

PERSPECTIVES

Parity - Prelude to a Fifth Cycle of Reform

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Abstract

Background: Based on 2000 Carl Taube Lecture at the NIMH Mental Health Economics Meeting.

Aims of the Study: This perspective article examines the relationship between a policy of parity in financing mental health services and the future of reform in service delivery.

Methods: Applying theories of static and dynamic efficiency to an understanding of parity and the evolution of mental health services, drawing upon Burton Weisbrod's concept of the "health care quadrilemma".

Results: Each of four cycles of reform in mental health services have contended with issues of static and dynamic efficiency. Each cycle was associated with static efficiency in the management and financing of services, and each was associated with a set of new treatment technologies intended to improve dynamic efficiency. Each reform proved ultimately unsuccessful primarily because of the failure of the treatment technologies to prevent future patient chronicity or to achieve sustained recovery. Recent advances in treatment technology and management of care can permit an unprecedented level of efficiency consistent with a policy of improved access to mainstream health and social welfare resources, including insurance coverage. This policy of so-called "financing parity" can improve current mental health service delivery, but it may also portend a future fifth cycle of reform. *If* new technologies continue to advance as "full technologies" - simple to deliver and producing true recovery - and mainstream resources are made available, *then* the specialty mental health services may contract dramatically in favor of effective care and treatment of mental illness in primary care and other mainstream settings.

Discussion: Predicting the future of health care is speculative, but it may be easier using the Weisbrod formulation to understand the process of mental health reform. Over-reliance on administrative techniques for building static efficiency and false optimism about dynamic efficiency from new technology have stymied previous reforms. All the same, a fifth cycle of reform could succeed, if the right conditions are met and mainstream resources are available.

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Introduction

Carl Taube was a mental health services research innovator who provided much of the initial support for the field of mental health economics in the 1980's. Initiating the NIMH Mental Health Economics research program and its biennial conferences are among his many contributions. He was a close friend, mentor and collaborator, so it is particularly meaningful to me to have presented the 6th Taube lecture at the 2000 NIMH Mental Health Economics conference. Ken Wells has already reported on Carl's history and contributions to the field in his recent paper based on Ken's 7th Taube lecture in 2002.¹ I wish to add only a few remarks about this fine man and special collaborator with whom I wrote more than 20 papers between 1978 and 1989, when Carl died.

Like Ken Wells and me, Carl was not an economist by training. We benefited from working with others with more formal education in economics. Although in general our work together was empirical and not theoretical, Carl was interested in theory and history, too. He enjoyed hearing about how the mental health service system worked from the perspective of a clinician and service provider, and he was interested in the history of how the service system became so complex. Mostly he hoped that a careful understanding of the effects of economic incentives and financing mechanisms might lead to improved care for individuals who receive mental health services.

This paper on the conference theme of "parity" is written from a more historical and theoretical perspective than any produced in my collaboration with Carl. All the same I think that he would have enjoyed sharing his thoughts with me about this essay - as he did about some of the earlier work I did on "cycles of reform" with another mutual colleague of Carl's and mine, Joseph Morrissey. He also would not be too surprised that I got the theoretical ideas for this paper from conversations with old friends of ours, economists Richard Frank, Thomas McGuire and David Salkever and from a relative newcomer, Sherry Glied, who never knew Carl. I appreciate the contributions that all of these colleagues have made to my own work and to this essay. As they like to say in economics papers, any errors in interpretation of their generative ideas are my own.

A Little History

Reform of mental health services has taken a cyclical path over the past two centuries in the United States.^{2,3} The cycles of reform have their parallels in other countries as well, as services have moved from the asylum to the community. Each reform cycle has been introduced by a critique of the *status quo* pattern of care. Each reform has championed a new treatment technology, usually embodied in some new locus of care. Each has been accompanied by a change in the financing of mental health services. There seems to be no end in sight to the cycle of changes as more can be done to improve the quality of care and services for people who experience severe mental illness. Reform presses onward because inefficiencies in the *status quo* demand better value for money, and new technologies offer the promise of better treatment and services in the future.

Asylum care replaced the neglect of individuals with mental illness in undifferentiated welfare institutions, supported by shared state and local categorical public funding. Asylums in the 19th century promised to prevent chronicity by providing “moral treatment” early in the course of mental illness. In response to their failure, the mental hygiene movement in the early 20th changed the locus of care to psychopathic hospital units and outpatient clinics. The focus was shifted to academic centers of learning with the hope that scientific medicine would improve treatment. Funding was further centralized and a private sector emerged. Results were not much better than those achieved in the prior century. By mid-century care moved more forcefully into community settings, including community mental health centers, again promising to prevent chronicity with early intervention. Although treatments and service technology had improved by this point, the promise was overstated, and the technology was insufficient to the task of preventing acute mental illness from becoming chronic.

