

Making activity-based funding work for mental health

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Abstract. The implementation of activity-based funding (ABF) in mental health from 1 July 2013 has significant risks and benefits. It is critical that the process of implementation is consistent with Australia's cherished goal of establishing a genuine and effective model of community-based mental health care. The infrastructure to support the application of ABF to mental health is currently weak and requires considerable development. States and territories are struggling to meet existing demand for largely hospital-based acute mental health care. There is a risk that valuable ABF-driven Commonwealth growth funds may be used to prop up these systems rather than drive the emergence of new models of community-based care. Some of these new models exist now and this article provides a short description. The aim is to help the Independent Hospital Pricing Authority better understand the landscape of mental health into which it now seeks to deploy ABF.

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The potential for a significant misalignment between national mental health reform and the introduction of activity-based funding (ABF) has been signalled by clinical and policy leaders in the field.¹ At the heart of this concern is whether ABF can provide the right incentives to foster the emergence of a genuine system of home- and community-based mental health care or whether it will provide new stimuli to the further development of the better-resourced acute and hospital-based systems.

To capitalise on the opportunity created by ABF, the central question is to define which mental health services are in scope. The National Health Reform Agreement² indicates that the following services are to be included: all admitted services, including hospital in the home programs; all emergency department services provided by a recognised emergency department service; and other outpatient, mental health, subacute services and other services that could 'reasonably be considered a public hospital service'.

The key issue is therefore not if mental health is to be included but which services are to be regarded as public hospital mental health services by the Independent Hospital Pricing Authority for the purposes of ABF, and therefore eligible for public hospital services development and increased Commonwealth funding under the reform agreement.

The jurisdictions have now agreed that ABF will cover acute care, emergency departments and outpatient services from 1 July 2012. However, ABF will not apply to mental health or subacute services until 1 July 2013 – the delay reflecting the need for considerable further development of the requisite casemix classification and costing infrastructure. Before then it is vital then to

determine the scope of ABF's application to mental health. Both growth in total recurrent funding and the location of that expenditure remain central issues in mental health reform.

Mental disorders represent 13% of the burden of disease but clearly account for only \$6 billion out of the \$121 billion (i.e. ~5% of total) health expenditure in Australia in 2009–10.³ Although this article raises issues in relation to ABF, it is worth noting that historical approaches such as 'block grant funding' of mental health services have failed to generate improved funding arrangements for mental health. Despite recent increases in specific programmatic areas (including some outside of health), mental health's real share of the health budget is in decline. Although the most recent report of progress under the Council of Australian Governments (COAG) 2006–11 National Action Plan attempts to put a brave face on progress, the perception of users of state and hospital services is that the gap between national political rhetoric on reform and implementation of real change is growing.⁴

The national health reforms now mean that there are four key sources of funding for public health services, the first of which are out of pocket payments by consumers and families. Second, funding is provided by the Commonwealth for primary care through the Medicare Benefits Schedule and the emerging Medicare Locals structures. Third, under ABF the Commonwealth and states will fund public hospitals under ABF, with the Commonwealth also committed to funding a share of the growth in ABF services.

The fourth funding route will be for those services not provided under the Medicare Benefits Schedule and deemed out

of scope for ABF. These services will be left to compete for their share of increasingly constrained state health budgets. Currently, traditional community mental health will be left to decline within this latter funding source.

With only 35% of people with mental disorders receiving any care⁵ Australia needs to grow the mental health service sector. This is an international phenomenon⁶ – and quite unlike most other areas of healthcare services in developed nations. It also clearly puts it outside one of the major objectives of ABF – namely enhanced efficiency (i.e. the same number of services delivered more cost-effectively or an increased number of services for the same approximate total expenditure).

