Setting Mental Health Priorities: Problems and Possibilities

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OTHER DEVELOPED COUNTRIES TAKE FOR GRANTED that scarcity and limits will be the mark of any sensible health care system. Universal access has as its necessary corollary a constraint on unlimited wants and desires. In the United States, by contrast, the most powerful ideology has been the conviction that only greed, inefficiency, or misguided politics stand in the way of giving everyone most of what they want. The language of limits and rationing does not sit well; it is judged to be a capitulation to the forces of conservatism or mismanagement. As part of the same attitude, the idea of setting formal priorities in health care, especially as a way of coping with scarcity, has not until recently attracted many followers. It no less flies in the face of an interest group politics that is reluctant to admit openly that some things are more important than others, that not all forms of disease, pain, and suffering are equally oppressive.

In a recent project at The Hastings Center, we decided to pursue a different direction. Taking for granted that some degree of scarcity will be a permanent part of any new health care scheme, we wanted to know what that perception could mean for the field of mental health. It is a field that, more than most others, has long struggled in the face of denial and stigmatization to attain parity within the health care system.

Our initial question was this: in a time of increasing economic scarcity and cost-containment pressures, what would be the most sensible set of priorities within the mental health field? Or, to phrase it differently, what is comparatively most important and least important within the wide range of mental health services that could, or should, be provided?

Almost at once, two important additional issues appeared, emblematic of a basic struggle within the mental health field. The first was this: quite apart from setting micropriorities, what should be the most basic mission of mental health and thus its highest priority? Should it be the advancement of mental "health," the positive effort to help people cope better with the wide range of emotional and cognitive disorders, both mild and moderate, that can burden and diminish the living of a life for millions of people? Or should it be mental "illness," with the focus on those most severe illnesses that affect far fewer people, such as schizophrenia, but that make living a decent life exceedingly difficult for most and altogether impossible for some? Questions of this kind are important when the mental health budgets are fixed and different programs must compete with each other. A second issue soon emerged: how should mental health priorities be established within the larger context of all health conditions, and what are the policy implications of shifting resources from other health budgets into mental health?

Part of the struggle on the first issue, setting mental health priorities, turns on that mix of aspirations, indignation, and resentment that so often marks the clash of advocacy groups within the field, battling not just for money but also to advance their own definition of what the *real* problem is. As so often happens in struggles of great complexity, each side has a good case to make; they differ because their eyes are fixed on different facets of experience. For the purposes of our project, however, a basic set of questions lay just below the surface of that struggle. Is it possible to find persuasive ways of comparing the degree of pain and suffering in different conditions—the suffering of the phobic against that of the schizophrenic, for instance—and no less to compare the social burden of milder conditions that affect large numbers with those terrible conditions that affect smaller numbers? Is it also possible, moreover, to make orderly sense of the fact that people differ enormously in their judgments about which conditions most affect the quality of a person's life and which are comparatively more or less tolerable and endurable? At stake were issues of a familiar political kind in medicine and health

care as well as fundamental moral questions about health and illness, pain and suffering, hope and despair.

That set of issues served as a backdrop for our project on priority setting in mental health. With the support of the John D. and Catherine T. MacArthur Foundation, we explored whether (a) it would be possible to set priorities, and (b) how and where that might best be done. The arguments among the psychiatrists and other mental health workers, representatives of various advocacy groups, philosophers, lawyers, and others were both intense and revealing. Some thought that setting priorities was difficult but not impossible; more significant was the viewpoint that priority setting will be imbedded in a political process where broad social policy can subvert the priorities. David Mechanic articulates that perspective in his essay published in this issue. By contrast, a group that had worked in Oregon to integrate fully mental health into that state's controversial priority-setting plan is much more optimistic (see the article by Pollack et al. in this issue). "We did it," they said, and they tell us how. Gerald Grob, also writing in these pages, falls somewhere in the middle, showing that whereas priorities can and have been set in ways that at times transcend pure politics, doing so can have unforeseen and untoward consequences.