A fourth cycle of reform focused on providing care and rehabilitation within community support systems.⁴ It abandoned the notion of early prevention of chronicity in favor of promoting recovery for individuals with severe and persistent conditions. The reform called for a broader involvement of social welfare organizations beyond the traditional boundaries of the mental health services system. These agencies were called upon to meet the complex resource needs of individuals with severe and persistent mental illness now living for the most part in the community. This community support reform called for a new service technology and new approaches to financing services. Unfortunately, the fourth cycle of reform has occurred at a time of fiscal conservatism and restraint. Cost containment has dominated thinking about mental health services, and broader social welfare institutions have not met their responsibility to individuals with severe and persistent mental illness.

Historically, resources for mental health services have been limited and subjected to arbitrary limitations. Advocates have championed a policy of “parity” to improve the funding of mental health services. The specific focus has been on insurance coverage, but the concept may be broadened to

encompass all efforts to reduce discrimination and finance mental health services to place them on a “par” with other health and social welfare services, such as housing and employment.⁵

This essay considers the relationship of “parity” to a possible fifth cycle of reform. Is a fifth cycle of reform likely and, if so, what form will it take? How will a policy of parity affect any reform in the delivery of mental health services in the future?

A Little Theory

This analysis of the relationship between parity and mental health service reform is based on the economic concepts of static and dynamic efficiency and draws on a framework for thinking about these issues introduced by Burton Weisbrod in 1991.⁶

From this perspective, each prior reform has foundered because of inefficiencies in service delivery -static efficiency- and weaknesses in the treatment technology -dynamic efficiency-. Dynamic efficiency is gained by advances in technology directed at production - in this case in the direct production of mental health. Treatment and other forms of clinical intervention are intended to improve mental health, gaining efficiency by increasing production -outcomes- without dramatically increasing inputs costs. Static efficiency is gained through administrative practices and management techniques designed to reduce costs or improve outcomes within a given set of technological possibilities. Static efficiency focuses on organizing, financing or managing care to improve value from existing therapeutic interventions. Goals of attaining dynamic efficiency and static efficiency come into conflict, creating a tension in policy (perhaps most evident in new drug development policy). The “health care quadrilemma” in the Weisbrod formulation requires a balancing of objectives related to technological change, insurance, quality of care, and cost containment.⁶

The historic pattern of ever-turning cycles of reform has demonstrated the importance of dynamic efficiency and the need for effective treatment technologies to achieve successful reform. Each reform was more-or-less able to deal with the static inefficiencies in the organization and financing of mental health services. Each reform brought with it new organizational forms for managing care and new mechanisms for allocating resources. For example, asylums eventually replaced almshouses; dispensaries and community mental health centers provided outpatient services when inefficient hospital stays were reduced in length; and state care acts were passed and implemented to reduce duplication of effort and diffusion of responsibility. The reforms ultimately failed, however, because the innovative technologies -such as “moral treatment” and “mental hygiene”- were unable to achieve their treatment and prevention goals. The difference between now and the past is that treatment is more effective.⁷ New technologies improve the quality of care without increasing costs. According to the Weisbrod formulation, these efficiencies encourage expanded financing of such services, for example through expanded insurance coverage.

Discriminatory mental health insurance policies have been decried as unfair.^{5,8} Until recently, however, parity has been criticized as wasteful on static efficiency grounds -likely to result in increases in use and cost beyond the real value of the mental health services added through the implementation of expanded coverage. Recent advances in treatment effectiveness have improved the dynamic efficiency of mental health services and new management technologies -embodied in managed care- have improved the static efficiency of mental health services.⁷ Advocates have argued with some success that a policy of parity, expanded coverage of mental health services, if accompanied by managed care is efficient. In this case, innovations in management have changed the static efficiency tradeoff to permit more generous financing on a par in coverage with physical health. Parity improves access to *effective* services, while new management techniques limit costs more *efficiently* than through benefit limits.^{5,8}

What new forms of service delivery can be expected in a reformed mental health service delivery system fueled by a policy of parity and expanded insurance coverage?