Mental health urgently needs many more services, more complex and integrated services and more services delivered in a more timely fashion to large numbers of persons who have not previously entered the healthcare sector for assistance – most notably young persons in the early phases of illness (where currently only 13% of males and 31% of females with a mental illness receive any care).⁵ ABF looks by far the best bet to drive this new and strategic growth. ABF also promises to deliver a new level of transparency and accountability, particularly significant in mental health, an area characterised as ‘outcome blind’.⁷

For two decades we have strived to institute national mental health policy – encompassing four national mental health plans, two national policies, myriad jurisdictional plans, a COAG National Action Plan from 2006 to 2011 and one national ‘roadmap’. Each of these plans and policies has prioritised the establishment of better home- and community-based acute and ongoing services. Despite this rhetoric, the mental health service system (and most notably the state-based acute sector) is hugely biased toward the acute and hospital sector.⁴ This represents a colossal waste of vital scarce resources, not to mention being traumatising for consumers.⁸ There is scant evidence to support continued investment in hospital-based care.⁹ By contrast, there is considerable evidence to indicate that community-based mental health care is both effective and popular.^{10–12}

Community services provided by non-government organisations (NGOs) account for only around 8% of annual mental health expenditure nationally.¹³ No jurisdiction apart from Victoria has developed a significant number of alternative services to provide mental health care outside of hospital. As made clear by the Australian Institute of Health and Welfare, the vast bulk of the expenditure classified as ‘community’ is in fact spending on hospital-based outpatient services.¹⁴ Given that ABF purports to be concerned with driving allocative and technical efficiency,¹⁵ it is worth noting that an unpublished 2006 snapshot survey of acute psychiatric wards across Australia, conducted by the National Mental Health Steering Committee, indicated that nationally 43% of all acute beds were occupied by people who could otherwise be cared for in other settings if suitable services were available.

The Independent Hospital Pricing Authority (IHPA) has already published a Pricing Framework for determining the scope of public hospital services eligible for Commonwealth funding under ABF.¹⁶ This Framework appears to understand the importance of encouraging community-based or hospital outreach-type programs, such as hospital in the home, while ensuring the funding model discourages unnecessary hospital admission. At

the same time, part of the IHPA’s role is to ensure states don’t try to move existing community services into the hospital.

The IHPA’s framework has undergone refinement and considerable tightening. It states that the list of in-scope services includes: post-acute care services; mental health crisis assessment services; mental health step-down services; and, importantly, mental health hospital-avoidance programs. However, the framework also states that such services must meet one of four criteria:

- (1) Be directly related to an inpatient admission or an emergency department attendance.
- (2) Be intended to substitute directly for an inpatient admission or an emergency department attendance.
- (3) Be expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission.
- (4) Been reported as part of the 2010 Public Hospitals Establishment Collection.

In truth, the details of how the IHPA’s framework will play out in mental health are far from clear.

What follows here has been prepared to assist the IHPA consider some practical examples of the kind of alternative services operating in Australia that are providing effective alternatives to hospital admission and that need to be supported by access to the growth funding offered under ABF.

Example 1: the Prevention and Recovery Care Model – South Yarra, Melbourne

In Victoria, Prevention and Recovery Care (PARC) services are managed by the local adult mental health service in conjunction with a mental health NGO. PARC offer step-up/step-down care and are typically staffed on a 24-h basis by NGO mental health workers, with clinical staff visiting and 24-h back-up care provided at the South Yarra PARC by the Alfred Hospital. The first PARC service was established as a pilot in 2004. There are now around 14 operating around Victoria and one in the Australian Capital Territory. Most are located in suburban streets and accommodate up to 10 consumers in single bedrooms. Length of stay is around 1–2 weeks, with a maximum of 28 days. Patient records for the South Yarra PARC are held by the Alfred Hospital among their acute inpatient admission data.

Over the past 7 years, Victoria has established 68 step-up/step-down prevention and recovery care beds, with another 70 promised. Evaluation of the PARC model is positive, noting particularly its capacity to bring together clinical services and psychosocial services, including living skills, rehabilitation, employment, housing and other services.¹⁷ PARC-type services are now opening up across different jurisdictions.

Example 2: the Housing and Supported Accommodation Initiative in New South Wales

The Housing and Supported Accommodation Initiative has already been extensively evaluated and can demonstrate startling results in reducing hospital admissions for people with low-prevalence disorders, such as schizophrenia.¹⁸ Although there are different models included under the program, the Housing

and Supported Accommodation Initiative effectively mixes housing and mental health care, clinical support and psychosocial support.

