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EDITORIALS

Parity of esteem between mental and physical health

Means different things to different people, making it difficult to enforce

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Although parity of esteem between mental and physical health has been a high profile political issue in the UK since 2011, debates about the relative esteem and provision for mental and physical health are long standing. For example, the report that preceded the 1959 Mental Health Act (which removed all restriction on mental health treatment in general hospitals) claimed—prematurely perhaps—that "most people are coming to regard mental illness and disability in much the same way as physical illness and disability."[1]

The recent coinage of "parity of esteem" is uncertain. The term parity became enshrined in US law in 2006, when it was mandated that mental health and substance misuse problems should treated the same as medical and surgical conditions in health insurance coverage and not be excluded. It became a key part of the 2010 UK coalition government's mental health strategy, No Health Without Mental Health, in 2011. The Health and Social Care Act 2012 was altered during its passage into law to include specific reference to mental health, and the NHS Constitution and NHS Mandate for 2014-2015 both include specific commitments in this area. Since 2012 there have been six major reports dealing with mental health in different ways.[2-7]

How should parity be interpreted?

Parity of esteem is beset by definitional and practical problems, and the term is not in common use outside the UK. The definition proposed by the Royal College of Psychiatrists has the virtues of simplicity: "Valuing mental health equally with physical health."[2] However, this gives few clues to achieving it in practice. It makes little sense to aim for exact parity in funding because there is no logical reason for a 50/50 split between mental and physical health spending. Instead, parity should mean funding according to the prevalence of the (mental or physical) health problem or "burden of disease." Currently mental health accounts for around one quarter of the disease burden across the NHS but receives only 13% of the funding. However, if funding is allocated on the basis of prevalence, does it make sense simply to compare physical and mental health? Should account be taken of the projected savings that some treatments secure for other health services? For example, money invested in programmes such as early intervention in psychosis, smoking cessation, and peer support save 15 times more than they cost over 10 years.[8]

Esteem is difficult to measure and nearly impossible to legislate for, despite the assertion of Norman Lamb, minister of state for care and support, that the NHS Constitution's commitment to parity has "legal force."[9] Nevertheless, such considerations go to the heart of the struggle against the longstanding stigma that is attached to mental illness**.** This stigma spills over into the attitudes of those who treat and research mental disorders. Efforts to combat this have recently met with some success, through the Time to Change initiative, led by Mind and Rethink Mental Illness.[10]

False separation

Conditions such as diabetes and cancer are spared the sorts of controversies that swirl round mental health conditions: specifically, are they diseases of the brain, pathological psychological states, or societal problems? (Probably all three.) Mental illness has always evaded precise definition, and to claim that there are no differences between mental and physical disorders does not accord with reality. However, attempts to achieve parity of esteem must negotiate the historical, unhelpful, and artificial separation of mental health from other kinds of medicine—including in the asylum. The most important part of parity must be to accord all people involved with mental illness—whether patients, carers, healthcare professionals, or academics—the same respect given to people involved with diabetes or cancer.

A good place to start would be addressing the findings that people with a diagnosis of severe mental illness die on average 15-25 years before those without—largely from preventable physical diseases such as heart disease and diabetes.[11 12] This stark statistic perfectly demonstrates both the lack of parity and the connection between mental and physical health. Recent changes to general practitioner payments may make things worse: three payments have been removed in England and Wales (but not in Scotland) for monitoring the physical health of patients with severe mental illness despite recommendations

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from the National Institute for Health and Care Excellence that they were retained. This undercuts parity in a crucial area, although a new national incentive (CQUIN) was introduced in April 2014 for mental healthcare providers to carry out physical health checks until 2016.[13 14] It is these questions of treatment that make it clearest that mental and physical health are inseparable. The above reports all stress integration and "joined-up care," which might be achieved through liaison psychiatry and educating medical professionals and healthcare commissioners.

Parity of esteem is thus not really about money. Funding is important, of course, but spent carefully, much of it will pay for itself in the medium term. The issue is one of political will to accept spending in the short term for financial and therapeutic gains later. It is not about literal or mechanical parity. The respect, hope, and relentless effort afforded to those with severe and chronic injuries (to the spinal cord, for example) are not always replicated in attitudes towards people with severe, chronic schizophrenia. Parity means equal respect and hope when dealing with difficult prognoses. Rather than focusing on definitions, we should first fix obvious disparity. It is through tackling excess mortality and stigma that we will be able to see more clearly what parity looks like. We must always discriminate in an analytical sense between different diseases or treatments, but tackling administrative and therapeutic separation and enduring stigma is vital to end inequality for mental health.

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