

The Independent Hospital Pricing Authority and mental health services: it is not a case of “one size fits all”

Applying a generic form of activity-based funding to mental health risks perpetuating an inappropriate hospital-centric model of psychiatric care

The upcoming implementation of activity-based funding (ABF) should drive unprecedented levels of transparency and has the potential to deliver vital funding increases to mental health services. However, current plans to apply a generic form of ABF based on diagnosis-related groups (DRGs) to mental health risk a continuation of Australia’s inappropriate hospital-centric model of psychiatric care. There is much work to do to ensure that ABF is implemented in an evidence-based manner to support patients with mental illnesses, who often require long-term community care and support.

What is the Independent Hospital Pricing Authority?

Implementation of the new ABF scheme is being driven by the Independent Hospital Pricing Authority (IHPA). Federal government and Council of Australian Governments (COAG) initiatives led to the advent of the IHPA (Box 1),¹⁻³ which was established as a statutory authority by the *National Health Reform Amendment (Independent Hospital Pricing Authority) Act 2011*. The IHPA commissioned a draft pricing framework,³ which detailed proposals to partially replace the current block grants provided to public hospitals and local health districts or local hospital networks with a generic system that assigns a “national efficient price” to each hospital-based acute treatment or clinical procedure. It was COAG’s decision, not the IHPA’s, to price only hospital services.

This article is based on our detailed response⁴ to the draft pricing framework proposal to use DRGs for pricing acute mental health services, at least initially and possibly indefinitely. Our key concern is that once the IHPA has started down this path, it will be difficult to switch to other forms of ABF that are known to fit mental health better.

What is activity-based funding?

ABF is a system of allocating health funding by giving a set price to each health procedure (eg, surgery, knee replacement) or acute diagnostic category (eg, DRG). In the proposed system, this price will be set by the IHPA based on DRGs, with no appeal mechanism. The IHPA only sets the prices; it does not fund. Hospital funding will be split between the federal and state governments. The federal government will initially take on a 40% share of the national

Alan Rosen
FRANZCP, MRCPsych, DPM,
Professorial Fellow,¹ and
Clinical Associate
Professor²

Patrick D McGorry
AO, MD, PhD, FRANZCP,
Professor of Youth Mental
Health and Executive
Director³

Hamish R M Hill
BA(Psych)Hons,
GradDipCouns, AssocMAPS,
Provisional Psychologist⁴

**Sebastian P
Rosenberg**
BA, MPA,
Senior Lecturer²

¹ School of Public Health,
University of Wollongong,
Wollongong, NSW.

² Brain and Mind
Research Institute,
University of Sydney,
Sydney, NSW.

³ ORYGEN Research Centre,
University of Melbourne,
Melbourne, VIC.

⁴ University of Wollongong,
Wollongong, NSW.

alanrosen@
med.usyd.edu.au

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1 A brief history of the Independent Hospital Pricing Authority

July 2009 — Final report of the National Health and Hospitals Reform Commission¹

The report’s recommendations were diluted between state and territory premiers and Prime Ministers Rudd and Gillard, but it eventually led to:

2 August 2011 — National Health Reform Agreement²

This agreement set out the intention of the federal and state and territory governments to work in partnership via the Council of Australian Governments to improve health outcomes for all Australians, by establishing an increasing federal proportion of reimbursement to local health districts or local hospital networks by casemix or activity-based funding. This led to:

15 December 2011 — Independent Hospital Pricing Authority (IHPA)

It is intended that this body will work in close collaboration with the new National Health Performance Authority and the Australian Commission on Safety and Quality in Health Care.³ The IHPA commissioned:

21 December 2011 — Activity based funding for Australian public hospitals: towards a pricing framework discussion paper³

This paper strongly recommends pricing based on generic diagnosis-related groups for mental health services. ◆

efficient price, with this share increasing in time to 45% and then 50% of growth in health services.³ The states and territories will continue to be large players in health funding.

How are hospital-based mental health services currently funded and how will this change?

Overall, the existing approach to block-funding of mental health has not delivered a good outcome. The demand on services generally outstrips the funding to supply them, and it is impossible under current arrangements to compare key aspects of performance across mental health services.