Although it was difficult to achieve consensus on many of these matters, there was general agreement on one basic and important point: the time has come to stop segregating mental health problems and policies from the more general run of medical and health problems. Full integration of the mental and the physical domains (which cannot in any case be neatly divided) is both necessary and possible. There can, then, no longer be any good reason, say, to set a limit on reimbursable days for a person institutionalized for a chronic mental health problem while setting none for a person admitted to an acute care hospital for a chronic medical problem. That is, of course, just what the Clinton administration proposed in its initial health care plan, while offering no rationale for the distinction, (although it was known that the real, unpublicized reason was, simply, that root of all evil, money).

Why should we make an effort to set priorities in mental health? For better or worse, we must as a society determine how best to spend the limited money we have and to deploy the resources at our disposal; that will be a permanent, not a temporary, condition. While the setting of priorities will have many practical benefits, its overriding value is to keep

constantly before our eyes the need to make comparative judgments in the context of scarcity.

Although preceded by years of work on measurements of the quality of life, as well as cost–benefit and cost-effectiveness analysis, the idea of formal priority-setting efforts has arisen primarily as a response to economic pressures. It emerged first, and most controversially, in the case of physical health, but has now begun to be extended to mental health as well. Oregon's success in integrating mental and physical health into a single priority system shows that, if care is taken and some traps avoided, setting priorities for mental health poses no greater problem than establishing them for physical health (see Pollack et al., this issue). Pain and suffering, disability and dysfunction, social and economic burdens, and the like can successfully be compared across the health and illness spectrum, both physical and mental. Accordingly, I will here discuss the general problem of priority setting as a policy instrument, not restricting my analysis to mental health.

Priority Setting: A Continuum

There are three possible ways of understanding the notion of priority setting. They fall along a continuum, not always clearly delineated, and they often reflect an ordinary language use of the term rather than a rationalized technical sense. There is a kind of loose, informal sense in which legislators or policy makers decide in some rough way to emphasize one policy strategy rather than another for a certain period. A state department of mental health might, in that vein, announce that its priority for the coming year is to improve community services. It may or may not increase funds to that activity; even if it does, however, there may be little or no careful effort to rationalize that policy in explicit comparison with other ways the same money might be spent. Sometimes this is done as a symbolic gesture, to indicate heightened awareness of a neglected problem, or to correct for past injustices, or simply in response to political pressure. I call the use of the term "priority" in this context "informal," to signal that it rests on no settled policy commitments and is often a response to transitory pressures and needs.

A second sense of priority setting is more formal and structured. As a matter of prudent management and perceived needs, it is decided that

there should be broad ranking of needs and goals into general categories and clusters. That ranking is set by relatively nonquantitative means, usually based on the values of those managing the system, on professional judgment, and on the give and take of politics and policy. New York State and Alameda County in California provide examples of this form of priority setting (Surles and Feiden-Waugh 1993; Kears 1993). There is no pretense that this form of ranking is based on a special, technical methodology, but it is meant to be rational, coherent, and systematic.

A third sense of priority setting is a deliberate effort to rank specific medical conditions and treatment priorities, using both general categories and more specific, numerical rankings, and to do so systematically and rationally. The addition of numerical rankings separates this from the first and second senses that I have outlined, and it was the method used in Oregon. It is the form of priority setting that will be my principal concern here. I will begin my inquiry by developing three theses, devoting most of my attention to the third. The first two theses are almost, but not quite, self-evident.

The first thesis is that ranked priorities make the most sense in closed, not open, economic systems; they are particularly pertinent in global budgeting plans (e.g., when there is a legislatively set state, or county, mental health budget). On the basis of market theory, purely market-driven health care systems should have no interest in, and logically should oppose, any formal priority system, especially one imposed by government. The theory of market-driven systems is that people are free to buy what they want, subject to no higher principle than their personal preferences. Such systems, moreover, are hostile to externally imposed limits or caps because they are based on the idea that people should be free to spend as much as they want on health care in any way they want to spend it. Although it might seem that a priority system would be one way to control costs in the absence of global budgeting, it is likely to lack bite and full plausibility in that context. As efforts to control costs in the United States in the absence of global budgeting indicate, there are too many ways to circumvent constraints and too few mechanisms available to enforce the discipline necessary for priorities to work effectively.

