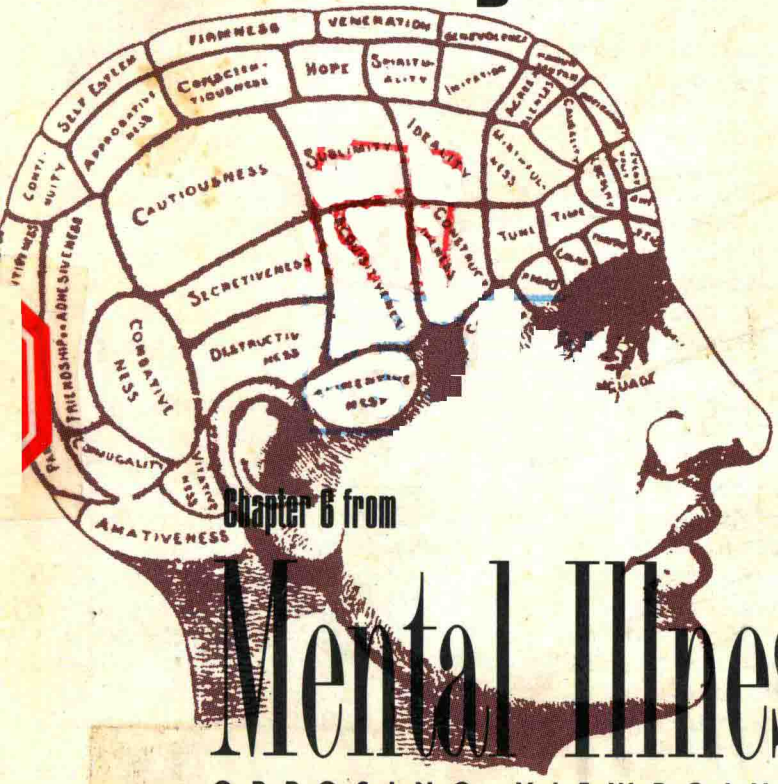
OPPOSING VIEWPOINTS® PAMPHLETS

What policies would benefit the mentally ill?



Chapter 6 from

Mental Illness

OPPOSING VIEWPOINTS®

What Policies Would Benefit the Mentally Ill?

This pamphlet is chapter six from *Mental Illness: Opposing Viewpoints.* Other chapters, also available in pamphlet form, are:

How Should Mental Illness Be Defined?
What Causes Mental Illness?
Are Mental Health Treatments Beneficial?
How Should Society Respond to the Homeless Mentally Ill?
How Should the Legal System Deal with Mental Illness?

Viewpoints

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The Importance of Examining Opposing Viewpoints

The purpose of this pamphlet, and others in the series, is to confront you with alternative points of view on complex and sensitive issues.

Perhaps the best way to inform yourself is to analyze the positions of those who are regarded as experts and well studied on the issues. It is important to consider every variety of opinion in an attempt to determine the truth. Opinions from the mainstream of society should be examined. Also important are opinions that are considered radical, reactionary, minority, or stigmatized by some other uncomplimentary label. An important lesson of history is the fact that many unpopular and even despised opinions eventually gained widespread acceptance. The opinions of Socrates, Jesus, and Galileo are good examples of this.

You will approach this pamphlet with opinions of your own on the issues debated within it. To have a good grasp of your own viewpoint you must understand the arguments of those with whom you disagree. It is said that those who do not completely understand their adversary's point of view do not fully understand their own.

A pitfall to avoid in considering alternative points of view is that of regarding your own point of view as being merely common sense and the most rational stance, and the point of view of others as being only opinion and naturally wrong. It may be that the opinion of others is correct and that yours is in error.

Another pitfall to avoid is that of closing your mind to the opinions of those whose views differ from yours. The best way to approach a dialogue is to make your primary purpose that of understanding the mind and arguments of the other person and not that of enlightening him or her with your solutions. One learns more by listening than by speaking.

It is my hope that after reading this pamphlet you will have a deeper understanding of the issues debated and will appreciate the complexity of even seemingly simple issues when good and honest people disagree. This awareness is particularly important in a democratic society such as ours, where people enter into public debate to determine the common good. People with whom you disagree should not be regarded as enemies, but rather as friends who suggest a different path to a common goal.

