

# Economics and Ethics in Mental Health Care: Traditions and Trade-offs

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## Abstract

**Background:** Both economic and ethical perspectives are exerting increasing influence at all levels of mental health policy and practice; yet there is little consensus on how these two different perspectives are to be reconciled or explicitly incorporated into decision-making.

**Aim:** This review article is directed towards a fuller understanding of the complex trade-offs and compromises that are or may be made by clinicians, managers and policy-makers alike in the context of mental health care planning and delivery.

**Method:** We briefly outline a number of key principles of health care economics and ethics, and then focus on the particular incentives and trade-offs that are raised by these principles at three levels of the mental health system: government and society; purchasers and providers; and users and carers.

**Results:** At the level of government and society, we find (economically influenced) attempts to reform mental health care offset by concerns revolving around access to care: whether society is prepared to forgo economic benefits in exchange for improved equity depends to a considerable extent on the prevailing ethical paradigm. The implementation of these reforms at the level of purchasers and providers has helped to focus attention on evaluation and prioritization, but has also introduced 'perverse incentives' such as cost-shifting and cream-skimming, which can impede access to or continuity of appropriate care for mentally ill people. Finally, we detect opportunities for moral hazard and other forms of strategic behaviour that are thrown up by the nature of the carer:user relationship in mental health care.

**Conclusion:** We conclude by highlighting the need to move towards a more open, accountable and evidence-based mental health care system. Acknowledgement of and progress towards these three requirements will not deliver *ideal* levels of efficiency or equity, but will foster a greater understanding of the relevance of ethical considerations to mental health policies and strategies that are often influenced strongly or solely by economic arguments, whilst also demonstrating that equity must come at a price. © 1998 John Wiley & Sons, Ltd.

Received 2 May 1997; accepted 17 April 1998.

## Introduction

Ethical and economic standpoints in mental health care appear to be very much at odds with each other: consider,

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Source of funding: none

for example, the principles inherent to the Hippocratic oath, which require clinicians to prescribe treatment to the best of their ability and judgement for the good of the sick. This professional code of conduct seems to sit uneasily next to the competing principles of cost-containment, rationing and efficiency, economic criteria that have steadily crept into the lexicon of health service management. But is this clash as head on as might at first appear to be the case? It could be argued, for instance, that rigorously pursuing the oath flies in the face of morality, on the grounds that, by ignoring the costs of their actions, clinicians may be denying treatment or access to care to others who could benefit as much or by more.<sup>1,2</sup> Similarly, recent developments such as 'league tables' of cost-utility can be viewed equally well as attempts to make explicit what can be achieved within a finite amount of resources as they can as interventionist cut-off points that restrict access to health care. Ethics and economics are in fact inextricably linked in decision-making at all levels of mental health care financing and delivery, and it is towards a fuller understanding of the complex trade-offs and compromises that are or may be made by clinicians, managers and policy-makers alike that this discussion is directed.

## Four Principles of Health Care Economics

Economic analysis has only been explicitly directed towards health care in the last twenty-five years or so, but has now established itself as having an important role in the planning, management and evaluation of health care. Particular interest and attention has focused on examination of different models of finance and delivery, as well as the behaviour of key health care agents, thereby making explicit the economic consequences of (previously covert) organizational arrangements or individual clinical judgements.

- (i) *Resource scarcity.* A common and useful starting point for many exegeses in applied economics is a reminder of the scarcity of resources, for, while society might decide to allocate, say, 30% of gross domestic product to the provision of health care, this would severely limit the availability of resources for other competing, and equally worthy, claims on national income. Implicit in the notion of scarcity,

then, are the linked concepts of sacrifice and choice, and a realization that potential programmes of investment must be prioritized.