Just the opposite is the case with planned systems, especially when working within a global budget. In those cases, priority setting makes special sense as a way of distinguishing the more important from the less important. Precisely this insight lay behind the Oregon efforts to de-

velop a ranking system for its Medicaid program as part of a larger effort to achieve universal health care in the state. Even if the legislature could be induced to spend more on the Medicaid program, that program would always have to live with a fixed budget; it thus seemed sensible to rank the priorities within that budget.

My second thesis is that any successful ranking scheme will have to find a middle way between two extremes, trying to do justice to the valid elements of each (and *appearing* to do justice to each). One of these extremes is the ever-present lure of a purely numerical approach, which seeks to quantify the important variables and come up with a mathematically precise set of priorities. I will call this the "pure numbers" approach. The other extreme goes in exactly the opposite direction, arguing that priority setting usually is, and ought to be, strictly a political matter, to be determined by the values and preferences of the public, rational or irrational. The most acceptable set of priorities emerges from a fair political process. I will call this the "raw politics" approach.

Neither the "pure numbers" nor the "raw politics" way seems adequate, and I will shortly say why. Objectivity — which I would define as the capacity to achieve a critical distance from policy judgments and to provide a reasoned, defensible justification of decisions — can be approached by means other than quantification. And appropriate ways of taking into account values and preferences can be achieved without descending into the rawest of politics (Jennings 1987; Reich 1988).

My third thesis is a refinement of the second. It is that the key to finding a successful middle way lies in (1) stimulating public debate on some seemingly intractable moral and philosophical puzzles generated by ranking efforts; and (2) creating a procedural method that will provoke a lively and perennial dialectical struggle between facts and data, on the one hand, and values and preferences, on the other. The depth and thus the ultimate success of the latter, procedural strategy will heavily depend upon the vigor and richness of the former, substantive debate; otherwise, procedural elegance will do no more than mask a dangerous emptiness of content, rendering the procedure meaningless or worse.

Before spelling out my third thesis, it is necessary to return to the second one, to examine what needs to be rejected, and what needs to be retained, in the battle between the political and the numerical approaches. Whatever can be retained will provide the ingredients for developing the strategy implicit in the third thesis.

Pure Numbers and Raw Politics

I begin with the "pure numbers" approach. I call it that to signal its utterly unadorned nature, purporting to take care of the priority problem with a simple numerical formula. A good illustration of this approach can be found in an article by two British economists. The economic approach, they say, "addresses two related questions: Is a health care intervention worthwhile? Given that it is worthwhile, what is the best way of providing it?" (Donaldson and Mooney 1991). They answer at least the first question by turning to the quality adjusted life years (QALYs) method, that is, the effort to measure the extent to which a particular treatment provides at a particular marginal cost a particular quality of life for a particular length of time. This method has had a special appeal to those concerned with setting priorities. Where cost effectiveness and cost-benefit analysis seek in different ways to maximize desired effects or outputs in relation to expenditures, the QALYs approach, by contrast, seeks specifically to factor together length and quality of life. More resources ought, accordingly, to "be allocated to treatments with a low marginal cost per QALY and less to those with a high marginal cost per QALY gained." It thus becomes possible to nicely rank, with a number, a variety of different ways of spending health care money. Time spent by a doctor advising a patient to give up smoking has a far more favorable QALYs ratio than hospital hemodialysis, with kidney transplantation somewhere in between.

The QALYs method, it is urged, is superior to another economic approach, that of "needs assessment." In the latter case, "need could be measured by lives lost, life years lost, morbidity, or loss of social functioning." The authors succinctly point to the pitfalls of the needs assessment approach. Whereas it might find that ischemic heart disease takes many more years of life than breast cancer — using, say, a "years of potential life lost" standard — it does not help us in determining the relative resources that the former should receive in relation to the latter or how to factor in other considerations of importance, such as morbidity. They argue that the QALYs method, by contrast, allows a nice, tidy ranking: we get numbers, larger or smaller, and thus our priorities.

What the authors do not dwell upon, however, are some of the well-known problems of the QALYs method, most notably the difficulty of objectifying "quality" or finding some agreement on the kind of life

worth living, about which humans notoriously differ. Without that agreement, of course, the method provides more the illusion than the reality of the objectivity it purports to provide. Finding agreement on "quality" in the mental health arena would be no easier than it was in the battles over the subject in physical health.