Example 3: Doorway housing and support program, Mental Illness Fellowship Victoria

With its origins in the evidence-based Housing First Program,¹⁹ the Mental Illness Fellowship Victoria (MIFV) Doorways Program is currently providing long-term, stable, private rental accommodation to 50 Victorians with a mental illness. Referrals to the Doorway program are made through the mental health units of Austin Health, St Vincent's Melbourne and Latrobe Regional Hospital. To be eligible for the program, a person must be: case-managed by one of the three participating clinical mental health services; homeless or at risk of homelessness; and referred by their clinical mental health service to Doorway.

Example 4: community care units

Community care units exist in Victoria and more recently in Queensland and provide medium- to long-term accommodation, 24-h clinical care and rehabilitation services for people with serious mental illness and associated psychosocial disability. Located in residential areas, community care units provide a 'home-like' environment where people can learn or relearn the everyday skills necessary for successful community living. Typically residents will have significant symptomatology that may be slow to respond to treatment or experience behavioural disturbances that make living in alternative community settings difficult. An evaluation of the community care unit model found it to be an appropriate alternative form of service delivery for most long-stay hospital inpatients.²⁰

Community care units operate as a specialist community mental health service for people with a severe mental illness.

Example 5: Orygen Youth Health, Parkville

Funded as an acute unit with 16 beds at Royal Melbourne Hospital, Orygen in fact provides leading-edge, multidisciplinary early intervention for psychosis among young people. Part of the collaborative approach to care includes psycho-education and vocational support. There is also 24-h triage and an assertive community team that operates across their area health service as well as group programs and case management.

The rollout of the Orygen Early Psychosis Prevention and Intervention Centre model is subject to current negotiations between the Federal and state governments and its relationship to ABF is unclear.

Example 6: St Vincent's (Sydney) Private Youth Program (ages 16–30 years) and University of Sydney Brain and Mind Research Institute

Co-located next to St Vincent's State Mental Health Services this new 20-bed service has been developed to meet the needs of young people with emerging mood or psychotic disorders who would not otherwise be able to access hospital-based assessment or care. It operates in active partnership with University Medical School partners (University of Sydney, University of NSW, Notre Dame) and more specifically the new primary and secondary care youth mental health pathways established by the Brain

and Mind Research Institute.²¹ This brings Commonwealth-funded *headspace* pathways, innovative nursing and allied health practitioners, specialist neuropsychological and neuroimaging services and research-enhanced specialist care into a more coherent stream of home- and community-based intensive services and targeted use of relevant inpatient services. The program focuses on using inpatient services not simply in an emergency setting but at the right point in the spectrum of more intensive forms of care and assessment for young people with emerging major mental disorders.

Conclusion

Each of the examples listed above contribute to hospital avoidance and better management of people with a mental illness and so could therefore be construed as within scope for ABF purposes.

In addition to the specific service examples listed above, ABF needs to clearly accommodate a range of other evidence-based community-based services,²² such as crisis and ongoing care management teams, assertive community treatment teams, psychotherapeutic interventions and 24-h supported residential respite, as well as other supported housing and vocational programs.

Even here however, the paucity of mental health service options means we must be careful to avoid creating any unintended disincentive to develop and evaluate vital, innovative models of care. For example, there are very few existing service structures designed specifically to respond to mental illness when it first occurs. It is likely that a person's interaction with any health service at this time will be desultory rather than profound, despite the strong evidence to support structured approaches to prevention in mental health.²³

Despite the evidence and despite 20 years of policy rhetoric, a genuine and sustainable home- and community-based mental health system has failed to thrive in Australia. The advent of ABF runs the risk of providing preferential financial incentives to develop more hospital-centric and isolated forms of mental health care. Instead, we need the ABF approach to develop in ways that deliver clear price signals that have the capacity to promote and sustain the styles of innovative services we have described. Although these services may fit the IHPA criteria, without specific attention they will be left to wither as state health budgets continue to focus on supporting traditional service structures.

At this time it appears likely that ABF will reinforce hospital-based acute care as the major entry point to emergency services. This will not only embed allocative inefficiency in the system but also be clearly out of step with contemporary mental health policy and community expectations. Such a system would risk losing the confidence of mental health professionals, service providers and, most critically, consumers and carers who have fought long and hard to assert the home and the broader community as the preferred loci of care.

Competing interests

IH is Commissioner of the Australian Mental Health Commission, member of the Medical Advisory Group, BUPA Australia, and was previously Director of Headspace, Youth Mental Health Foundation.

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