- (ii) *Opportunity cost.* Rather than direct expenditure flows between principal agents (financial or accountancy costs), economists perceive costs as a set of foregone opportunities; thus the opportunity cost measures the true private or social value of a resource, based on its value in its best alternative use. For example, an acute psychiatric bed is theoretically valued by reference to the alternative use with which those resources could be put to, such as within another medical speciality, outside medicine completely or investment into an interest-bearing savings account.
- (iii) *Efficiency.* Efficiency is first and foremost concerned with establishing that health care programmes are worthwhile, in the sense that their benefits exceed their costs (allocative efficiency); at a technical level, efficiency is concerned with ensuring that best use is made of the scarce resources channelled into these worthwhile programmes. Efficiency therefore provides a cost:benefit framework with which to determine an optimal allocation of resources to various programmes of expenditure, including health care.
- (iv) *Welfare maximization.* Health care is most appropriately described as an intermediate good, that is not of intrinsic value in itself, but of value in its contribution (along with other inputs such as environmental and social factors) towards the production of health itself, which in turn enables or satisfies other functions such as work, leisure or fulfilment.<sup>3</sup> In this sense, the ultimate aim—or maximand—of health care delivery is the optimization of social welfare.

## Four Principles of Health Care Ethics

Many developments have raised the profile of ethics in mental health care practice, including increased consumer knowledge of medical practice generally and issues of informed consent (for example, involuntary hospitalization or treatment). A number of ethical issues now confront the practising mental health professional: how to assess the respective moral cost and benefits of their actions; how to maintain confidentiality whilst retaining objectivity and remaining accountable; and how to treat clients effectively whilst maintaining their confidence.<sup>4</sup> Beyond these concerns there are also wider ethical considerations to do with fairness in society. There are therefore a number of essential ethical principles that can and should be brought to bear on decisions effecting the financing and delivery of health care generally. The following four principles are those reached by Gillon,<sup>5</sup> and used in a more applied setting by a working party on the ethics of resource allocation in health care.<sup>6</sup>

- (i) *Autonomy.* Autonomy, self-government or free will represents a core individual right that encompasses the capacity to deliberate upon reasons, change decisions and act on the basis of those decisions, a

concept expressed by economists as consumer choice. This capacity for autonomy—whether of thought, will or action—is distinct from the principle of respect for autonomy (the difference between voting for a particular political party onself, and accepting the voting preferences of others).

- (ii) *Beneficence.* Beneficence is a broad term encompassing the notions of virtue and duty that requires individuals and institutions to pursue beneficial goals and positively shift the balance of good over harm, and represents a key individual ethic that has provided the *raison d'être* for clinical freedom in medical practice. Services should be provided purposively to do good to the client or patient, providing the basis of the notion of money following the patient. Some moral theories, notably utilitarianism, elevate beneficence to the supreme moral obligation, drawing on the notion of 'the greatest good to the greatest number'.
- (iii) *Non-maleficence.* The principle of non-maleficence is closely related to beneficence, exhorting decision makers not to impose harm or evil upon those affected by their actions. This is a clear enough ethical rule to follow in terms of deliberate violation of accepted medical practice, and therefore violation also of patients' rights. It is less apparent when maleficence can be imposed (perhaps unwittingly) on a particular patient by the use of risky or unevaluated interventions (such as in clinical trial settings), or indeed in the pursuit of benefit for the majority (for instance, unpleasant side-effects of psychotropic drugs administered to individuals who pose a risk to others).
- (iv) *Justice.* Considerations of justice or fairness revolve around the ideas that each person must be given their due and equals must be treated as equals, referred to in the economic literature as equity. On what basis, and from what starting point this collective notion of justice is assessed, is a source of theoretical debate: egalitarian approaches emphasize the social basis of justice by arguing for equal shares of a distribution of a commodity such as health care while libertarian approaches, by contrast, argue for consumer sovereignty and willingness to pay as the measures of the direction of society's preferences with respect to health care. Debates on justice or equity at a policy level have typically concentrated on the distribution or redistribution of (scarce) resources, which in the context of mental health care is typically determined by need and expressed in terms of access to or utilization of services.

Having outlined a number of salient economic and ethical principles in relation to health care decision-making, it is now appropriate to move on to a discussion of the tensions that manifest themselves in the organization, financing and delivery of mental health services. The focus of attention will be to look at how *economic incentives* are affected by

*ethical trade-offs* at three distinct levels of decision-making: government and society; purchasers and providers; and users and carers.