That lack of quantitative objectivity has bedeviled all of the leading economic techniques, especially because their claim to the policy maker's ear is an ability to find objectivity through quantification. It is all the more disturbing in their case because proponents of these techniques have considered that their best contribution to the policy maker is a detached, nonpolitical perspective, well above the ordinary fray of interests and passions. To the extent that the economic techniques are themselves inadequately quantifiable, and also caught up in the very ideological struggles they would purport to cut through, their policy clout is diminished. To be sure, to the extent that the economic analysis can document differences in values and preferences, it can make an important contribution. Only when such analysis is viewed as a way of neatly slashing through the political jungle in the name of detached objectivity does it begin to mislead.

Precisely because of that hazard, many economists and health planners have wisely given up their claim to a superior objectivity, trying instead to locate their optimal contribution within a context of openly acknowledged values and ideologies. As James C. Robinson has noted, "The intensity of the debate surrounding the ascription of dollar values to life and health . . suggests that more than mere technical issues in measurement and accounting practices are involved; rather, basic social values are coming into conflict" (Robinson 1986). Robinson's basic point is nicely deployed in another critique of the need-based approach. Behind many disputes about a need-based approach lie different and incommensurable conceptions of health (Green and Baker 1988). Health can be understood as an investment good, the creation and sustaining of human economic capital. Alternatively, health care can be seen as a social investment, providing communal goods other than economic benefits. Still another possibility is to understand health as an end in itself, as a natural right for all individuals. Given any one of these notions of health, we might be able to work out some priorities. But how do we decide among them in the first place?

After raising this and other problems (with cost–benefit and cost-effectiveness analysis, among other techniques), Green and Baker con-

clude "that priority-setting is *not* and cannot be a 'rational objective' process, but is ultimately concerned with power relations and value judgments. . . . As such it is the province of the communities and politicians and cannot be left in the hands of planners and their superficially attractive techniques" (Green and Baker 1988, 926).

The British health economist Alan Williams goes a step further. He not only notes the unavoidability of ideology, but also stresses the importance of putting it up front in any economic analysis. He uses as a case in point the long struggle between "libertarians" — for whom health care is to be treated as a consumer good, to be bought according to income — and "egalitarians" — for whom health care is a right that should not be determined, much less limited, by income" (Williams 1988). The choice between these two views is an ideological one, which will determine priorities once the choice has been made, but which is itself not capable of a purely economic determination.

This distinction seems eminently sensible, allowing a helpful use of quantification to set priorities, but doing so in a context sensitive to external determinants and ideological points of departure. Even so, the authors might have added still another qualification: even within their context, values will permeate the priority rankings, although the numbers will, if carefully derived, strengthen their claims to relative objectivity.

Just how important the political and values factors are can be seen by recalling the way in which the Oregon priority-setting program went awry in its early stages and encountered an unexpected obstacle in its last stage. The early problem was manifest in May 1990 upon release of a computer-generated list of 1,600 medical treatments that had been drawn up using a form of cost–benefit analysis in its methodology. The results were odd indeed, and intuitively objectionable: reconstructive breast surgery, for instance, ranked above the treatment of an open fracture of the thigh, and the straightening of crooked teeth ranked higher than treatment for Hodgkin's lymphoma (Dixon and Welch 1991). As a result of the public and professional outcry at such rankings, the economic formula was dropped and a condition–treatment pairing system, using a scale of medical necessity, was adopted. At the same time, out of respect for community values and other considerations, the final rankings were in part hand shifted to find a good fit between technical and value considerations.

That was not the end of Oregon's problems, however. After the program had been polished and made acceptable to the Oregon legislature,

it was denied a required federal waiver on the grounds that it would discriminate against the disabled. I will not recount the details of that issue, other than to note the way in which an ideological and moral objection was used, once again, to overcome a technical solution that had otherwise seemed satisfactory. That many of us judged the disability attack to be misguided is beside the point here: what matters is the power of an ideological attack to derail a course of action otherwise reasonably developed (Capron 1992; Hadorn 1992; Menzel 1992). The Oregon priority-setting commission learned for a second time that a technically good methodology is no defense at all if it generates politically unpalatable results. The political realities thus cannot be ignored, nor are they necessarily harmful. Methodological purists might think so, but their embrace of such a belief is in itself ideological.

