Financial sustainability of primary mental health care services

This issues guide is linked to the vignette ‘Following the dollars’.

Our system model of primary mental health care (PMHC), described in the Systems Planning Guide (see Part 5 of the Toolkit: A population–based approach to planning mental health services in primary care), highlights the point that the adequacy of resources, in this case dollars, is dependent upon both the amount of resources available and the type and volume of demand on those resources.

Let us examine the scale of the issue. Currently, in 2010, specific PMHC activity across the whole country is supported by $22.5 million of funding. This modest amount has to support the 16% of the population estimated to have mild to moderate mental disorders, including substance use disorders, in any 12-month period. That is, assuming a population of 4.3 million, and that prevalence rates are similar for those under the age of 16, 688,000 people. Let us assume that half of these people will naturally remit or not want formal treatment, and continuing the assumption that people under the age of 16 are included, this represents 344,000 people in a year, with an allocation of $65 each per year.

To put this into context, in the primary mental health initiatives evaluation, the additional cost (over the usual consultation cost) of a single extended GP consultation was $60 per visit; and a standard package of care covering psychological

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treatment ranged from $400-$550, with all-up costs ranging from $580-930 per person.

Of course, PMHC does not exist in a vacuum. There is now a matrix of services for the management of common mental disorders, including a range of self-help tools such as The Journal, which is a self-administered course of problem-solving therapy, and for younger people, the Lowdown programme which is also web-based. These programmes are funded from other allocations. There are also developments in new brief low-intensity psychological treatments that can be delivered from primary care by GPS or practice nurses without on-referral and without the need for extensive mental health expertise (e.g. Mathieson, Collings, Dowell et al. 2009⁴).

Clearly services will only be sustainable if you manage to match the demand to the available financial resources. There are three ways to do this: increasing the funding allocation, tightening the access criteria or decreasing the cost of providing the service. Figure 1 show the links between these three factors.

Figure 1: Factors affecting the financial resources available for PMHC

⁴ Mathieson F, Collings S, Dowell A. 2009. Sub-threshold mental health syndromes: finding an alternative to the medication of unhappiness. Journal of Primary Health Care 1(1); 74-77
What can be done to match demand to resources?

Increase your effective funding allocation for PMHC

One of the features of funding for mental health services is that there are numerous funding channels. The millions that are spent on mental health as a whole, including secondary services, are separated out into different funding streams, often from different sources, themselves held in different budgets and often having different health outcomes to report on. While there is only just over $22 million of sustainable funding for PMHC there is, for example, over $1 billion available for specialist and community health. Even if you are unable to access additional dollars directly, bringing the relevant ‘budget holders’ together to explore common goals, overlaps, and ways in which each can support the other can be a valuable exercise. There is no doubt that the constraints on total funding limit the services you can offer, but there is also no doubt that within DHBs throughout the country; there are multiple budgets that are often managed separately. Finding ways to bring these together is an important step in increasing understanding and so being able to access more of the financial resource that is really available.

Explicitly managing access criteria

Demand is a reflection of both the need in your community and the criteria you set to control access. Accepting that we are unable to fund services for everyone who may benefit we make judgement calls about who will get those services. In some PMH services those judgements are made by the individual service providers and the resources are spent on those who present first. If the provider, usually a GP, considers that you are appropriate for PMHC service then you get the service, until a point is reached where the funding allocation runs out. In other PMHC services, decisions are made about where the money will be spent e.g. to focus on those with depression.

In both scenarios, the sustainability of the programme is determined by the access criteria that have been set. Claiming that a programme is sustainable or not simply on the basis of the dollars available, ignores the impact you have by establishing the
rules that decide who can and cannot access the programme. Being clear and transparent about those rules and ensuring that they reflect both the priorities of the community within the constraints set by the funder, and the financial resources available is essential.

Decrease the cost of the service

The cost of delivering PMHC services is highly variable. The all-up cost per service user for the original Primary Mental Health Initiatives ranged from $583-$934. This reflects the costs of different providers; for example, doctors, clinical psychologists, counsellors: different philosophies of treatment; the size of the programme (larger programmes had a lower cost per patient); and different set-up costs, as at the time of the evaluation the programme had been running only a year. For comparison purposes, the cost of a 6 month supply of fluoxetine is $182 (at $1 day/40mg), although this does not include the cost of assessment and monitoring which should add $100-$200. It must be remembered that for sub-threshold, mild and moderate common mental disorders the efficacy of psychological and drug treatments is similar, and patients will vary in their willingness to engage in these two options.

There is emerging evidence that brief therapies are effective irrespective of the professional background of the person delivering them, as long as they are experienced and treatment fidelity is maintained. Brief therapies by their very design enable more people to be seen with the same level of financial resource.

Decreasing the cost of PMHC services in the future will be challenging because as services become more embedded and also a core part of primary health care, there will be some additional costs associated with the need for career development opportunities and training, as well as the need to extend the reach of existing services. The most likely scenario is that costs will need to be contained with more achieved per dollar.
How to decide

We do not suggest one approach is preferable to others, but it is obviously critical that in your service design you consider the implications of that design for financial sustainability. Every service design has implications, not only for the quality of the service provided but also for the numbers of people who can access that service. Quality and quantity do not necessarily trade off against each other, because, for example, reducing the number of psychological treatment sessions but making them more effective or retaining the same degree of effectiveness may maintain or even increase overall quality. It is important to consider the values and purpose of your service in the decision-making. We suggest that you work systematically through the three options outlined above and review your progress against them proactively as part of your service planning and review.

For those involved in policy and funding, the points about multiple funding silos are important. At the coalface of service delivery, the experience is that multiple programmes with their multiple sets of deliverables to report on can get in the way of doing the work, and can have high transaction costs especially in terms of professional time, which is the health system’s most valuable resource. It is important for policy makers and funders to allow some latitude in the way funding streams can be used synergistically at the coalface and also to keep the reporting burden to a minimum.
‘Following the dollars’

( click here to go back to guide)

John is an experienced programme planner in a PHO. He has been working in mental health services in various roles since the mid 1980’s. Originally trained as a nurse, John has become involved in planning as he feels he can have more impact on the type of services provided in his region. John is acutely aware that there is far more need in his community than they are currently meeting and he is always looking for new ways of delivering more and better services. He is determined to get programmes up and running, to capture any funding that is available. However, John is also concerned that the numerous funding streams that can be tapped into are not linked and are often ‘ring fenced’ to a particular population or service type. While ‘following the dollars’ means that services will be provided, and patients will be seen, John is concerned that it is resulting in a range of disparate initiatives that do not support and even possibly conflict with each other. He is concerned that the result will be a series of disconnected initiatives that may provide great care for those lucky and/or privileged enough to access them, but do very little to improve the health of the population in his region.

Questions to consider

How does John ensure that

1. The services respond to need and not just those lucky enough to be able to access them?
2. There are linkages built between each initiative, regardless of which funding stream is supporting it?
3. Consideration is given, especially in the case of time limited funding, to what will happen when the funding stops?