Into the Mainstream

As noted above in the brief discussion of history, the post-World War II era has been characterized as a partial movement of mental health services into the community and into the mainstream of health and social services.⁹ The need to think about mental health services in the mainstream of health and social welfare policy is a natural concomitant of the change in the locus of care and the move to the community. Where once the public mental hospital was the center of life for individuals who experienced severe mental disorders, now their lives in the community involve mainstream health services and insurance, vocational rehabilitation and competitive employment or disability income supports, and neighborhood housing or residential care. There have been some important advances in personal freedom and improved care resulting from the community mental health reform, but currently there are also manifestations of neglect and continued discrimination in mainstream policies.¹⁰

The lack of insurance parity is one of the most glaring examples of discriminatory health care policies in the era of reliance on mainstream health care. Advocates and the U.S. Surgeon General alike cite the lack of parity as an important barrier to access to appropriate mental health services.⁷ Parity advocacy is justified by a principle of fairness that asserts that mental health care should be available on the same basis as care for other conditions. It has become an important policy initiative, however, only as a result of the movement of mental health services into the mainstream of health care. Large numbers of individuals experiencing a mental disorder present for care in general health care settings, so a policy of parity is critical for access to primary care as well as to specialty mental health care.

The dramatic shift of mental health care into the health care mainstream illustrates the interdependencies at the heart of Weisbrod's quadrilemma.⁶ In the mainstream newer treatment technologies have been introduced but incomplete

implementation has challenged the quality of care. Furthermore, the lack of full insurance coverage in an effort to control costs also restricts access to effective services. The relationship of newer technologies to financing policy is the key to this four-sided balancing act.

First, the move from the asylum to the community was advanced by the availability of newer treatments for severe mental illness, particularly the anti-psychotic and antidepressant medications in the 1950's and 1960's.² When State and local resources were inadequate to meet the demand for mental health services in to community, services were financed with expanding federal resources in the form of community mental health center grants and Medicare and Medicaid.¹¹ Not all community providers possessed the requisite skills to provide complex treatment to severely ill individuals in the community and limitations in insurance coverage compromised the quality of this care further. Community based mental health services and services in the general medical sector expanded dramatically during this period.

Second, the introduction of newer generation anti-psychotic medications arguably made it easier to deliver care in community settings.⁷ Although some of the newer generation drugs, such as clozapine, might be more difficult for primary care providers to use, all of them have more acceptable side-effect profiles for patients. However patients on these medications need even greater general medical attention to assess patients for somatic side effects, such as agranulocytosis, diabetes, and obesity.⁷ Without parity there are limits on access to office visits where these medications can be appropriately prescribed and monitored. The cost of these new agents also has raised questions about their inclusion in formularies and insurance coverage, and patterns of their misuse as well as under-use suggest quality of care deficiencies, as well.¹²

The experience with psychosocial treatments and rehabilitation services has been somewhat similar. Newer technologies, such as assertive community treatment, family psycho-education, and supported employment, make care and rehabilitation more effective.^{7,13} They are complex services delivered in specialty mental health settings -not yet feasible in primary care settings. Some, but not all, financing programs will cover these services. It has been difficult to disseminate these evidence-based practices due in part to lack of insurance coverage.¹⁴

In the first two cases illustrating Weisbrod's quadrilemma mental health care has moved more into the mainstream of health care, but the lack of insurance parity has made access to quality care more difficult. The third example, the case of the newer generation of antidepressant medications, is most dramatic and perhaps most illustrative of where parity may fit in a new cycle of reform.

The newer antidepressant medications are simpler to use and have side effect profiles that make treatment in primary care settings easier.^{7,15} Often the initial dose of medication is the effective dose; complex titration schedules are less frequently needed compared to the pattern with the older agents. As a result, the dramatic expansion in use of these

medications has been outside of the specialty mental health sector in primary care and other general medical settings. In specialty care the newer agents have replaced older agents selectively; in general health care settings the newer agents are being used to medicate new patients never before identified and treated.¹⁶ Where once quality of care was marred by inappropriate use of agents and dosages in complex regimens, care is simpler and dosing is more appropriate. Several studies indicate that in recent years the quality of care for the acute treatment of depression has been improving - both in specialty and primary care settings. Furthermore, this care is more efficiently delivered. Costs are lower, and the price index for treatment has fallen.¹⁷

Lack of insurance coverage, however, still makes delivery of effective, quality care more limited. Some insurance policies and financing schemes -such as carve outs- make it difficult to treat an individual that presents with a mental disorder in a primary care setting. Even when there are no specific coverage policy barriers, higher cost-sharing provisions, arbitrary limits, and special managed care procedures discourage beneficiaries from seeking care. Parity in nominal mental health care benefits and similar rules to guide care management and formulary design will encourage further the treatment of depression in primary care settings. (It may also encourage further drug research and development activities -a key point in Weisbrod's formulation. Special incentives are needed for psychosocial treatments, where there are fewer incentives for new treatment development.) Simpler and more effective technologies introduced with parity and fairness in managed care will improve access, outcomes, and continue to reduce costs -and care will continue to expand in primary care and general medical settings.