The shortcomings of a pure numbers approach make it easy to understand why some commentators despair of rationalistic methods of setting priorities, whether economic or otherwise. What they see is the power of politics, that is, the power of subjective values, personal preferences, interest group power, and the sheer irrationality of much public policy. In looking at the way different policies have emerged, the historian can see the influence of the zeitgeist and the values of the times, the sociologist can spot the class, economic, and cultural forces at work, and the philosopher can see the power of the reigning mores.

Those possibilities would seem nicely to demolish the dream of a rational process for priority setting. The dream can be taken apart by stressing the impossibility of perfect objectivity, noting the force of interest-group power, pointing out the incommensurability of different initial ideological premises (e.g., libertarianism versus egalitarianism), and underscoring the simple fact that people will reject whatever offends their sentiments, allowing emotions to trump reason almost every time. The cleared-eyed, if somewhat cynical, critics of claims of rationality in general, and of rational priority-setting methods in particular, have a strong ally, therefore, in the testimony of "the real world": the nasty, brutish, but long-lived world that trashes our dreams and schemes with callous abandon.

Yet that greatest of all myths, the "real world," is more complex than the one visualized by these critics. Some plans actually work out, some systems actually run, some overwhelming needs are responded to, and now and then reason triumphs over unreason and selfishness. The cynics are ideologues also; they just dress up their ideology in sober clothes, as if to suggest their greater maturity and higher standpoint. In point of

fact, moreover, people do not like to remain in worlds dominated by narrow self-interest, lack of planning, absence of agreed-upon goals, and rampant irrationality. We cannot live for long that way. Our dreams, our reason, and our desire for order and stability will eventually intrude. Just such a point has come, I believe, with the American health care system, which is a nonsystem, dominated by interest groups, beset with fragmentation, burdened with unexamined values: in other words, a big, expensive mess. It is as nice an example of the shortcomings of raw politics as one could ask, a politics that has tried in the name of pluralism and choice to allow every interest group to have its day and its say. We are drawn to priority setting, not just because of scarce resources, but also as a way of cutting through some of the chaos of the present system.

Finding a Middle Way

Priority setting can be a plausible venture, one that need succumb neither to the failings of a purely numerical solution nor to raw politics. A middle way can be fashioned despite many obstacles on the path. The middle way I propose must confront problems of substance and of process. The key will be, on the one hand, to produce sophisticated ways of dealing with each one, and, on the other, ensuring that they interact successfully. The pure numbers approach has never worked out all of its internal, technical problems. That is less important, however, than the fact that it has been even less successful in how it relates to ideology and the political process. It can and should inform that process without becoming a substitute for it.

The clear-eyed realism of the raw politics approach has failed to appreciate the need for human beings to move beyond chaos and the unfettered expression of interests and power, or to consider how people can be moved to act differently when confronted with good evidence. Put another way, there will always be a war between facts and values, as there should be. It is also possible, however, to work out rules for that warfare, which will on occasion produce peace.

Matters of Substance

I turn now to some of the major problems posed by priority setting and then move on to the process question. Three issues of substance are particularly important:

1. aggregating benefits
2. taking the measure of pain and suffering
3. determining an ideological point of departure

Aggregating Benefits.   In an interesting article on priority setting in international health, C.J.L. Murray (1990) comments on the desirability of combining death, morbidity, and disability into a single health indicator, which could easily be used to set priorities. He notes, however, that this would run into familiar difficulties: "Relative weights must be chosen to compare death at different ages and disability or morbidity versus death." We cannot depend upon empirical information for answers to questions that must be determined by community and individual values.

Norman Daniels, however, calls attention to how poorly we are prepared, either in ethics or the community, to deal properly with such questions. Looking at a different set of aggregation issues, he notes, for instance, that if we choose to give preference to one group over another on the grounds that the former would achieve a greater net benefit, the result will be to eliminate from treatment altogether those who could benefit, but just not as much (Daniels 1992). Those patients with simple phobias might gain comparatively more from treatment than chronic schizophrenics and yet lose out entirely in this kind of priority system. Or we may be able to improve modestly the situation of the worst off, but at the price of neglecting those who, although initially better off, could gain comparatively much more than the worst off. Daniels observes that there are no principled ways available for dealing with these problems. We are likely to reject a "straightforward arithmetic aggregation" (which is why the initial Oregon ranking was rejected), but—save for our intuitions and feelings of discomfort about particular medical conditions—we may have no better, systematic way of making the difficult comparisons; that is, we encounter the old apples and oranges problem, but now with the human face of suffering and sickness.

