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Mental health services commissioning and provision: Lessons from the UK?

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The commissioning and provision of healthcare, including mental health services, must be consistent with ethical principles – which can be summarised as being "fair", irrespective of the method chosen to deliver care. They must also provide value to both patients and society in general. Value may be defined as the ratio of patient health outcomes to the cost of service across the whole care pathway. Particularly in difficult times, it is essential to keep an open mind as to how this might be best achieved. National and regional policies will necessarily vary as they reflect diverse local histories, cultures, needs and preferences. As systems of commissioning and delivering mental health care vary from country to country, there is the opportunity to learn from others. In the future international comparisons may help identify policies and systems that can work across nations and regions. However a persistent problem is the lack of clear evidence over cost and quality delivered by different local or national models. The best informed economists, when asked about the international evidence do not provide clear answers, stating that it depends how you measure cost and quality, the national governance model and the level of resources. The UK has a centrally managed system funded by general taxation, known as the National Health Service (NHS). Since 2010, the UK's new Coalition* government has responded by further reforming the system of purchasing and providing NHS services – aiming to strengthen choice and competition between providers on the basis of quality and outcomes as well as price. Although the present coalition government's intention is to maintain a tax-funded system, free at the point of delivery, introducing market-style purchasing and provider-side reforms to encompass all of these bring new risks, whilst not pursuing reforms of a system in crisis is also seen to carry risks. Competition might bring efficiency, but may weaken cooperation between providers, and transparency too. On the other hand, it is hard to implement necessary governance and control without worsening bureaucracy and inefficiency. The pursuit of market efficiencies has been particularly contentious in men-

*Since May 2015, following general elections, the UK has a Conservative government.

tal health care, where many professionals are defensive about the risks to vulnerable patients and to traditional ways of professional working. Developments and debates in the UK may be instructive for others. We conclude this paper with a set of questions that may help inform debate and evaluation of mental health services internationally.

Key words: Mental-health services, commissioning services, provision of services, UK.

Introduction

The ethical foundations of the modern state rest with respecting, protecting and enhancing the liberty of citizens, and negotiating such social arrangements as protect and advance the interests of the most vulnerable in society.[1] The ethical foundations of professionalism in medicine are respect for patient autonomy, promotion of patient welfare and social justice.[2] The commissioning and provision of health services, including mental health services, must be consistent with these ethical principles. Because resources are always finite and must be prioritised, ethical healthcare services must also deliver value to patients and society, defined by the Harvard economist Porter[3] as the ratio of patient outcomes divided by cost of service across the whole care pathway.

Every country should have adequate national mental health policy and service provision.[4] Mental health services must provide for the population as a whole, but also ensure that the human rights and welfare of the most vulnerable, such as those with severe mental illness, are safeguarded and enhanced.[5] However the mental health of the population is affected by factors beyond mental health practice, particularly by levels of inequality in the population.[6] Psychiatrists are now seeing the fall out of the international debt crisis roll through society, and affect the most vulnerable in the population. This is inevitably placing significant extra demands on national systems of mental health care.

Systems of commissioning and delivering mental health care vary from country to country, bringing the possibility of learning from others. Particularly in difficult times, with major challenges in meeting levels of need, it is essential to keep an open mind as to how things might be done differently. In the current harsh economic era, that often means how to provide more with less – how to successfully achieve service reform, to bring greater efficiency and effectiveness. In the field of public healthcare this often requires a fresh, "business-like" approach, which unfortunately raises the spectre of unfair treatment of vulnerable people through unrestrained markets. On the other hand, as evidenced by well-documented scandals in state-run mental health services in the UK and elsewhere, such provision is by no means an absolute guarantor of the welfare of the vulnerable.