## Government and Society

In a perfectly competitive market, the supply and demand for a particular good attains equilibrium, such that no more and no less of the good is produced or consumed than is optimal. In reality, markets do not behave in this harmonious fashion, manifesting 'failures' due to unfair competition, uncertainty and externality effects. The market for mental health care is no exception. These failures are so prevalent that some form of government intervention is almost inevitable. The extent of government involvement is influenced not only by economic and political considerations, but also by the prevailing model of social choice. In most countries a careful balance of both individualistic (autonomy and consumer sovereignty) and collective (justice and welfare maximization) principles will need to be considered.

### *Economic Incentives*

Mental health services in industrialized countries are financed through a variety of means, the main mechanisms being general taxation (such as Sweden and the UK), social insurance (including France and Germany), private insurance (notably the US), or a combination of these (for example, Spain and Italy).<sup>7,8</sup> In the face of competing and escalating demands on scarce public funds, both within and outside the mental health sector, governments have been anxious to explore the extent to which alternative patterns of delivery and funding may offer efficiency improvements over existing arrangements. Consequently, the last decade has seen unprecedented change and reform to the way in which mental health services are financed, delivered and organized. The basic rationale behind recent reforms in countries such as Australia, New Zealand, Sweden, the United Kingdom and the United States is that market forces such as competition are more likely to improve the (technical) efficiency with which services are delivered than bureaucratic regulation.

Inherent to these reforms has been an accompanying interest in evidence-based decision-making, reflecting the intent to evaluate—in terms of efficacy, outcomes and costs—the relative merits of alternative strategies or programmes of mental health care and prevention. Ideally, governments would wish to hold comparative data on the costs and benefits of alternative courses of action which would allow priorities to be made in relation to different programmes of investment, enabling societal welfare to be maximized within the available resources (allocative efficiency). However, since mental health outcomes are uncertain, heterogeneous and in many cases intangible, quantification of benefits in monetary units is problematic. The absence of readily quantifiable outcomes not only constrains explicit government priority-setting exercises between different sectors of the economy, but also hampers mental health decision-makers,

who increasingly need to be able to demonstrate to government the economic pay-off (in terms of benefits exceeding costs) of investment in, say, reprovision of care into the community rather than a new road-building programme.

### *Ethical Trade-offs*

Governments need not only seek an efficient allocation, but may also strive towards a fair allocation, based on the principles of autonomy, justice and beneficence outlined earlier. That is to say, even if an optimal allocation could be arrived at on economic cost:benefit grounds, the resultant mix of services across different patient groups might be rejected on the grounds that it confers an unequal or unfair distribution of benefits.

Ethical considerations are incorporated into the decision-making process in a number of ways and to varying extents, depending on the prevailing model of social choice and health care financing. In egalitarian, public insurance systems such as that found in the UK, Canada and much of Scandinavia, the collective ethical concepts of access for all and provision of care irrespective of ability to pay represent fundamental principles of health care provision. These principles are operationalized by financing health care from a progressive income tax system based on ability to pay (vertical equity), and weighting allocations of resources to districts or regions on the basis of relative need (such as poverty, deprivation and social isolation, each of which are positively associated with increased psychiatric morbidity and admission rates).<sup>9,10</sup>

In more libertarian health care systems such as the US, consumer sovereignty and market forces remain pre-eminent, thereby promoting the individual ethics of virtue and duty over collective notions of fairness or equity. Thus, the majority of the population are covered by private insurance, through which they are able to access high quality (though expensive) mental health care. Specific federal programmes of care for the indigent and the elderly enables these particularly vulnerable populations to access services (if eligible), but this leaves a sizeable minority of the population (15%) who have inadequate or no health insurance coverage at all, demonstrating the relatively inequitable nature of this system. The failure of recent efforts by the Clinton administration to introduce universal coverage only serves to reinforce the apparent unwillingness of US society to pay for improvements in access to health care.

A key issue at this societal level of decision-making relates to the confusion of definitions in use and the absence of any one common measure of equity across countries. Equity or fairness can be defined with reference to need for/capacity to benefit from care, access to care or utilization of care, both in a financial or geographical sense.<sup>7</sup> The choice of definition carries significant implications for distributions of health itself (which is assumed to be the focus of policy interest). For instance, it has been demonstrated that distributing health care resources according to the principle of capacity to benefit is unlikely to promote equality of health itself, and may actually increase inequality of health.<sup>11</sup>

Improved understanding of alternative definitions of equity and open and explicit agreement on the distributional principle to be pursued is therefore of paramount significance. One notable and recent example of this has been conducted in Sweden, where a government commission was established to recommend guidelines for priority setting in health services on the basis of a clearly specified ethical framework.<sup>12</sup> The three ethical principles that were established by the commission to underpin its recommendations were human dignity (all people have equal rights), need and solidarity (targeting resources according to need) and cost efficiency (an appropriate balance of costs and benefits).