David L. Bender
Publisher

Chapter Preface

In January 1993, U.S. president Bill Clinton established the White House Task Force on National Health Care Reform, headed by First Lady Hillary Rodham Clinton, to formulate a national health care plan. While most commentators agreed that mental health should be included in the plan, a debate emerged over the extent and nature of treatments to be covered.

Some critics contend that only treatments for severe mental illnesses such as schizophrenia, manic-depressive disorder, and major depression should be covered under a national plan. These critics oppose coverage for what they see as less crucial care, such as substance abuse treatment and psychotherapy for so-called "problems of living." Laurie Flynn, the executive director of the National Alliance for the Mentally Ill (NAMI), a group consisting of family members of people with mental illnesses, argues that "there's a difference between illness and unhappiness." She contends that priority should be given to people with severe "mental illnesses that are diagnosable, treatable, disabling disorders," over people with the "wide range of mental health problems that affect everyone."

Others contend that a national health care plan should include comprehensive mental health benefits, including coverage for substance abuse treatment and psychotherapy. According to Kathryn Pontzer, former director of government relations at the American Association for Marriage and Family Therapy, giving the severely mentally ill priority would establish "a two-tiered system for mental health care, giving the impression that, somehow, certain mental health illnesses are more debilitating and disabling to individuals and their families, and therefore warrant special attention." She concludes that "a continuum of mental health services must be available to all adults and children with mental and emotional disorders." Former first lady Rosalynn Carter agrees: "We must not provide for care based on a hierarchy of pain. We must actively lobby for fair and equitable coverage under any plan of health care reform for everyone who is in need of mental health care."

Like most political issues, the debate over the inclusion of mental health in the nation's health care policy will likely result in some form of compromise that will in turn trigger more argumentation. In the following chapter, various mental health policy proposals are discussed and debated.

1 VIEWPOINT

"Mental health care represents a significant part of the overall health care system."

Mental Health Should Be Part of General Health Policy

Denis J. Prager and Leslie J. Scallet

In the following viewpoint, Denis J. Prager and Leslie J. Scallet argue that mental health and physical health are interdependent. Consequently, they contend, the traditional barriers between mental and physical health care should be eliminated, and mental health should be included in mainstream health care policy. Prager is director of the health program for the John D. and Catherine T. MacArthur Foundation, a private philanthropic organization in Chicago, Illinois. Scallet is the executive director of the Mental Health Policy Resource Center, a nonprofit research organization in Washington, D.C.

As you read, consider the following questions:

1. According to the authors, whose responsibility is it to develop human potential?
2. Prager and Scallet reject the idea of mental health as two "mutually exclusive categories—mentally well and mentally ill." What conception of mental health do they prefer?
3. According to the authors, what percentage of all hospital days are devoted to mental health care?

From Denis J. Prager and Leslie J. Scallet, "Promoting and Sustaining the Health of the Mind," *Health Affairs*, Fall 1992. Reprinted with the publisher's permission: *Health Affairs*, 7500 Old Georgetown Rd., Ste. 600, Bethesda, MD 20814, 301-656-7401.

In the changing landscape of American domestic politics lies the opportunity for the mental health and well-being of individuals to emerge as a central element of the nation's social agenda. To seize this opportunity, however, our nation must rethink the issues and policy priorities. Despite mental health's relatively low position on the nation's priority list since the early 1980s, much progress has been made, particularly with regard to the most disabling mental disorders. That progress represents a foundation of achievement and experience on which to build for the future.

This viewpoint is a synthesis of views that have emerged from our discussions with leading scientists and policy thinkers. Our purpose has been to develop a working model of the conceptual and strategic elements that are critical to efforts to raise the priority of mental health on the American social agenda and, ultimately, to enhance the mental well-being of individuals. Our hope is that these challenges will suggest a direction for the next decades—guideposts against which we can measure our progress.

Perspective on Mental Health

Our perspective begins with a society that places its highest value on the well-being of the individual. In our view, society's goal should be the realization of every individual's potential, whatever it may be; society thus should assure the conditions under which that potential is developed and expressed. The responsibility to develop human potential is shared among society and individuals. The conditions that promote the development of the individual differ from person to person, and some individuals need more help and support than others.

