

## **How should the costing of mental healthcare be improved?**

Money comes into state health and care services 'from the top', with budgets divided up as they pass through successive layers of management. In mental health services most of the money is spent on personnel and facilities, which are relatively fixed costs. A top-down accounting system will tell us how much it costs to run each service line (department, unit, team, etc), in terms of spending on staff of various types, on each of the facilities, heating bills, travel, equipment, drugs, etc. Within each line one could also potentially see, using currently collected data, how many patients have been seen, or how many completed episodes of care there have been within each month, quarter, or year.

For planning purposes, if we know what buildings we need in order to house roughly the right number of staff, budget requirements can fairly easily be computed once additional costs ('on costs') have been added to the raw figures. In practice, such careful estimations rarely need to be made, because services are not often started from scratch.

But the system described above does not tell us anything about the costs of providing care and treatment for *specific* groups of patients with particular needs or conditions. That matters, because most MH teams provide care to a broad mix of cases varying in severity, complexity and condition, and from varying socio-economic and sub-cultural origins. All of those factors are generally assumed to affect the costs of care, and therefore also the quality of service that can be provided on a *per capita* budget. In addition there may be pressures to favour certain types of patients, or to spend clinical time doing interventions that are rewarding or erroneously believed to be effective. And when they are managing their caseloads, staff may be unaware of the wider needs of the population, and of gaps in the local services.

There must be many different ways of ensuring that resources are most effectively allocated at this grass-roots level, but they all require some way of splitting up the caseload into clinically meaningful groups, and quantifying how much time, and therefore money, is allocated to each.

There is therefore a strong argument for developing a direct, information-based system which can take note of how money is allocated, not in terms of *services* but in terms of *service users*, their needs, and how well those needs are being met. Whether that system is then used only to assist service providers with their internal financial planning (the better to budget for fairer, more inclusive services), or to provide a 'costing currency' for a competitive health market, depends at the moment upon national politics.

To provide that sort of information, there is a need for a 'bottom up' MH costing methodology which could ideally be resolved against, and reconciled with, top-down budgets ('*this service, with this budget, provided this amount of this type of care for these service users*'). There is continuing discussion about whether condition-based, activity-based, or intervention costing groups would best serve the purpose, but the answer

depends upon what the purpose is. In practice nobody has so far found any single measure or classification of a care dimension that alone will predict costs accurately enough for service management – so it is better to collect a wider range of information. Development of a costing methodology for MH has been given an impetus in England by the intention to introduce Payment by Results by 2010/11. But many of the principles underlying that work and the lessons learned could be made use of in other countries. We will report on the work as it progresses.

**Related questions:**

- [How can commissioning decisions be based upon quality and outcomes measures as well as levels of activity?](#)
- [What are the criteria for judging a MH funding mechanism?](#)
- [How can we measure quantities of mental healthcare in the health market so that they make clinical sense?](#)
- [What is the Payment by Results Project?](#)
- [How can the right level of resourcing be proven for an area?](#)

**Sources:**

Department of Health (PBR team) (2008) Developing a Payment by Results tariff for mental health (includes factsheets and updates):  
[See Website](#)