In conclusion, equity is achieved at a price, and whether society is prepared to pay this price will depend to a considerable extent on the prevailing ethical paradigm. In countries where individualistic ethical principles have the ascendancy, governmental/federal responsibilities are restricted to ensuring access to care for vulnerable sub-populations in society and regulating third-party insurance systems. Where governments are given a mandate to provide universal and comprehensive health care coverage, however, national policies or strategies considered to be efficient in terms of optimizing health gains for the population—perhaps in the form of league tables of relative priority—will need to be moderated in the face of equity considerations, the effect of which reduces the pure efficiency with which services are delivered but which confers a more equal distribution of health care and its consequences for social welfare. A fair allocation of resources is unlikely to be the most efficient allocation.

## Purchasers and Providers

The second level of decision-making concerns those agents responsible for purchasing, managing or providing mental health care. Decision-makers at this level do not concern themselves so much with meeting overall societal objectives, as with objectives that commonly revolve around the maximization of gain, in terms of clinical and cost effectiveness, for the local population for whom they are responsible.

### *Economic Incentives*

While national or federal health care policies, strategies or reforms are conceived and designed at the government level, they are implemented or enacted at the level of purchasers and providers. Most notably, there has been a widespread international move away from institutional care to more community-based systems of mental health care.<sup>8</sup> In the US, a system of 'managed care' has been implemented that seeks to constrain mental health service utilization and costs through risk-based contracting, whilst in the UK and New Zealand specialist mental health care provision has been largely moved into a quasi-market of purchasers and providers. Mental health care purchasers are required to assess the care and support needs of their local populations and purchase appropriate services on their behalf by arranging

contracts with providers that make the best use of available resources; providers, for their part, need to pursue strategies that will allow them to survive in the marketplace. The tensions created by this division of roles are intended to eliminate waste and inefficiency and encourage an environment of improved accountability, mutual dependency and cost consciousness through contestability (competition).

A central theme of these organizational changes is the increased need for data or evidence with which to evaluate the clinical and cost effectiveness of new and current therapies. Purchasers in particular require information on the relative worth of alternative interventions in order to improve or maximize the health gain of their populations. In the absence of a genuine cost:benefit framework (in which both costs and benefits are measured in monetary units), the form of evaluation that has come closest to this specification is cost:utility analysis, in which the outcomes of intervention are conflated into a single index, the most common being the quality adjusted life year (QALY); by relating QALYs to cost, an indication of the relative cost-effectiveness of different interventions emerges.<sup>13</sup> Policy-makers in the US state of Oregon, for example, ranked the relative costs and benefits of a whole range of mental (and other) health care interventions (in consultation with the local populace), using the derived rankings as an explicit basis for prioritization and resource allocation.<sup>14,15</sup>

While the division of roles implicit in a quasi-market for mental health care might lead to more effective and appropriate services, it also generates less positive economic incentives. For example, UK health authorities have an incentive to reduce hospital bed numbers, whilst social service departments and primary care providers would prefer to maintain such beds.<sup>16</sup> By contrast, the retrospective reimbursement systems that exist in France and Germany, based on a daily fee basis, provide an incentive for mental hospitals to hang on to their caseloads—particularly the less dependent and therefore less costly in-patients—in order to maintain bed-occupancy rates and consequent income levels.<sup>8</sup> In the US managed care system, there are incentives to provide as little care as necessary, manifested by the restriction of psychiatric bed-days, the shift of service provision away from psychiatrists and psychologists to general physicians and social workers and lower intensity of mental health services for patients. These courses of action have been dubbed as 'perverse incentives', in the sense that they are attractive and even rational from a financial point of view—income is maintained; costs are contained or transferred onto other budget holders—but are not necessarily pursued in the best interests of patient care or service quality.