Is there a way out here? Because it is unlikely that we will find the desirable principles, Daniels emphasizes the importance of process to deal with their absence. While acknowledging the rightness of his conclusion, I suggest that we might make sense of the aggregation problem even without elegant sorting principles. We can have an orderly discussion and debate, drawing on a combination of our intuitions, historical experience in dealing with analogous questions, and the available patterns of

practice that offer models of different de facto ordering schemes. We can then attempt to determine, from this assorted evidence, what works well (and for what purpose) and what does not. It is a perfect situation in which to manifest, and exercise, the classical virtue of prudence, creating an interplay between reason, experience, and feeling. The goal is to act sensibly, not perfectly, and to make good, defensible judgments, not unimpeachable ones.

What criteria can we use to make such judgments? Our bias, I contend, should be to give priority to persons whose suffering and inability to function in ordinary life is most pronounced, even if the available treatment for them is comparatively less efficacious than for other conditions. But I would stress here the word "bias," to indicate an inclination, a starting point, and not a simple decision procedure. The first goal of a health care system should be the relief of suffering, and the greater the suffering the greater the claim upon the rest of us to respond. Our prima facie duty is toward those whose suffering is the greatest, but other considerations can lead us to qualify, and limit, that duty, overcoming or modifying the initial bias. Thus, if we have made a minimally decent effort to help persons whose suffering is the most severe, we would be justified in diverting additionally available resources to persons who are not so badly off, even if those same resources might marginally improve the worst off. We can judge our efforts by asking whether the balance we have struck does, in fact, honor the initial bias without allowing it to trump all other claims. This will be a matter of *judgment*, not formula, and good political debate should include arguments about the wisdom of the balance thus achieved. As Aristotle long ago reminded us, in matters where precision is not possible, precision should not be sought.

Lurking below the surface is another question of more general importance for health policy: what priority should be given to chronic disease compared with acute care medicine? The latter has, for many decades now, had the pride of place, economically, medically, and socially. Chronic disease, by contrast, represents the failures and frustrations of scientific medicine, signaling the limits of its skills and the mischievous tendency of human biology continually to reassert its unwillingness to shape itself obediently to the modern medical goals of mastery and control of nature. The rise and persistence of chronic illness, however, call for a different policy and another ethical response, giving more weight to all chronic conditions and not just to some forms of mental illness (Fox 1993; Callahan 1990).

Taking the Measure of Pain and Suffering.   Although in one important sense, taking the measure of pain and suffering is simply one more aggregation problem, in another sense it poses troubling puzzles that are especially pertinent to mental health. How are we to rank treatments that will relieve a great deal of suffering for a few people compared with those that will alleviate lesser suffering for a great many people? This question bears on a comparison between treatment for the severely depressed and treatment for the milder, but still burdensome, neuroses and phobias. Or, to mention an even worse problem, how are we to compare the care of schizophrenics, for whom sometimes little may be done, with treatment of patients experiencing transient anxiety, for whom much can be done, often definitively? We may relieve some of the schizophrenic's severe suffering, whereas we might succeed totally in relieving the symptoms of anxiety, a condition that causes less suffering.

In Oregon, advocates for the elimination of the mind/body dichotomy and for the establishment of parity between mental and physical illness successfully argued for the inclusion of "milder" conditions in the basic health care package. Nonetheless, a general problem remains that may require making a choice under other circumstances. Are we to decide, ab initio, to give priority to the worst off, even if we can make only a slight difference, or offer it instead to those who can most benefit from help? A utilitarian bias would lead us toward the latter, which would seem to offer the best aggregate outcome for our dollar. Yet something about the situation of persons in great suffering stops us. What is it?

