

Mental Health Policy 2008 Winner's Curse?

Richard G. Frank
Harvard University

“We must act to bestow the full benefits of our society to those who suffer from mental disabilities; to prevent occurrence of mental illness...wherever and whenever possible; to provide for early diagnosis and continuous care in the community, of those suffering from these disorders; to stimulate improvements in the level of care given the mentally disabled in our State and private institutions, and to reorient those programs to a community-centered approach; to reduce, over a number of years and by hundreds of thousands, the persons confined to these institutions; to retain in and return to, the community the mentally ill... and there to restore and revitalize their lives through better health programs and strengthened educational and rehabilitation services...”

Kennedy, J.F., *Message from the President of the United States Relative to Mental Illness and Mental Retardation*, Washington D.C.: USGPO, 1963.

Introduction and Overview

- ◆ Mental health care and the well being of people with mental disorders improved notably 1955-2001
- ◆ Much still needs to be done
- ◆ The forces that drove gains create new challenges and threats
- ◆ Institutions aimed at creating a new stewardship for mental health represent a new frontier
- ◆ What research needs to occur in support of these new policy challenges?

Dimensions of Performance

- ◆ Access to care
- ◆ Quality of care
- ◆ Support for people with severe mental disorders
- ◆ Cost/spending

Access to Care

	1990-1992	2001-2003	%Δ
Any Tx All	12.2%	20.1%	64.7%
Any Tx SMI	24.3%	40.5%	66.7%
Any Tx Disorder	20.3%	32.9%	62.1%

Source: NCS and NCS-R

Quality of Care Indicators

	1975	1997	2002
% of ADD care likely to be effective (acute phase)	17%	58%	60%
antipsychotics for schiz % appropriate dose and duration	25%	47%	59%
% appropriate bipolar prescribing (mood stabilizer)		45%	56%

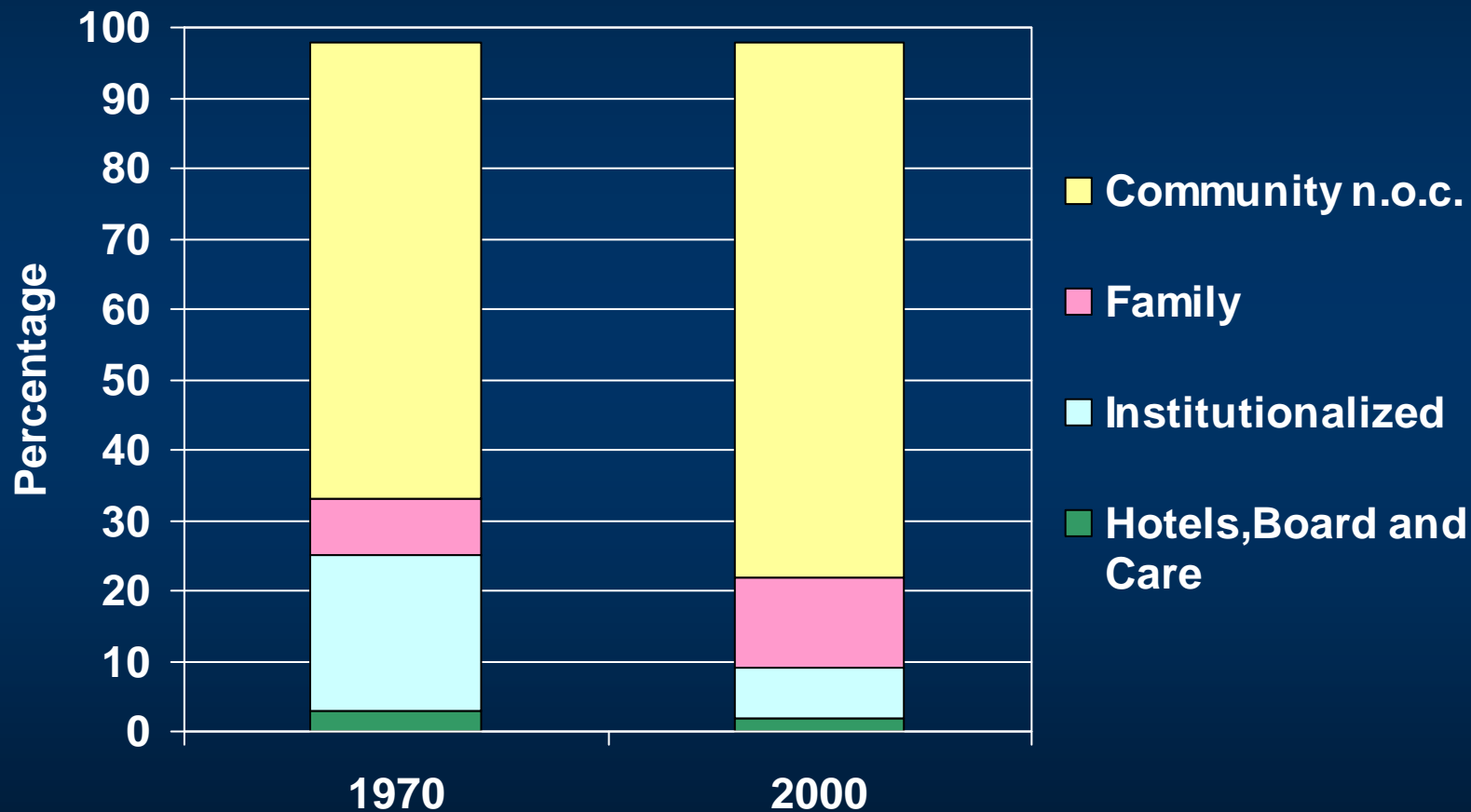
HEDIS Antidepressant Management: Commercial