This trend -advances leading to implementing "full" rather than "halfway" technologies- may be new to mental health services but it is not unique in other areas of health care.¹⁸ In a historic pattern that parallels deinstitutionalization in mental health services, the introduction of new treatment technologies and insurance coverage to support care in general medical settings led to the closing of specialized facilities for the care and treatment of Hansen's disease -leprosy- and tuberculosis. Antibiotics generally made it more effective and easier to treat most infections in primary care settings. Treatment of diabetes also became the province of general medicine rather than highly specialized care with the introduction of insulin and oral hypoglycemic agents. "Full" technologies improve dynamic efficiency and, if accompanied by adequate financing, move quality care from specialty to general health care settings with a minimal decline in quality at lower cost.

Could this mean that the recent advances in treatment technology, if coupled with parity and general acceptance of responsibility for support from other mainstream financing -such as housing subsidies and employment supports- will lead to a dramatic shift in the locus of mental health care? Will the specialty mental health system go the way of the asylum, relegated to a highly defined and limited role in a mainstream system of care and treatment?

A Little Speculation

The crystal ball is cloudy. It is difficult enough to understand the past and deal with the present; so predicting the future is at best wild speculation. With that warning of a low probability of success this final section suggests a possible future direction for a fifth cycle of reform. Further it suggests that the reform is foreshadowed and fueled by the drive toward insurance parity more narrowly and toward a policy of inclusion in other mainstream social welfare programs more broadly.

From the perspective of Weisbrod's quadrilemma parity represents a mechanism to finance some aspects of community mental health care (elements of the third and fourth cycles of reform), but it may also be a prelude to a major reform -perhaps a fifth cycle. Just as earlier reforms ultimately failed to deliver because of a weak treatment technology and limited resource and administrative supports, the success of a fifth cycle will depend both on dynamic and static efficiencies.

Imagine a future -perhaps several decades from now. If the field can continue to develop treatment interventions that are "full" technologies and that are simple to use, then perhaps the specialty mental health system will shrink dramatically. Perhaps all that will remain will be a residual of services that cannot be absorbed by the mainstream of primary care and other general medical and social welfare services. (It is likely that specialized forensic inpatient services will be required, and there will be services for people with treatment resistant conditions. It is also possible that new technologies will not be simple to use, and like rapidly changing cancer treatments, psychopharmacology will remain the responsibility of specialists.) Otherwise in this reformed system of the future treatment will occur early in the course of illness and will produce recovery without residual impairment or disability. "Full" technologies will facilitate such a result, enabling care to occur in the mainstream without a significant decline in the quality of care and at a controllable cost. Of course, according to the terms of the quadrilemma, this reform will not take place without insurance or some other financing mechanism to provide the resources and the right incentives. Parity and other access to mainstream health and social welfare resources will be essential to turn this fifth cycle of reform.

History is again instructive in cooling enthusiasm for a successful reform. Each of the prior reforms was predicated on similar therapeutic optimism that never materialized. Perhaps we are similarly blinded by the therapeutic optimism of our own era. For that reason the prediction of a fifth cycle of reform is couched in strictly conditional terms. *If* the conditions are aligned and mental health financing achieves parity and access to mainstream resources and *if* a set of simple, "full" technologies are introduced, *then* the specialty mental health service system will disappear as we know it. It will be replaced by services for individuals who experience mental disorders in general health settings and unspecialized social services, similar to the current situation for individuals with other health conditions. Ominously perhaps, this is where

Dorothea Dix and other social reformers around the world originally “discovered” individuals suffering from mental disorders and neglect by those very mainstream institutions.²

The fifth cycle of reform will require that all of the pre-conditions for efficiency are met, and that will require a commitment from the society. A commitment of political will is needed to provide decent and effective care to citizens in primary care settings, schools, welfare offices, jails and prisons, and the workplace -without discrimination associated with stigma. Surely now is a time for reform; societies around the world can do better in providing for the needs and promoting opportunities for individuals with mental disorders.

The anticipated “full” technologies of the quadrilemma are a modern *deus ex machina* in this formulation, but even if these sources of dynamic efficiency are delivered it will require resources and efficient administration and management of care to implement them with static efficiency. Passage of parity legislation has provided rhetorical evidence of society’s commitment to be inclusive of individuals with mental illness and to provide equal access to care.^{19,20} Implementation of a broad vision of parity coupled to services that are effective at promoting recovery can be a prelude to a fifth cycle of reform in mental health services. Perhaps it will be the final turn of the cycle of reforms, eliminating need of future reforms, and perhaps it will never come. It is in our hands to set the right conditions.

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