My guess is that we tacitly distinguish between those whose lives are strikingly and decisively harmed by a particular disease or illness and those whose lives are crippled but not devastated. We know the latter can probably get by, even if not well, whereas the former will not be able to do so at all. Put another way, we know that some forms of illness and suffering do not allow for even a minimally decent quality of life; one instance would be severe and chronic depression, which leaves its victims feeling that they have hardly any kind of life. Human beings can adapt to a life of low quality, but not to a life of no quality. Thus, in our health care planning, the goal is protection against devastating illness; in our acute care services, we want to achieve the capacity to save life; and in the mental health field, we give first priority to those who are dangerous to themselves or whose capacity to function is severely threatened or curtailed. This is a defensible bias despite its seeming unfairness to indi-

viduals who could achieve great benefits from treatment. There can be no fair race if some cannot run at all (McKerlie 1992).

For my purposes, complete agreement with this argument is not important. I only want to stress the issue of what it means to live different kinds of lives, that is, how to confront the variety of mental health ills that dreadfully compromise the living of a life. The obvious difficulty about a bias toward the worst off is that meeting their needs may swamp all others, thereby lowering significantly everyone else's quality of life. As this may be indefensible, it might be necessary to shave the care of those worst off to ensure that some relief can be found for others. Again, there are no principled ways of doing this, to use Norman Daniels's standard, that is, no sorting standards and tightly formulated norms that can produce incontestable results. Does it matter? Not altogether, because over time we can debate these matters, look at the consequences of different policies, stimulate public concern with the meaning and impact of pain and suffering, and ask people to consider what they most want from a health care system. Although this is not a clean method, it can be illuminating if pursued persistently and has parallels with other issues that admit of no greater precision.

Determining an Ideological Point of Departure.   The problem of evaluating pain and suffering, and choosing the standard we want to use as our point of departure, also shows the importance of ideology. We can, for instance, say that the relief of suffering, even when not accompanied by social dysfunction, should be the primary aim of mental health programs. Alternatively, we could subordinate subjectively experienced suffering to an external dysfunction standard, requiring an inability to do something, a failure to function according to a norm. The former standard might be seen as more individualistic, and part of the tradition of medicine, and the latter could be viewed as more communitarian. Or it may express a bias toward the inner life of people as distinct from their actions in a community. Ideology—by which I mean a more or less coherent way of ordering several important values according to an overriding one—will bear on the importance we give to relative degrees of suffering, to physical as opposed to mental suffering, to the choice between libertarianism and egalitarianism, or a mix of the two, and to the status we ought to give to the most afflicted (and whom we determine these to be).

We run into a familiar puzzle here. If our ideological point of departure is more likely to lead to adoption of one set of priorities rather than

another, how are we to get, and set, our ideological priorities? Are we, as Gilbert and Sullivan averred, just born "little liberals or little conservatives"? Although it may not always be apparent, we know that people do change their ideologies. They change as a result of thinking about and considering the objections to their viewpoints, or finding them wanting in practice, or sometimes simply by having a change of heart and looking at the world in new and fresh ways.

The only point I want to make here is that we can evaluate our ideologies and starting points. We can look for their failings, and we can be open to the advantages of other starting points. Many people, chastened by the experience of communism in the Eastern European countries, are newly drawn to market solutions; a harsh egalitarianism, we now see all too starkly, can become oppressive, stifling important parts of human nature and generating, at its worst, murderous totalitarianism. Those of us in the United States, more used to seeing the nasty side of a market economy, whose cruelty is just more random and less organized, will have corrective insights to offer those prepared to throw over egalitarian aspirations. We will debate these matters, and we do know from history that the debates count, that shifts do take place. This is good enough, especially since it is all we have anyway.

Matters of Process and Procedure

In the absence of a substantive way to find good solutions to policy questions, it is often said that we must look to good procedure and process. The aim of doing so is to ensure, despite the inevitable disagreements and, often, the lack of a clean method for resolving them, that any political outcome will at least be seen as fair. This perfectly reasonable way of thinking sometimes generates an error: the notion that how people argue, and what they argue about, is less important than a fair procedure for reconciling their disagreements in order to create viable policy. I have tried to stress that even though no clean, agreed-upon procedure exists for disposing of the most vexing matters of substance, they all can be the subject of profitable public debate.