In relation to mental health, the federal government is proposing to include only emergency department and acute inpatient services in the new generic ABF system from 1 July 2012, with the possible addition of other hospital-based outpatient services and other adjustments to the mental health pricing system after 1 or 2 years. It is not yet clear which mental health services will be covered by the new system from 1 July 2012 or after any adjustments are made, or indeed whether such adjustments will eventually be made at all.⁴

Although some non-acute health care activities performed by public mental health services will continue to be block-funded, the intention is for most (if not all) acute

Perspectives

2 Likely practical implications of generic versus mental health-specific casemix for a 25-year-old person presenting with recurrent psychosis and drug dependency

DRG-based casemix, acute services only*	Mental health-specific casemix
Family/friends or police referral	Family and general practitioner referral
Emergency department fraught presentation and assessment	Home-based or <i>headspace</i> /community centre one-stop shop early assessment
Late intervention pattern	Early intervention pattern
Involuntary psychiatric inpatient admission plus inpatient drug detoxification	Voluntary community-based non-government organisation-staffed residential respite house admission, specialised drug detoxification centre and/or drug rehabilitation program
Transfer to depleted after-care community mental health team (if existent) or to already over-burdened GP	Seamless follow-up by same enhanced community mental health care coordination team. Ongoing continuity of care by combined crisis and care management, early intervention or assertive community treatment team

Implications for service users and providers:

- revolving-door relapse and readmission trajectory
- more involuntary care
- higher violence and suicide rate
- more forensic involvement
- personal and family recovery trajectory
- more voluntary care
- stronger therapeutic alliance
- lower suicide rate
- less forensic involvement

Implications for GPs:

- unrealistic expectations on GP to ensure attendance for care
- loss to follow-up
- patients fall through gaps in the system
- partnership arrangements for physical care of and psychiatric prescribing for mentally ill individual
- community mental health care team-assisted follow-up
- access to the "Better Access" initiative and Access to Allied Psychological Services psychotherapy and COAG support services

DRG = diagnosis-related group. COAG = Council of Australian Governments. *As proposed in the Independent Hospital Pricing Authority draft pricing framework.³

and hospital-based mental health services to be funded according to the DRG system within a few years. While all states and territories currently collect DRG data on hospital-based acute psychiatric presentations, DRGs have limited, if any, use for mental health funding purposes.

Further, the IHPA will be using DRGs to classify hospital-related mental health care in some jurisdictions but not others, depending on whether each state or territory agreed with this in recent bilateral negotiations with the federal government (Professor Kathy Eagar, Director, Centre for Health Service Development, University of Wollongong, personal communication, 2012). The federal government will only fund hospital-based services in the "agreement" jurisdictions on an ABF basis from 2012–13. This patchy partial implementation could be quite a mess.

What are the risks and likely outcomes if reform is implemented as currently proposed?

Under the new scheme, the funding will be driving the services, when it should be the other way around. The IHPA's need to drive implementation of ABF nationally risks implementing a simplistic DRG approach to mental health, rather than developing a more appropriate form of ABF specific to mental health. We need a comprehensive mental health classification that is not limited to the acute inpatient setting and that creates incentives for best-practice integrated community and hospital care.

“Under the new scheme, the funding will be driving the services, when it should be the other way around”

While more accurate than the current block-funding arrangements, the proposed DRG-based funding system is a poor predictor of the resources required to care for people with a mental illness. DRGs for mental health are much less accurate than DRGs for all other conditions, and have by far the worst degree of "fit" of all medical or surgical procedures.⁵ In spite of this, the IHPA argues that it is better to get a system up and running now and iron out any problems over time.

There are three issues with this. The first is that the system could be (further) underfunded by using DRGs that underestimate mental health resource requirements. If services are already inadequately funded, as the evidence on resource distribution and comparative health burden shows that mental health services often are,⁶ the current average price will also be inadequate. Therefore, pricing of services should be based on the cost of good practice, not the current average.

The second issue is that implementing ABF for hospital-based mental health care services while still block-funding other mental health care services could perpetuate a focus on hospital-based care and contribute to the ongoing degradation of Australia's endangered community mental health services. This blunt version of ABF appears to offer no place for services seeking to integrate acute mental health care with evidence-based community-based services, such as crisis and ongoing care management teams, assertive community treatment teams, psychotherapeutic interventions and 24-hour supported residential respite, as well as other supported housing and vocational programs that are often run in partnership with non-government organisations. The likely practical implications are illustrated in Box 2.⁷ Research clearly shows that integration between acute and community care is more cost-effective and provides better outcomes.⁷

Third, chief executive officers of local health districts or local hospital networks will now be formally allowed to move resources received from the federal government for mental health activities out of mental health and into other budgets. Such transgressions are already too common with state general hospital-dominated funding, but rather than curtailing them, the proposed funding system will now officially sanction them. It is also unclear how any new system will anticipate and prevent "gaming" by the management of local health districts (ie, playing the system to get more funding by diverting service users to more lucrative emergency department and inpatient services). This will also add to the current problems with access gridlock in emergency departments and psychiatric inpatient units.⁷

Are there alternative approaches?