Inherent in this perspective is recognition of the mind as the core of each individual's being. The mind plays a critical role in the way one learns, thinks, reasons, plans, and makes decisions; the way one relates to others and to the environment, responds to the challenges of living, bounces back from serious life events, and learns from life experiences; and the way one behaves toward oneself, others, and society.

Our future society would value the health of the mind at least as much as it values the health of the body, implementing policies and programs that promote healthy mental development and prevent mental illness, and that provide caring and supportive environments and competent care for individuals with mental, emotional, or behavioral disorders. This will require that society (1) recognize mental health as more than the absence of disease and mental illness as more than categorical disorders defined by standard psychiatric criteria; (2) comprehend the range of mental function and dysfunction; (3) understand mental state to be highly dynamic; and (4) accept the challenge of developing

and delivering effective means for sustaining mental health and preventing and treating mental illness.

Defining people as either mentally healthy or mentally ill fails to account for the range of severity of mental dysfunction we routinely lump under the term "mental illness." In reality, one's mental well-being cannot be neatly assigned into one of two mutually exclusive categories—mentally well or mentally ill—any more than one can be described as either physically well or sick.

Just as we routinely view physical health as arrayed along a continuum from poor to excellent, we should conceive of mental health as a continuum of well-being from good health at one end to catastrophic dysfunction and suffering at the other. In between are a number of points, representing greater or lesser degrees of well-being, at which the state of an individual's mental health is a result of the interaction between the nature of his or her disorder—either long-term or transitory—and a range of personal strengths and social or family circumstances.

A Continuum of Intervention Strategies

Treatment Settings Based on Level of Impairment

A whole array of treatment settings is available to psychiatric patients. Increasingly, insurance payers are recognizing the need to provide coverage for all levels on the continuum.

Source: National Association of Psychiatric Health Systems.

This concept should not be misunderstood. It does not imply that every illness has definable stages or could be prevented if caught early enough; nor does it suggest that each definable condition or disorder has its place on a continuum of severity. Rather, we use it to portray an individual's mental condition at a point in time, taking into account all positive and negative factors that apply in a person's life.

Responding effectively to a continuum of mental well-being requires a continuum of intervention strategies. In the more familiar realm of physical disorders, we recognize that treatments range from "sleep, drink fluids, take two aspirin, and call me in the morning," to heroic, lifesaving therapies. Similarly, we should perceive efforts to enhance the health of the mind as ar-

rayed along a continuum, from programs that promote well-being and prevent pathology to crisis intervention.

Since society does not ordinarily categorize people as either always well or always sick, why do we stigmatize individuals with mental disorders and assume that their conditions are permanent, unchanging, and hopeless? Few people with even the most serious mental disorders are ill all of the time. Rather, many long-term conditions are episodic. A person with a severe and long-term mental illness may, with appropriate treatment and support, maintain a relative level of well-being most of the time. A person also may experience a brief but devastating bout of illness that temporarily pushes him or her to catastrophic dysfunction. Many people experience mental conditions at various times that are transitory, treatable, and compatible with a normal, productive existence.

Although society has structured its health policies, programs, professions, and institutions as though there were little relationship between mental and physical health, experience and, increasingly, empirical evidence speak strongly to the contrary. We know from everyday experience that the state of the mind has a profound influence on the state of the body. That influence is deeply embedded in our explanations for ill health, from backaches to cancer. Physicians also know from their experiences that many of the physical symptoms they see in patients are manifestations of mental distress or illness. This base of experiential knowledge is slowly being substantiated by studies documenting the role of mental state in the maintenance and deterioration of good physical health, and in the treatment of and recovery from physical illness.

Health Care Policy

This perspective has significant implications for public policy. . . . One of today's most pressing social issues is the quality, accessibility, and cost of health care. Mental health is considered a basic part of health care when costs are being discussed, otherwise, however, the two are most often treated as distinct. Conceptual and institutional barriers isolate mental health care from the mainstream of health care and sustain the myth that mental and physical health are independent states. The imperative to rein in runaway health costs impedes attempts to break down those barriers.

