How can we measure quantities of mental healthcare in the health market so that they make clinical sense?

Historically, mental healthcare has been purchased in 'block contracts' by state funding, annual budgets being set for each geographically-defined area by making adjustments to the previous year's total. It has been mainly up to providers themselves to split their finances further between different units and teams, balancing governmental directives and strategies against local priorities.

Many countries have now begun to try to match resources more directly to specific measured local health needs, particularly in the acute sector. The intention is that where the demand for more activity has been met, the money will follow. Either the number of cases treated for each type of condition is counted, or each procedure is counted. The groupings of conditions or of procedures are selected so that all of the cases will be both clinically similar and cost more or less the same. These groupings are sometimes called 'costing currencies' or casemix groupings. In England the current set is called Healthcare Related Groupings, HRGs. A tariff, a fixed price, can be set for each grouping.

Any Mental Health costing currency must be:

- Clinically meaningful
- Have a manageable number of groups
- Be produced from readily available or attainable data
- Have comparability in (actual, not planned) resource use

Note that such systems only provide an immediate mechanism for *distributing* a health budget. If the total budget has already been set, they just redistribute funds from one area of care to another. Hopefully, the figures from a previous year can be used to contribute to the decision process of resetting next year's allocation, but even the weight of that evidence will not automatically swing the political balance.

Tariffs therefore shift financial risk (responsibility for meeting resource constraints) from providers to commissioners. They can be seen, if they work properly, as part of a move to better commissioning.

Also, the unbundling of block budgets necessarily increases transparency regarding the cost of individual services and also

variations in cost both between and within providers. That should tend to improve efficiency.

And the whole system improves the incentive to implement better information systems.

However, one of the assumptions that is sometimes made about such systems is that the need of a population for care of a specific type can be measured by the number of cases that present themselves or are referred to the providers. But we know that is not the case so far as mental health needs are concerned, because many people with MH problems do not seek help or get referred to secondary services. And the poorer resourced services may have the lowest referral rates because expectations have become so low. Therefore, if a system is used in which finances reward activity ('met need'), there must be some independent additional means for measuring the unmet need as well. Otherwise a population whose expectations are low or whose services are difficult to access, or a cultural sub-population which is reluctant to seek help, will not get adequate funding.

Costing currencies in the acute sector have worked best in conditions that require discrete procedures that are time-limited. In chronic conditions, both in the 'acute' sector and in mental and community healthcare, it is much harder to define a start and end point for the costing and remuneration process. If long term care is simply costed by the month or quarter, there is too much variability between individual cases *within* each group to allow distinctions to be made *between* client groups and so the system represents little improvement upon block contracts.

A further problem results from the poor correlation in our sector between the 'condition' (whether it is classified using a medical diagnosis, a psychosocial formulation, a functional measure, or all of them combined), and the amount of care that the person requires or eventually gets. That makes the goal of tariff-based funding of condition-based groupings unattainable. Instead, recent projects (including the Payment by Results programme for MH in England) have attempted to identify broad groupings of clinical interventions, or care packages, which have both clinical meaning and similar resourcing implications. Detailed costing methodology has not yet been applied to the proposed groupings, and it is by no means certain that the care packages could support the use of a nationally-set tariff. Some way of assessing the whole population need would still be required. Nonetheless, a valid means of

classifying mental healthcare activity would enable comparison between areas and between providers to begin.

Related questions:

- **What are the dangers of a tariff-based system of funding for mental health services, and how could they be avoided?**
- **How can the right level of resourcing be proven for an area?**
- **What is the Payment by Results Project?**
- **How can we ensure that mental health gets a fair deal compared to other sectors?**

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