Managed Mental Health Care: Will It Be Rationed Care or Rational Care?

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The increasing popularity and acceptance of managed mental health care has intensified people's concern about the rationing of mental health services. The obvious worry is that the definition of what services will be available in a managed care benefit package will be minimal in extensiveness and intensiveness. Bennett (1992) believes that "…such parsimony contrasts with a model common in fee-for-service practice: comprehensive, state-of-the-art care for each patient" (pp. 203–204). Fink and Dubin (1991) point out that "…the fiscal reality is that hospitals and physicians affiliated with HMOs can break even or generate income only by providing less care…. The clinical reality, however, is that HMO patients usually receive a level of care that is not the standard for the community." (p. 363)

The rationing of mental health care has occurred for many years. The controversy over the cost and public funding of clozaril is but the most recent example. Perhaps the most notorious example of rationing mental health care was the historical omission of medicaid funded community support and rehabilitation care. Anyone who works in the psychiatric rehabilitation field can attest to the rationing of these services due to the lack of a meaningful funding stream (Anthony, 1992).

As Santiago (1992) correctly points out, the issue is not whether mental health services will be rationed, but how. "The debate in health care, as well as in mental health care, is not whether rationing is acceptable or even exists, but how to ration and which form is tolerable" (Santiago, 1992, p. 1097). The question then becomes, can we ration mental health care in a rational way? Do we know enough to make some educated guesses? I believe we do.

The introduction of these "newer" services (e.g., basic support, case management, rehabilitation, self-help, etc.) can have a significant impact on people's vocational, educational, residential, and social functioning while at the same time reducing the cost and utilization of inpatient treatment services.

Most importantly, we need to base our service offerings on what the consumers of services say they want. Anthony, Cohen, and their colleagues have identified a system of services based on what consumers say they want, using as the conceptual foundation the Community Support System of services and the psychiatric rehabilitation model's perspective on the impact of mental illness (Table 1). This services system outline reflects the notion that people with severe mental illness want more than symptom alleviating treatment; they also want such things as a suitable place to live, appropriate work and educational opportunities, and friends. From a managed care perspective, the value of an expanded constellation of comprehensive services lies not only in providing people with the services they want, but also in their potential to reduce more costly inpatient treatment services. For example, successful rehabilitation efforts aimed at increasing people's vocational and educational functioning can also reduce hospitalization (Unger, Anthony, Sciarappa, & Rogers, 1991). Case management, often in combination with community-based rehabilitation and treatment services, has routinely been shown to decrease hospital utilization (Santos et al., 1993; Surles et al., 1992).

The introduction of these "newer" services (e.g., basic support, case management, rehabilitation, self-help, etc.) can have a significant impact on people's vocational, educational, residential, and social functioning while at the same time reducing the cost and utilization of inpatient treatment services. In a sense, inpatient care is being reduced (rationed?) at no discernable cost to people's quality of life. In this way, the expense of hospital care is reduced as a by-product of deliberate interventions to increase people's functioning. It may well be that the reduction of more costly inpatient services, in the context of increased opportunities for services such as case management, rehabilitation, and self-help, is an improvement rather than a rationing of mental health care. For example, one successful rehabilitation-oriented managed care agency has reported a decrease over time in members' use of both inpatient hospitalization and private psychotherapy (Anthony, 1993).

Table 1

Focus of Mental Health Services

Mental Health Services (and Outcomes)	Impact of Severe Mental Illness			
	Impairment (Disorder in Thought, Feelings, and Behavior)	**Dysfunction** (Task Performance Limited)	**Disability** (Role Performance Limited)	**Disadvantage** (Opportunity Restrictions)
Treatment (Symptom Relief)	X			
Crises Intervention (Safety)	X			
Case Management (Access)	X	X	X	X
Rehabilitation (Role Functioning)		X	X	X
Enrichment (Self-Development)		X	X	X
Rights Protection (Equal Opportunity)				X
Basic Support (Survival)				X
Self-Help (Empowerment)			X	X

Adapted from: Anthony, W. (1992). Psychiatric rehabilitation: Key issues and future policy. *Health Affairs, 11*(3), 170.

Critics of managed care are worried that people with severe mental illness will receive less comprehensive care in a managed care environment (Bennett, 1992; Fink & Dubin, 1991). As the managed care drama unfolds, it may well be that people receive both more comprehensive care and less care. However, the type of care that is reduced (not eliminated) will be the care provided by the most costly professionals in the most costly settings. At the same time, the comprehensiveness of care will be increased by providing a greater variety of the less costly services that people want and need.

It seems to me that managed mental health care can be rationed and rational. Perhaps said in a more positive way, it can be more efficient and more effective. Quality and cost do not always have to be competing values—especially in the

managed mental health care field where an argument can be made that the relatively lower cost services are preferred by the consumers, improve their quality of life, and decrease the use of more costly services.

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