In fact, greater efficiency and effectiveness require strengthened systems of governance to ensure fair provision of healthcare. Daniels[7] suggests that the hallmarks of fairness are equity, efficiency and accountability. Health equity reflects all policies affecting public health, not just health policies, as well as financial barriers to equitable healthcare access, non-financial barriers to access and comprehensiveness of benefits. Efficiency includes quality improvement and administrative competency. Democratic accountability requires empowerment, and patient and provider autonomy. Such hallmarks provide a possible way of evaluating health services irrespective of specific purchasing arrangements and support reasoned debate and implementation arrangements which deliver value and fairness in mental healthcare.

The challenge

A study by the European Union and the World Health Organisation compared mental health care systems across Europe.[4] The report's conclusion that the best policies and practices could be found in the English National Health Service (NHS) was based on data provided by central government departments, although outcomes or cost-effectiveness were not assessed. England has among the highest rates of mental ill-health and other social problems in Europe,[6] and spends a larger proportion of its health budget on mental health than any other country

in the continent.[8] At the time of the EU/WHO study there had been significant increase in spending on mental health services. While the report highlighted the strengths of the English system, some senior psychiatrists have expressed concerns about the actual quality of assessment and care that patients receive.[9–10]

The UK has a centrally managed system funded by general taxation, known as the National Health Service (NHS). Funding has doubled every decade since its foundation in 1948, irrespective of political party in power, with the exception of the decade to 2010, when the total investment trebled. In the economic boom years, government and commercial healthcare spending and investment in many countries was supported by large scale borrowing. Such funding has depended on public borrowing and tax receipts, including in the UK high tax receipts from the strong banking and finance sector.

Significant investment has been channelled into UK mental healthcare, including novel programmes of community care and psychological treatments focussed on priorities such as fitness to work.[11] Of the increase in adult mental health and social care in England between 2001 and 2009, 83% was commissioned by the NHS, but over 30% was provided by independent organisations.[12] The UK saw many new modern hospitals and community homes built, and new teams and service models launched, from which mental health patients greatly benefited. However the debt crisis is now bringing new constraints in health spending, and sharp reductions in social care expenditure, with mental health patients amongst the vulnerable people most affected. At the present time public, commercial and charitable healthcare providers are affected adversely, with some providers struggling to survive. The authors are aware of an increasing number of quality scandals and bankruptcies in the UK healthcare sector. These strains are compounded by increasing healthcare demands from the impact of unemployment, and increasing numbers of elderly – essentially the ratio of sick people to tax payers is growing.

Since 2010, the UK's new Coalition government has responded by further reforming the system of purchasing and providing NHS services – aiming to strengthen choice and competition between providers on the basis of quality and outcomes as well as price.[13] This pursuit of market efficiencies has been particularly contentious in mental health care, where many professionals are defensive about the risks to vulnerable patients and to traditional professional ways of working. Whilst there is some evidence that forms of commissioning in primary care, as proposed by the Government, can reduce costs, little of this relates to mental health, and such changes may bring other risks to patients.[14]

The debate

Different systems of governance, such as in state, commercial and charity sectors have different strengths and weaknesses. Introducing market-style purchasing and provider-side reforms to encompass all of these bring new risks, whilst not pursuing reforms of a system in crisis is also seen to carry risks. Competition might bring efficiency but is likely to weaken co-operation between providers, and transparency too. On the other hand it is hard to implement necessary governance and control without worsening bureaucracy and inefficiency.

Following de-institutionalisation programmes, the reduction of UK state in-patient beds, provision of community care homes and specialist housing and support for people with chronic mental health problems, the elderly and people with intellectual disabilities are now largely independent of the state. Several areas of specialist hospital care, ranging from longer-term forensic units to eating disorders to brain injury, are now mostly provided for by commercial organisations, and this is reflected in data on compulsory detentions to independent hospitals.[15] Some national commercial groups running psychiatric hospitals and care homes are now larger than the local, catchment area based, NHS providers in which, for the time being, most psychiatric in-patient beds and professional multi-disciplinary teams remain. The income of the commercial sector is largely derived from NHS commissioners and local government authorities. Many are uncomfortable with the

large profits made by some private equity owners in this market.