Year	Contacts	Acute Phase	Continuation
1998	22.7%	54.3%	38.0%
2000	20.6%*	57.8%*	41.0%
2002	19.2%	59.8%	42.8%
2004	20.0%	60.9%	44.3%
2005	20.6%	61.4%	45.0%

*interpolated

Source: NCQA

More People with SPMI are living Independently or with Family



Income Support, Homelessness And Incarceration Have All Increased For People With SPMI

	1970	1980	2000
SSI/DI for SPMI	-	17%	62%
Correctional Facilities	2%	3%	7%
Homeless SPMI	2%	2%	3%

Summing Up

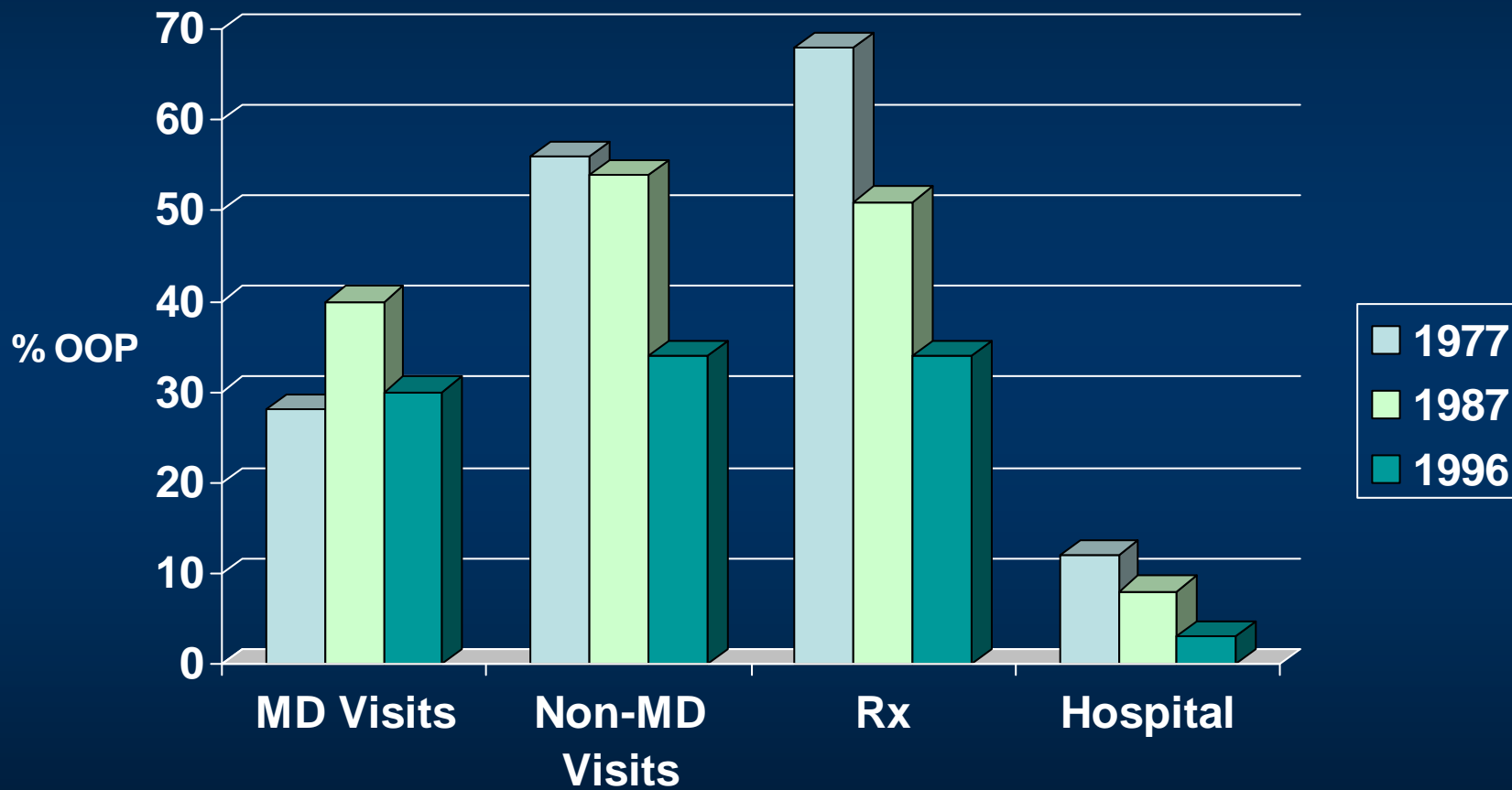
- ◆ Far more people are getting care today than ever before
 - There remains much under treatment
- ◆ A higher proportion of people receiving care obtain more effective care than in past
 - A large portion of people in treatment do not receive evidence based care; Many treatments for major illnesses offer only modest improvements
- ◆ More people with SPMI are living independently in community settings
 - People with SPMI are most often condemned to a life of poverty: percent of people with SPMI who are homeless or in prison increased