Mental health care represents a significant part of the overall health care system; more than 20 percent of all hospital days are devoted to mental health care. Health policies that perceive the systems as separate and fail to take into account trends in mental health systems are likely to create perverse and costly distortions in patterns of care. For example, viewing hospitaliza-

tion for mental illness as the responsibility of the state mental health system belies the reality that expenditures for care in scatter beds in general hospitals now constitute the single largest element of all hospital expenditures for mental disorders.

The health/mental health dichotomy also contradicts the reality of patterns of care. Most people with mental health symptoms—recognized as such or not—are seen first by primary health practitioners. Given the growing reliance on such practitioners for providing the first line of care and for serving as gatekeepers to specialty care, a particular challenge is to develop strategies to increase their capacity to recognize, diagnose, treat, or refer individuals with mental illness. That capacity will be greatly enhanced by diagnostic criteria that are consistent with the realities of the mental conditions that people experience and with the health care system. It also will be enhanced by the development of effective mechanisms for bringing mental health expertise to a range of health care settings. Such advances will assure greater access to competent mental health care without the need for labeling or formal referral.

An integrated approach to health and mental health care also will require that reimbursement [insurance] systems eliminate the current discrimination between interventions for mental and physical conditions. Reimbursement rules [limiting coverage of mental health care] . . . do far more than discourage recognition and appropriate treatment of mental problems. They drive up health costs—often for inappropriate care—masking them under reimbursable diagnoses. Reimbursement systems also discriminate against the use of psychosocial interventions in the treatment of physical illnesses. As we learn more about the relationship of mental state and health, psychosocial interventions proven effective in the treatment of physical conditions should be included in the armamentarium of the health care system and reimbursed accordingly.

Research Policy

One's mental, emotional, and behavioral health at a point in time is determined by a complex set of factors—individual and environmental—that interact to shape the course of human development across the entire life span. Policies capable of enhancing the mental well-being of individuals must be based on sound knowledge of these forces and the ways in which they interact. That knowledge can only derive from research with the capacity to elucidate the genetic, biological, psychological, social, and cultural determinants of health and illness, and to synthesize integrated models of their interactions.

Today's research, hobbled as it is by narrow perspectives, disciplinary boundaries, and institutional compartmentalization,

lacks that capacity. The challenge for researchers is to develop intellectual frameworks and models capable of integrating the diverse factors that determine mental well-being and its relationship to physical health, and to translate new knowledge into effective interventions. The challenge for policymakers and administrators is to develop organizational structures, incentives, and funding mechanisms capable of fostering and sustaining intellectual collaboration among those researchers. The challenge for advocates is to promote the broadest, most comprehensive research agenda possible, with the understanding that there are no easy answers. . . .

An important challenge for public policy in the 1990s is to explore how mental health and disorder affect and interrelate with high-priority policy concerns, from homelessness to substance abuse to family preservation. This is not simply a matter of restoring balance to the National Institute of Mental Health (NIMH) [a federal mental health research agency] research portfolio, so that it addresses psychological, behavioral, and social as well as biomedical processes, although this is needed. We must assure that mental health knowledge and perspectives are appropriately incorporated into the nation's conceptualization of and response to critical social problems. . . .

The challenge is to forge a comprehensive concept of mental health capable of linking and integrating the increasingly fragmented elements of policies and programs. Particular attention is needed to assure continuing interaction and dialogue among the research, training, and services communities, to assure that knowledge moves from the laboratory to practice and policy and that questions derived from practice and policy inform research planning.

In a time of extreme pressure on public resources, priorities must be set. If everything is a priority, then nothing can be. However, in setting priorities, we must still recognize the reality of "lesser" needs and the implications of failing to address them. Priorities inevitably will be set through a political process involving disparate groups and interests both within and outside the mental health field.

What is needed is a common set of goals related to enhancing the mental health and well-being of our population. Common goals would provide a positive context for debating specific policy issues and public funding priorities, and a framework within which diverse elements can work to promote their specific interests. They also would point the way to strategies for transcending the barriers that now isolate mental health from health, mental health care from health care, mental health services from social services, and people with mental disorders from other people.

2 VIEWPOINT

"To the degree that health policy subsumes mental health policy, the latter is doomed to fail."