### *Ethical Trade-offs*

Market-based reforms, imbued with powerful economic and financial incentives, are liable to provoke concerns regarding equitable levels of service provision. One type of risk is the practice of 'cream-skimming' by mental health care professionals who, if they work within a fixed/capitated

budget, might choose to accept only the most economically desirable patients onto their lists and refuse those liable to generate heavy resource use. A particularly worrying aspect of this trend in the mental health context is that it is individuals with the more serious and enduring psychiatric problems who stand to be most marginalized, since there is an incentive to concentrate on the numerically greater number of people with less severe problems. One recent UK study estimated the incentive for cream-skimming for different patient groups,<sup>17</sup> 'incentive' being defined as the difference between total costs as allowed by the capitation formula and total costs as predicted by a model based on patient records. Mental disorders showed one of the highest levels of incentive, greater than smoking, hypertension, cancer and diabetes. The authors conclude that 'cream-skimming in the specific context of fundholding [budget-holding primary care providers] is both technically feasible and financially attractive' and that 'medical ethic[s] provide no more than a short-term protection against cream-skimming'.<sup>17</sup>

At an institutional level, private or social insurance schemes have been slow to accept responsibility for mental health problems, particularly for those with severe or enduring illness in need of long-term care, who represent a bad risk from an insurance perspective. The basic problem of insurance in a non-compulsory context, notably in the US, is one of 'adverse selection', which arises from the prior knowledge that individuals have regarding their perceived risk of mental illness (for example, due to a history of mental illness in the family) and consequent need for/use of services. This has led insurance companies to offer a range of benefit packages (at different premiums) with a view to revealing policy-holders' relative degrees of risk, and to exclude some individuals from coverage altogether.<sup>18</sup> As a result, some individuals are not insured, whilst others are unable to obtain the comprehensive coverage that they perceive themselves to need.

Another way in which ethical problems are seen to arise is in the process of 'cost-shifting', where providers may attempt to move patients into a setting where they will impose costs on a different budget. In the context of mental health services this is well illustrated by the division between health care and social care (each with their own responsibilities, funding streams and infrastructure). In the UK, there are many people with mental health problems in residential care, particularly the elderly, who could be cared for in either a health care or social care setting. If clients are treated as health service patients, the care provided is free at the point of utilization; if they receive the same care from a social services provider, then the care is means tested and the patients may have to contribute, in whole or in part, towards the services received.

The multifaceted nature of current purchasing arrangements, pursued in the interests of improved efficiency, has arguably impeded access to services (justice principle) and the ability to provide continuity of care for vulnerable mentally ill people (beneficence principle). The gaps in care that have opened up, through which even the most seriously

ill have fallen with inevitably tragic consequences, has forced governments to reconsider the organizational framework, with increasing consideration being given to the establishment of unitary authorities with responsibility for planning, commissioning and purchasing mental health and social care.<sup>19,20</sup>

There are also inevitable ethical trade-offs to be made when attempting to prioritize potential health care interventions, so that even those who agree in principle that rational prioritization is inevitable are quick to appreciate the distributional shortcomings of attempts to prioritize in solely economic terms.<sup>21</sup> QALYs have been criticized on the grounds that they may discriminate against certain groups, such as the elderly or chronically mentally ill, since interventions for these client groups (assuming no weighting) 'produce' fewer QALYs than interventions in, say, acute care which significantly extend both life expectancy and quality of life. The marginalization of such interventions in any resultant list of priorities is likely to raise political and distributional concerns that greatly affect the end allocation of resources.<sup>13</sup> Indeed, for all the attempts made in Oregon to prioritize interventions (including mental health care) on the grounds of cost-effectiveness/utility, the final list of priorities was essentially arrived at without reference to service costs, reflecting in large measure the pre-eminence of social acceptability and political expediency.<sup>14,15</sup>

## Users and Carers

The final level of decision-making is the face-to-face interaction of individual patients or clients and their carers. This interpersonal relationship is perhaps the most sensitive level of decision-making in mental health care—it is the level at which all previous decisions at a more aggregated level end up.