Changes in Financing

Mental Health Spending by Payer Class 1971-2001

	1971	1991	2001
Medicaid	\$1.28b	\$9.2b	\$23.4b
	(14.2%)	(18.8%)	(27.4%)
Medicare	\$0.23b	\$3.3b	\$6.3b
	(2.6%)	(6.7%)	(7.3%)
State (exclude Medicaid)	\$2.720b	\$13.1b	\$20.0b
	(30.4%)	(26.7%)	(23.4%)
Private Insurance	\$1.10b	\$10.6b	\$18.7b
	(12.3%)	(21.7%)	(21.9%)
Fees/OOPs	\$3.19b	\$7.5b	\$10.9b
	(35.6%)	(15.3%)	(12.8%)
Total	\$8.96b	\$48.9b	\$85.4b
	(100%)	(100%)	(100%)
Share of National Health Expenditures	11.1%	6.4%	5.9%
Share of GDP	0.84%	0.82%	0.84%

Reduced Out of Pocket Financial Burden



Observations on Changes in Financing

- ◆ Much more money is being spent on mental health than in 1971 but share of GDP is constant and share of health spending is declining

The mental health “cost” problem is different from the health care cost problem

- ◆ What we count as spending is different today

1971 much money spent on room and board in long stay hospitals was health spending

Today Section 8 housing vouchers, income support through TANF, SSI and SSDI, and employment programs not counted as mental health spending

Observations on Financing

- ◆ Medicaid is single largest financing source in 2001 (27.4%)
- ◆ State mental health agency spending now accounts for about 23% and it is increasingly tied to Medicaid
- ◆ Private insurance accounts for almost 22% of spending
- ◆ Out of pocket cost burden has declined (improved financial protection)

Implications of Shifts in Financing

- ◆ Increased resources for mental health care have come from “mainstream” public health insurance and social programs
- ◆ If housing policy is your issue, mental health issues pose a challenge
- ◆ If income support and welfare reform work are your concerns, mental health issues challenge policy design (28% of TANF adults; 30% SSI; 35% SSDI)
- ◆ If child welfare or juvenile justice is a policy challenge, mental health issues must be addressed
- ◆ If mental health is your issue you need to know housing, income support, and child welfare systems

An Observation on Mental Health as Social Issue

- ◆ Mental Health spending and progress has been driven by broader social programs
- ◆ The amount of spending in this area has not out paced general growth in income
- ◆ Throwing money at THIS social issue has made matters better

Additional Implications

- ◆ Because mental health resources have shifted to mainstream programs away from state mental health authorities
 - There is frequently a deficit in mental health expertise in key agencies running these programs
 - There is little “voice” representing mental health sensibilities

Challenges from Policy-Leadership Vacuum

- ◆ What new institutions, administrative structures and policies must be created to continue the progress of the past 50 years?
- ◆ How do we define a new stewardship for mental health in an era when state mental health agency influence has waned?

Some Strategies for Mental Health Stewardship

- ◆ Consolidation of mental health issues across agencies under single management entity
 - Can address key leadership and management challenges
 - Complicated politics, bookkeeping
- ◆ Create matrix state organization
 - Consulting versus action function
- ◆ Bring mental health expertise into “mainstream” program agencies
 - Seldom tried— mental health marginalized

What does this mean for research?

◆ Key Questions

- What set of organizational, regulatory and payment changes would improve the alignment of incentives across systems that serve people with mental disorders?
 - Example: SMHA supported employment and TANF policy
- What set of organizational, financial and programmatic features offer the most promising platform for alternative models of stewardship in different state political—historical contexts?

Research Implication

◆ New Opportunities to Study Stewardship

- State Models: New Mexico; Texas; Mass.
- Federal supported employment

◆ Qualitative

- The mental health system must get “smart” about income support, Medicaid, Medicare (SNPs), criminal justice, TANF, SSI/DI
 - This implies conducting mental health services research within those systems

◆ Data

- Investments need to be made in data systems that count people, services and dollars across all service delivery settings

Concluding Remarks

- ◆ Mainstream health insurance, income support and social service programs have been key drivers of progress in mental health
- ◆ As the center of gravity in mental health policy has shifted away from SMHAs, a leadership/policy design vacuum has been created
- ◆ The new policy challenge is to ensure stewardship of modern mental health care arrangements
- ◆ The research challenge is to inform decision-makers about which models to bet on and the consequences of working specific policy levers