Some argue that the UK reforms have not gone far enough as they do not allow real competition, based on a choice of quality services by empowered patients and purchasers of services. Current debates in the UK[16–20] demonstrate the complex arguments in gauging the risks and benefits of market approaches to healthcare, and the strong feelings of psychiatrists who have given their professional lives to public service.

Opponents of private care typically quote experience in the United States[18–20] and cite quality and financial scandals in private healthcare, whilst proponents are similarly tempted to cite equally unacceptable failures in public mental health care.[21] A persistent problem is the lack of clear evidence over cost and quality delivered by different local or national models.[5] The best informed economists, when asked about the international evidence do not provide clear answers, stating that it depends how you measure cost, the national governance model and the level of resources.[22] In mental health the definition of outcomes can be difficult, as a variety of dimensions need to be assessed including prevention, patient experience, patient safety as well as symptomatic change. The complexity of this issue is evidenced by repeated delays in the UK government extending is "payment by results" programme into mental health.[23] Meanwhile examples of providers publishing comprehensive outcome data in mental health are rare.[24]

The US-based Commonwealth Foundation[25] compared seven healthcare systems in English-speaking and European countries (Australia, Canada, New Zealand, UK, US, Germany and the Netherlands). The study found that overall the US system ranked last of the seven countries – despite the fact that the US spent on healthcare more than the other countries both in absolute and relative terms. The Netherlands had the best system overall – one feature is that the Dutch system allows citizens choice between purchasers as well as providers of health services.

In the Commonwealth Foundation study the UK scored second overall – it is a less wealthy country per head of population than the Netherlands and spends significantly less on healthcare in absolute terms. However, it was assessed as best for effectiveness and appropriateness of care. On the other hand it scored worse than all others on measures of person-centred care. Furthermore the UK population as a whole was found to be 6th out of 7 in terms of long productive lives.

It could be concluded from the study that choice[26] can be effective in healthcare, that level of expenditure does not necessary determine outcomes, and that nature and quality of the health service is not the fundamental determinant of a country's population health. However more can be learnt by looking closely at the unequal benefits for different sections of the population. Whilst wealthy US citizens get some of the best healthcare anywhere, the poorer, vulnerable population in the US clearly receives worse care than most European counterparts. Such concerns are compounded with real political issues[6] –there is inequality in care but also in the burden of resourcing– in the UK 50% of the population pays 90% of total tax, 25% of which pays for the NHS.

The experience between countries of more severely ill, vulnerable patients requires further scrutiny. Roehr[27] found that for people with complex needs coordination of care was best in the UK, compared with other Anglo-Saxon and European countries, whilst the Commonwealth Fund[28] found that for sicker adults, the UK was average in terms of timely access to care and availability of records at appointment. It seems likely that different systems serve better the needs of different patient populations, for example Netherlands for the acutely sick, UK for complex long term conditions.

In reality in the UK elements of a mixed healthcare economy system of state and independent providers has been in development for at least two decades. Market reforms in acute healthcare have been supported by successive Governments – especially commercial provision of elective surgery offering a solution to long waiting times in the NHS, with elements of general practice down increasingly involved with private companies. In mental health, whilst value for money and quality from the private mental health

sector have long been questioned,[29] a diversity of state, private and voluntary mental health provision continues to develop, focussed on provision for the more severely ill and vulnerable patient populations.

Conclusion

The NHS has been in the UK a long standing social landmark strongly supported by the public and professionals including mental health professionals. Over the last 20 years the NHS has been operating more as a business organisation, in pursuit of market efficiencies and improved effectiveness. This has brought out many challenges and debates. Ultimately, the test of the method chosen to purchase and deliver health care is whether it produces "fair outcomes" for whole populations and patients.