## Economic Incentives

Economic contributions to health care have been mostly directed towards system-level consideration of efficiency and welfare maximization. At the level of the individual client or patient, maximization of these societal objectives is not a guiding principle for decision-making. However, opportunity cost and resource scarcity are every bit as valid to decision-makers at this level as they are to purchasers or planners of mental health care. Indeed, the input of any mental health professional towards the care of service users is a scarce resource which has an opportunity cost—the resources tied up in that input could be put to an alternative use, such as spending time with another client. Clinicians exert restraint and choice in numbers of patients seen and the time spent on them, using rationing devices such as waiting lists or restricting length of appointments. What complicates cost:benefit judgements at this level of decision-making (as opposed to more aggregated levels of decision-making at which the patient is an anonymous statistic) is the face-to-face relationship that exists between carer and user.<sup>1</sup>

One of the defining characteristics of the doctor:patient agency relationship is the presence of information inequalities, with the provider/carer supplying much of the technical knowledge relating to the costs, benefits, risks and outcomes of interventions, while the consumer possesses information on their perceived health status and factors potentially relevant to this status. The wide scope for reliance of people with mental health problems on their professional carers provides the potential for misappropriation, and in particular provides the supplier with the opportunity to induce consumer demand in excess of what would have been chosen by a fully informed consumer. Interventions paid for on a fee for service (FFS) basis, such as psychotherapy, create an incentive on the part of the professional for long-term therapy beyond any point that such intervention would be cost-effective, leading to a reduced degree of accountability.<sup>22</sup> However, the presence of uncertainty, plus the existence of considerable variation in mental health practice, makes assessment of induced demand elusive.

Users may also employ information in a strategic way, particularly in terms of choosing a health care provider or insurer. With reference to managed care, users may choose to withhold information relating to psychiatric history or contact with mental health services in order to avoid being considered a poor economic risk.<sup>18</sup> Users may also utilize or consume more of a service or product than they require in terms of clinical need (referred to by health economists as 'consumer moral hazard'). This is brought about by the existence of a zero price at the point of use and elasticity in the demand for health care. One area where this issue has been commented on by clinicians has been in the use of antidepressants, with some more 'acceptable' products such as Prozac now being argued to have uses in shaping personalities rather than just treating clinical conditions.<sup>23</sup> This type of drug use, labelled 'cosmetic psychopharmacology', is a seemingly classic case of moral hazard. Consumer moral hazard can be effectively countered by the medical profession in a number of ways, which can be concisely described as the four 'D's: deterrence (user charges and the gatekeeping role of primary care physicians); deflection (referrals to other agencies); dilution (thinly spread service provision) and delay (waiting lists and other rationing mechanisms).<sup>24</sup>

### *Ethical Trade-offs*

At the level of the individual, one of the oft-cited, if at times exaggerated, claims of recent mental health reforms is the extension of consumer choice in the specification and receipt of health services, reflecting a perceived increase in consumer knowledge concerning the risks, benefits and choices of medical intervention. One of the requirements of an efficient market, after all, is fully informed consumers. Consumer choice should be rational, however, in that patients should be able to make comparisons of alternatives and to rank them consistently.

In the mental health sector, rational choice may be

restricted, either through lack of information given to them or through mental impairment. The potential loss of patient autonomy implicit in these circumstances is self-evident, although some consumers may in fact prefer to pass difficult decisions on to their doctor; having to make choices might actually represent a loss of satisfaction or utility for these individuals.<sup>25</sup> The experience of managed care in the US suggests that patient choice may actually have been limited, as managed care agencies seek to reduce the scope for expensive care. There has been a substantial debate on the ethics of managed care and potential restrictions on services offered, particularly in contrast with fee-for-service provision,<sup>22</sup> which has illustrated the ethical trade-off implicit between limiting service availability, which reduces an individual's access to care (although less care does not necessarily mean worse care), and protecting the consumer from the excesses of induced demand.

