Paul Errera, M.D., and Thomas Horvath M.D., F.A.C.P., for their leadership of VA mental health programs and advocacy for persons with severe and per-

sistent mental illness, was held on March 27, 1998, at the Cannon Office Building of the U.S. House of Representatives in Washington, D.C. Participants included representatives from academia, government, the private sector, and both VA and non-VA consumer groups. Conference presenters generated the following consensus statement summarizing major points of agreement.

Consensus statement

Foundations. Civilized societies have a deep and irrevocable obligation to people with serious mental illness. This moral imperative derives from a compassionate response to the suffering and impairment of the least well off members of society, the need to remedy both the ancient stigmatization of people with serious mental illness and the persisting misunderstandings of those conditions and their treatability, and the growing potential for recovery or improvement with new pharmacologic and psychosocial treatments and with the participation of consumers as partners in service delivery.

Fairness in access to health care services. As a general principle of fairness, people with similar needs and potential for improvement should have similar access to services, and people with different needs and potential for improvement should have different access to services.

Fairness in decision making. Setting priorities between different groups of people with mental illness and between people with serious mental illness and people with other serious medical disorders is difficult. Available data do not allow precise quantification of either patient need or the relative cost-effectiveness of treatments across the broad spectrum of medical conditions (for example, we lack data that compare the benefit of treatment for schizophrenia with the benefit of treatment for coronary artery disease).

In the absence of a simple empirical basis for resource allocation, decisions are typically made through political or administrative processes in which the complex needs of people with serious mental illness are often neither fairly nor accurately represented. Sometimes less severe, but more common

illnesses receive more support because they affect more individuals and appear more amenable to treatment. Both the improvements in treatment for serious mental illness, and the moral imperative to give priority to the least well off undermine this argument. 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.

From values to action

Clarification of values, as represented by the consensus statement, does not in itself change societal values or organizational decision making or even generate local action plans. However, values matter. VA administrators, program managers, and clinicians who participated in the conference experienced renewed commitment and support for their work with the most severely ill patients. They felt emboldened to advocate within their local health care facilities for maintaining a commitment of resources for those who need our help most.

We have yet to see whether clarification of values can actually increase our influence in the "trench warfare" of organizational decision making, as it was referred to by one conference participant. It is unlikely that such influence could be demonstrated empirically, and we do not want to naively dismiss the dominance of bottom-line thinking in decision making today.

It may, however, be useful to think about how such influence might occur. This publication of this statement—the result of a consensus conference of national experts held in the chambers of the U.S. Congress, an important symbol of our national commitment to equality of opportunity—may strengthen the voice and resolve of readers, conference participants, and other stakeholders to speak up for special programs that serve the most seriously ill. With this consensus statement behind them, rooted as it is in the nation's founding guarantee of equality of the right to life, liberty, and the pursuit of happiness, advocates need not stand alone.

Continues on page 1290

In speaking out, they can draw on more than their personal belief and private commitment that we have an obligation to the least well off that demands we provide certain services. Additional persuasive leverage may come from the knowledge that the argument is supported by ancient values whose relevance has been reaffirmed and clarified by the consensus of a concerned group of experts at a national meeting in the House of Representatives. Symbol, authority, clarity of concept, and deliberateness of purpose may all serve to promote the impact of the advocacy.

Charles Black, the Constitutional scholar, has suggested that the operational basis of all law is "reasoning from commitment" (2). The principles embodied in statements such as ours may remind readers— even as we and they participate in the hurly burly of institutional decision making— of personal commitments to hallowed principles and traditions of justice that claim our deepest loyalties but that we may lose sight of in our day-to-day professional or institutional lives. Animated by such principles, we may find ourselves speaking out with increased persuasiveness, confidence, and passion on behalf those who have no place at the table at all. Views backed by broadly and deeply held values that bear the weight of history, consensus, and authority may indeed turn out to have unanticipated power. ♦

References

1. Sabin JE: Lessons for US managed care from the British National Health Service: "the vision thing." *Psychiatric Services* 46: 993–994, 1995
2. Black C: *A New Birth of Freedom: Human Rights, Named and Unnamed*. New York, Grosset-Putnam, 1997