Mental Health Should Be Independent of General Health Policy

Charles A. Kiesler

Charles A. Kiesler is chancellor of the University of Missouri, Columbia. In the following viewpoint, he argues that mental health policy in the United States is defective because it is dominated by general health policy that supports hospitals and physicians instead of promoting appropriate treatments. By emphasizing acute, inpatient hospital care and surgery, says Kiesler, U.S. health policy fails to meet the mental health needs of most Americans, who would be best treated through prevention, outpatient care, and attention to chronic problems. Kiesler concludes that mental health policy should be developed separately from general health care policy.

As you read, consider the following questions:

1. According to the author, how does the health of Americans rate when compared to other developed countries?
2. Why were prepayment plans originally developed, according to Kiesler?
3. According to the author, how do hospitals and physicians view the problem of indigent care?

From Charles A. Kiesler, "U.S. Mental Health Policy: Doomed to Fail," *American Psychologist*, September 1992. Adapted by permission.

The themes of this viewpoint can be expressed quite simply. Mental health, although historically linked to social welfare policy rather than health policy, has always had nontrivial dependence on federal health policy. Since the early 1980s, this dependence has increased at a rapid rate. The increasing dependence is due in part to changes in federal health policy, which have allowed clever mental health entrepreneurs opportunities in a changing marketplace. However, part of the dependence is also due to the unwitting undercutting or elimination of leadership roles in mental health policy.

The result is a forced mimicry of health services by mental health services under federal health programs in which mental health plays a trivial role. For example, although opportunities for mental health services increasingly exist under Medicare, only 3% of Medicare funding goes for mental health. Because appropriate bodies are not available to articulate mental health policy and services needs, the mental health services most easily reimbursed are those emphasized in health policy, that is, inpatient services, which are demonstrably less effective and more expensive. Lack of articulation of mental health service opportunities and needs, combined with the funding opportunities under health policy, has led to a rapidly increasing dependence of mental health policy on health policy. . . .

The increased absorption of mental health policy under health policy inevitably dooms mental health policy because *U.S. health policy is itself inherently flawed.* Furthermore, the ways in which health policy is flawed have even more negative implications for mental health than for health.

Doomed to Fail

Throughout the 20th century, the cornerstone of U.S. health policy has been the short-term general hospital—the "doctor's workshop"—emphasizing acute care and especially surgery. This fact has led the United States to have the best hospital care in the world but a population that, on average, has only mediocre health compared with other developed countries. This irony is largely determined by the fact that the strengths of U.S. health policy—centered on the short-term, acute-care general hospital—do not match up well with the health needs of the nation. Left underemphasized in U.S. health policy are preventive services needed by the least wealthy 40% of the population; the needed behavioral changes in the population that could lead to healthier practices; and various chronic health problems, especially those experienced by the elderly, children, and youth.

This disparity between service strengths and national needs is exaggerated for mental health policy to the extent that it mimics health policy. In the United States, health care in a short-term

acute-care hospital is the best in the world. However, in mental health, care outside a hospital is demonstrably better and less expensive than care in the hospital. Consequently, whatever limitations current health policies have in addressing the health status of the average citizen, the limitations are much more severe for any mental health policy that mimics it. Inevitably, to the degree that health policy subsumes mental health policy, the latter is doomed to fail. . . .

Cornerstone of Health Policy in the United States

One could argue—and effectively—that we do not have any national health policy in the United States. However, to the extent that we do, our health policy is inherently flawed. Current health policy is certainly not an appropriate model for mental health. . . . Numerous articles [have been written] regarding hospital cost containment and health care cost containment in the United States; numerous professional articles on PPS [Prospective Payment System—a capitation scheme (a uniform per-capita fee) introduced by Medicare] and its imitators; and comparisons of health care costs and outcomes with Canada, England, and other industrial nations. A very succinct summary of this literature is that the United States pays more than any other country for health care, has arguably the best hospital care in the world, and as a nation has mediocre health. Over 30 million Americans do not have health insurance at all, and another more than 30 million do not have health insurance sometime during the year.

Rosemary Stevens has described how the United States has found itself in this quandary in her brilliant book *In Sickness and in Wealth: American Hospitals in the Twentieth Century*. Stevens documented the notion that American health policies have always focused on short-term, nonfederal general hospitals, sometimes called voluntary hospitals or community hospitals. These hospitals have always had one primary emphasis—surgery—and one overriding concern—paying patients. Although the terms *voluntary* and *community hospitals* would imply potential treatment for all citizens, this has never really been the case. Historically, capital expenses have come from gifts and investments, but patients have paid for their hospital treatment. In England, the opposite trend could be seen early. In 1911, patients in London provided only 10% of total hospital income. In short, our lack of emphasis on access to health care in the United States is not recent.