The thorny issue of informed consent also has its roots in the doctor:patient relationship, and the ethical issues raised span philosophical, legal and clinical viewpoints. Informed consent clearly touches on the question of respect for autonomy—patients should be able to exert their right of free choice in deciding to receive care or treatment—and yet in psychiatry, particularly for those experiencing an acute episode of illness, individuals may be unable temporarily to make reliable judgements about the need for, and the risks or side-effects of, intervention. The psychiatrist may therefore be required to make decisions on behalf of the individual in the best tradition of beneficence, but in so doing immediately introduces a conflict between self-choice and paternalism. Failure to keep the user fully informed of treatment options leaves the door open to allegations of misconduct, negligence and non-disclosure. In the increasingly litigious health sector, psychiatrists must have well supported arguments, on legal grounds alone, to involuntarily commit an individual to a particular course of treatment or under law to institutionalized care. However, psychiatrists must also have considerable justification in order to violate the principles of respect for the patient's autonomy, the right to give consent and to be fully informed about the nature of illness and treatment, a reminder of the Kantian ethic that people must be treated as ends in themselves and not merely as means.<sup>26</sup>

### **Conclusion**

In attempting to draw together a number of economic and ethical principles and examining the kinds of dilemma and trade-off experienced in mental health care policy and practice, this article has been necessarily cursory and selective, and yet consideration of the issues that confront users, carers, managers and policy-makers reveals a number of basic recurring themes—the need for explicitness, evaluation and accountability—elucidation of which would assist at all levels of decision-making.

## Explicitness

A fundamental requirement of sound economic and ethical decision-making in mental health care is the openness with which objectives and priorities are set, assumptions and criteria are stated and problems and constraints are recognized. This is particularly so when trade-offs must be made in order to provide an efficient and also ethical service. At the highest level, explicitness translates into the formal adoption of acceptable and agreed assumptions and principles, and the explanation of what can be achieved with different levels of resources. Recent attempts made in New Zealand and Sweden<sup>12,27</sup> could be usefully replicated in other countries. At the purchaser/provider level, too, local decisions on priorities should be based on explicitly defined measures of need, costs and outcome, whilst more flexible exchange of information (qualitative as well as quantitative) and an openness in pricing could be fed into their respective strategies. Clinicians, for their part, must as far as possible inform patients of the range of service or treatment options available, together with any attendant risks, side-effects and follow-up implications, based on an informed understanding of the evidence supporting those options. Finally, users need to be able to share information and ideas with carers and/or insurers with confidence and without the potential for subsequent expropriation.

## Evaluation

Awareness of the costs and consequences of taking particular courses of action has been repeatedly and increasingly asserted by policy-makers. Cost-consciousness has been espoused on the grounds of achieving more cost-effective use of resources. It is in fact possible to go further and argue that it is actually *unethical* to ignore cost if mental health care is to be provided within an equitable framework constrained by a finite amount of resources.<sup>1,2</sup> Evaluation of alternative therapies is necessary not just on the grounds of choice through sacrifice, but also to ensure on moral grounds that the therapies that are used are non-maleficent; this is as true for the clinical research necessary to produce the evidence (owing to the uncertainty of outcome) as it is about existing practice. Assessment of the ethical dimension of health care is an intrinsic element of this process of evaluation. Assessment and evaluation, of course, will only be heeded if the underlying reasons are widely understood in health and social care practice. A greater investment in ethical and economic aspects of training programmes therefore seems a prerequisite for improved decision-making.

## Accountability

Closely linked to both the ethos of openness and the undertaking of evaluation is the concept of accountability. This does not just mean being able to demonstrate where resources have been directed or redirected, but is an altogether wider and more powerful obligation to ensure that resources are obtained and used in a justifiable manner.<sup>6</sup>

All decision-makers in mental health care, whether they be users, carers, managers or policy-makers, are accountable for their actions: government to specify its expectations, objectives and limits, and to be prepared to be judged accordingly; purchasers and providers of care to pursue strategies that meet their charges' needs; carers to ensure treatments are worth their cost and do not impinge on their patients' autonomy and users to utilize services according to need and to pursue agreed treatment goals and strategies.

Acknowledgement of and progress towards these three requirements will not deliver *ideal* levels of efficiency or equity, but will foster a greater understanding of the relevance of ethical considerations to mental health policies and strategies that are often influenced strongly or solely by economic arguments, whilst also demonstrating that equity must come at a price.

## Acknowledgements

The authors thank referees and members of the CEMH/PSSRU Mental Health Economics Workshop for comments on earlier drafts of this paper.

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