In that sense, substance and procedure cannot be neatly separated; inherent in the richer notions of democracy, which eschew a technology of mere decision procedures, is a combination of dialogue, judgment, and action. Only a kind of methodological obsessiveness should lead us to throw up our hands in the absence of an exact methodology, that is, one

that would spare us the messy business of political give and take and the compromise and uncertainty of democratic dialogue. A procedural process that ignores the quality of its discourse will have its own kind of illusory result. That is why the jury system, whose purpose is justice rather than truth, nonetheless must rely on a wide range of rules of evidence and admissible arguments to ascertain that it can produce reasonably reliable results.

An important background condition should loom large in the setting of priorities: determining the appropriate unit or range within which the priority setting should take place. With that condition met, two procedural goals are of special importance. The first is that the procedure appear fair and satisfying to those who will be affected by it, and the second is that it establish a strong dialectic, a continuing struggle, between community values and the available empirical evidence on efficacy and outcomes of procedures.

Establishing the Priority-Setting Unit. Because setting priorities will trigger an expression of community values and predilections, and require fair procedures, the ideal unit consists of a reasonably strong and natural preexisting community. Only then is there likely to be strong agreement on the priorities. Ideally, it should be a unit smaller than a state, although for practical purposes a state may be the smallest feasible political unit (e.g., a state Medicaid program). The success of Alameda County in California in establishing a mental health priority system shows the possibility of smaller subdivisions (Kears 1993). A national priority system is likely to be unworkable, failing as it must to reflect regional and cultural differences. Because some priority setting must inevitably be "by hand," as Oregon discovered, in order better to reflect community values, the more homogeneous is the community in which this is done, the greater is the likelihood of political acceptance. Nonetheless, even at the national level, some general categories of priorities might be established, leaving a detailed ordering to the local level. Although the point of allowing local values to shape priorities is to achieve consensus and political acceptance, too great a diversity between regions or jurisdictions could easily suggest unfair variations. Some broad priority categories could help avert the most egregious problems in that respect while still honoring local values.

Devising a Fair and Representative Procedure. A fair procedure treats the interests of all relevant parties in an equal way, eliminates lingering unjustifiable historical discriminations, and provides opportuni-

ties to correct perceived injustice. A representative procedure receives input from the major groups to be affected by the priority system and from medical experts who can sift the available evidence on outcomes and efficacy of different treatment modalities. The appointment of a special committee charged with making recommendations to a legislature (or given a final power to decide on priorities, as was the case in Oregon) is one way to foster such a procedure. There should be, suitably and appropriately, not only a struggle among persons with different values, but also a systematic means of confronting those values with confirming or disconfirming data. Thus arises the need for individuals who have command of the empirical evidence, such as it may be, and the skills to interpret its meaning to lay people. The possibility even of frequent revision should be built into the procedures; there should always be a second, and third, chance to reconsider the problem with new information and arguments in hand. Evidence changes over time, and provision must be made for that eventuality.

The appropriate expertise would minimally include an economic slant, in order to calculate costs, and a medical slant, to evaluate treatment effectiveness and reflect clinical realities. Beyond those conditions, a fair procedure also establishes rules for reaching closure, means of adjudicating disputes, and ways to achieve compromise when agreement is not possible.

Creating a Dialectic between Values and Data. I have already suggested the importance of certain kinds of expertise being represented in any body charged with priority setting. That, however, will not be enough. Additional skills and procedures are required to ascertain that the struggle between values and data is sophisticated and enlightening. This calls for prior agreement on what counts as good, fair, and poor data; on what kind of additional information might help to resolve debates; and on what constitutes a good fit between values and available evidence. Preliminary methodological debate will be necessary, a debate that should be renewed when various problems present themselves for resolution.

The success of finding a middle way between pure numbers and raw politics lies in forcing those perspectives, in an orderly way, to wrestle it out over specific issues. Values set facts in a context, giving them a meaning and elucidating what they will mean in practice. Facts and data serve as a necessary check on, and corrective to, the indulgence of self-interested politics, which will be prone to manipulate data to its own

ends. The procedures I have outlined should help curb the excesses of each extreme without altogether discarding what is valuable in each. That is likely to be the best we can do.

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