Furthermore, a concern with separating doctors' income and hospital income was also always present. In 1904, for example, the Mayo brothers [Charles and William, of the famed Mayo Clinic] and their associates performed more than 3,000 surgical operations. They obviously made a fortune. But their patients stayed in St. Mary's—a Catholic, charitable, nonprofit hospital.

The American Hospital Association (AHA) was formed by hospital administrators in 1899 and was originally called the Association of Hospital Superintendents. In World War I, the enormous success of surgical teams in combat zones (formed largely by groups of surgeons from university hospitals) had a dramatic impact on health policy in the United States then and now. From the 1920s on, hospitals—particularly teaching hospitals—became the cornerstone of the U.S. health care system. They have consistently emphasized short-term acute care, especially surgery, and still do.

The hospital system became big business. By 1930, $2 billion had been invested in general hospitals, making it the fifth largest industry in the nation. By 1923, 23% of the entire nation's medical bill was going directly to hospitals.

The Development of Prepayment

But hospitals were still places for the rich, and the principal question for hospital administrators was how to attract persons of moderate means to inpatient care. In 1929, Baylor University offered services to white school teachers and other groups for a fixed annual fee, collected in monthly installments. The fee depended on whether ultimate care was desired in a ward or in a private room. All standard hospital charges were included in the fees. Stevens emphasized that the primary purpose of this development was not to increase the access of the average citizen to medical care but to stabilize the income of hospitals by providing for a prepayment for potential use.

The American Hospital Association was strongly behind the development of prepayment plans to produce income. Originally, the American Medical Association (AMA) was opposed to any kind of "corporate medicine," including salaries for physicians. Both AHA and AMA opposed the original social security legislation in 1935 for two reasons: They did not want to treat welfare patients, and they saw potential federal control over hospitals and physicians. Throughout the 20th century, despite huge federal contributions to hospital construction, to medical education, and to medical technology, the AMA and the AHA have opposed any strings to the money.

Building on the Baylor Plan, Blue Cross plans were begun to *prepay* hospital expenses, not to provide increased access of the average citizen to care. Of 39 Blue Cross plans surveyed in 1944-1945, hospitals contributed to the starting capital in 22 of them. As Stevens said, "Blue Cross schemes were corporations founded by corporations (hospitals), which responded to the needs of corporations (employers)." Excluded from the Blue Cross plans were mental health, the elderly, the unemployed, the disabled, agricultural and domestic workers, and part-time workers. In gen-

eral, physicians opposed Blue Cross, and no doctor fees were covered. The opposition was largely on grounds of who would be in control, but negotiations led to increased autonomy for physicians. In the late 1930s Blue Shield was started for similar reasons, to provide income for physicians in hospitals.

Excessive Hospitalization

Not every patient symptomatic with a mental disorder or substance abuse needs the protection or supervision available in 24-hour inpatient care. . . . Many psychiatric patients with acute exacerbations could be treated with day hospitalization to adjust medication, more frequent office visits, domiciliary care, or in other outpatient treatment settings. However, insurers have not traditionally recognized the differences among various outpatients settings, nor have they structured benefits to encourage use of such alternatives. As a result, in-hospital stays are longer than necessary.

Steven S. Sharfstein, Anne M. Stoline, and Howard H. Goldman, *American Journal of Psychiatry*, January 1993.

These themes from the 1930s continue to the present day: (a) Hospitals or medically controlled corporations independently contract for prepayment for services; (b) doctors are independent from hospital control and separately contract for services; (c) both are willing to accept federal funds but not federal control or federal oversight; (d) both hospitals and physicians see indigent care as the government's problem, not the hospital's problem; and (e) both hospitals and physicians' services in them are based on the latest and most expensive technology, which in turn has been mostly paid for by the federal government.