Back in 1998, Australia developed its own mental health classification. The Mental Health Classification and Service Costs (MH-CASC) Project⁸ examined 18 000 episodes of care, encompassing acute, rehabilitation, inpatient and community components. Such an approach, replicated in New Zealand,⁹ was shown to be a far more accurate "fit" and resourcing formula template than DRGs for mental health. MH-CASC would need considerable review and updating, but resources to do this have not been made available. More

recently, both Canada¹⁰ and the United Kingdom¹¹ have spent considerable energy developing promising approaches to the classification of mental health care. The successful application of ABF to mental health requires careful examination of these models to find the best fit.

What needs to be done?

Mental health services do need an appropriate form of ABF. They need to be able to recoup funding on the basis of accurate, whole-episode-of-care-generated costings, and they need a reform-shaping casemix funding system. The mental health sector is now becoming much more engaged in the ABF debate.¹² Mental health clinicians and other stakeholders see the importance of ABF, especially if it will result in growth in funding where it is most needed.⁴ Many mental health clinicians would favour a form of ABF to improve allocative fairness and efficiency, but DRGs are unlikely to provide these for mental health. The sector needs ABF to deliver the right incentives — towards and not away from community-based care. Given that only what is counted and funded gets done, the mental health sector is looking for ABF funding signals to assist in reshaping services and to help fuel the engine of reform.

Development of a mental health-specific casemix system should be an urgent priority, and the IHPA has indicated it will commission development of a specialist mental health classification.³ This work should be tendered out by the IHPA and undertaken immediately. Until this model has been developed and is ready for implementation, all public mental health services should remain block-funded. Further, all state and federal funding generated via mental health service casemix should be tracked and returned to these services by local health districts.

In relation to mental health, the IHPA's mandate is to deliver a convenient standard pricing system, not a quality service system. The states and territories should not simply accept that only acute and some hospital outpatient mental health services are "in scope" for a generic DRG casemix approach. According to Schedule B of the National Health Reform Agreement,² to which all jurisdictions are signatories, a national efficient price for mental health interventions cannot be fulfilled using an ABF casemix system that fails to accurately predict the "actual cost of delivery" or to allow for complexities, comorbidities and anomalies. Specific price weight enhancements have recently been conceded by the IHPA for specialist paediatric and Indigenous services (as recommended in the draft pricing proposal,³ and due to be published in the final pricing framework). The IHPA should work with those states willing to experiment with tailored mental health ABF approaches to encourage such developments nationally.

Under the new scheme, hospitals may become very good at generating products that have little benefit. Historically, DRG funding has often been based on existing services and not necessarily on the best evidence regarding outcomes. This must change.

We also need to "join all the dots". The National Mental Health Commission (NMHC)¹³ is the appropriate body to oversee and ensure coordination between all national

initiatives in this field. The current arrangement of leaving key leadership decisions to the Department of Health and Ageing and COAG has resulted in directionless and vague documents like the *Ten year roadmap for national mental health reform*¹⁴ and multimillion dollar budgetary measures often devoid of evidence. The NMHC needs to be appropriately resourced to conduct a thorough national grass-roots consultation and survey the evidence, so as to set targets based on systematising cost-effective interventions that are achievable within a 10-year time frame. To this end, the NMHC could establish a knowledge exchange centre, as the Mental Health Commission of Canada¹⁵ has done. Only then will the NMHC's National Report Card on Mental Health and Suicide Prevention¹³ make sense — we need a commitment to specific evidence-based and humane goals before we can monitor how close we are to reaching them.¹⁴ The NMHC should do this in collaboration with the new National Health Performance Authority, the IHPA and the Australian Commission on Safety and Quality in Health Care.

A well designed casemix system specific to mental health could then be useful in providing clear pricing signals that will encourage decommissioning of ineffective service inputs and shape our services towards these agreed objectives, improved outcomes and real, palpable reform.

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