There are two major themes throughout the 20th century regarding U.S. health policy: (a) Short-term, acute-care hospitals are the cornerstone of health care in the United States, and (b) the hospital is regarded as the doctors' workshop—which others pay for but physicians control. The current view of hospitals as effectively conjoining science and treatment is not a new view but one that has been put forth by service providers throughout this century. Stevens argued that discoveries such as sulfa [a bacteria-inhibiting chemical] and penicillin had a much more substantial impact on health care than did hospitals or high technology equipment (and neither was an American discovery).

Nonetheless, the emphasis in the United States now and throughout the 20th century is (was) on hospital care and not health care. Nationally, the emphasis is on quality of care and

not access to care. There has never been effective national planning; planning has always more or less been regional in nature, leaving doctors alone and providing them with enhanced hospital and diagnostic facilities.

Hospital Policy, Not Health Policy

My purpose here is not to deprecate either physicians or hospitals but rather to show the following: To the extent we have a health policy in the United States, it is to support general hospitals (rather than health) and the physicians who use them, along with the expensive technology they desire. Our national policy supports *acute care* and technology, along with providing all capital expenses. Hospitals remain the doctors' workshop, and they heavily emphasize surgery.

On the other hand, our health needs as a nation do not match up well with a de facto policy that emphasizes acute care and surgery. In particular, the needs of the elderly, children and youth, families, the uninsured or underinsured—meaning the majority of the citizens of the country—take two forms: prevention and addressing chronic problems. Even partial solutions to both these problems require easy access to general medical care but not necessarily specialized care.

National health policy is flawed at its core: It represents national general hospital policy, not health policy. Mental health—even though traditionally seen as a state and welfare problem—has always been dominated by health policy. However, mental health policy has lost its traditional roots—state hospitals and the CMHC [Community Mental Health Center] system [a federally funded program to establish community-based mental health centers nationwide], and very flawed roots they were—and increasingly comes unwittingly under de facto health policy through Medicaid, Medicare, Blue Cross/Blue Shield, and other commercial insurance.

This increasing domination of mental health by health policy allows us to understand better a number of trends: (a) Although policy analysts have consistently concluded we need to decrease children's hospitalization for mental disorders, it is increasing. Indeed, children's mental hospitalization is increasing dramatically in hospitals without specialized units, in RTCs [residential treatment centers], and in private psychiatric hospitals—all of which represent unknowns regarding treatment effectiveness. (b) Although we conclude that the problems of the elderly are disproportionately chronic, 12% of Medicare eligibles had surgery in 1979, and the total population of Medicare eligibles spent 4.1 days on average per year per person in general hospitals (six times as many as the rest of the population). It appears that acute problems are being emphasized rather than the

chronic problems that exist. (c) We conclude in mental health that outpatient care works better than inpatient care, but inpatient care continues to increase, and outpatient care is difficult to fund. (d) In spite of data to the contrary, there are consistent incentives in public and private insurance programs in mental health that favor inpatient care.

Independent Mental Health Policies Needed

In conclusion, our national health policy supports hospital care, not health care. Mental health treatment data are clearly inconsistent with and indeed contradict the bias toward inpatient care. Even though there is improvement in the linkage between mental health policy and data, there are severe limitations of how far we can go in those otherwise encouraging trends, working under an umbrella health policy that favors inpatient acute care.

Some have argued that health and mental health practice and policy should come closer. One could make a good argument for that point of view because of the obvious overlap regarding health and mental health problems in individuals. However, when health policy is flawed and when the cornerstone of health policy is acute inpatient care, the more mental health policy is subsumed under health policy, the more expensive and inappropriate mental health care will become.

Perhaps the best outcome data in either health or mental health are those that demonstrate that psychiatric care of serious mental disorders is more effectively and less expensively treated outside hospitals than in them. I emphasize that the inpatient care in those studies represents perhaps the best psychiatric inpatient care available. The psychiatric inpatient sites that have recently substantially increased their episodes of care—private psychiatric hospitals, RTCs, and quasi-units [organized services and personnel within general hospitals that do not meet the formal legal requirements of a psychiatric unit]—provide demonstratively less intensive care than psychiatric units, and their treatment effectiveness up to now is completely unassessed.

These notions pragmatically dictate a clear conclusion: Mental health policy analysts and advocates need to articulate mental health service needs and treatment data more clearly and to work to develop public federal and state policies that are specific to those needs but independent of health policy.