It would be appropriate for all countries to benchmark their current or proposed commissioning systems on the following criteria:

Is the system designed to deliver fair, ethical healthcare?

Have we defined what we mean by 'outcomes' within our services?

What data do we have on which to audit this?

Do we have a balance between providers of different kinds to provide a choice to patients?

How might we move forward to close some of the gaps identified from the above mentioned questions?

What can we learn from experiences in other countries?

Ανάθεση και παροχή υπηρεσιών υγείας: Διδάγματα από το Ηνωμένο Βασίλειο (UK);

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Η ανάθεση και η παροχή υπηρεσιών υγείας, συμπεριλαμβανομένων των υπηρεσιών ψυχικής υγείας, πρέπει να συνάδουν με τις αρχές της Ηθικής και της Δεοντολογίας – οι οποίες θα μπορούσαν να συνοψιστούν ως «δίκαιες», ανεξάρτητα από την επιλεχθείσα μέθοδο παροχής φροντίδας. Επίσης, πρέπει να είναι συμφέρουσες τόσο για τους ασθενείς όσο και για την κοινωνία γενικότερα. Το «συμφέρον» θα μπορούσε να ορισθεί ως ο λόγος των αποτελεσμάτων στην υγεία των ασθενών προς το κόστος των υπηρεσιών καθόλη τη διαδικασία της φροντίδας. Ειδικά σε δύσκολους καιρούς, είναι απαραίτητη η δεκτικότητα ως προς τους τρόπους που κάτι τέτοιο μπορεί να επιτευχθεί. Σίγουρα οι εθνικές και οι περιφερειακές πολιτικές θα διαφέρουν, καθώς οι τελευταίες αντανακλούν την ιστορία, την κουλτούρα, τις ανάγκες και τις επιλογές της συγκεκριμένης περιφέρειας. Καθώς η ανάθεση και η παροχή ψυχικής φροντίδας διαφέρουν από χώρα σε χώρα, υπάρχει η δυνατότητα να μάθουμε από άλλους. Στο μέλλον οι διεθνείς συγκρίσεις μπορούν να χρησιμεύσουν στην αναγνώριση πολιτικών και συστημάτων ικανών να λειτουργήσουν διακρατικά και διατοπικά. Ένα επίμονο πρόβλημα είναι η έλλειψη σαφών στοιχείων για το οικονομικό κόστος και την ποιότητα που παρέχουν τα διάφορα τοπικά ή εθνικά συστήματα. Όταν ερωτώνται για τα διεθνή στοιχεία, οι οικονομικοί αναλυτές δεν δίνουν σαφή απάντηση, υποστηρίζοντας πως η τελευταία εξαρτάται από το πώς μετριούνται το οικονομικό κόστος, το εθνικό μοντέλο διακυβέρνησης και το ύψος των πόρων. Το Ηνωμένο Βασίλειο έχει ένα κεντρικά διαχειριζόμενο σύστημα που χρηματοδοτείται από τη γενική φορολογία, γνωστό ως Εθνικό Σύστημα Υγείας (National Health

Service). Από το 2010, ο νέος κυβερνητικός συνασπισμός του Ηνωμένου Βασιλείου προχώρησε στην περαιτέρω μεταρρύθμιση του συστήματος αγοράς και παροχής υπηρεσιών του NHS, με σκοπό την ενδυνάμωση των επιλογών και της ανταγωνιστικότητας μεταξύ των φορέων παροχής υπηρεσιών με βάση την ποιότητα, τα αποτελέσματα και το οικονομικό κόστος. Αν και η πρόθεση του κυβερνητικού συνασπισμού είναι η διατήρηση ενός συστήματος χρηματοδοτούμενου από τη φορολογία και δωρεάν στο σημείο παροχής, η εισαγωγή των πρακτικών της αγοράς στην ανάθεση υπηρεσιών και οι μεταρρυθμίσεις από την πλευρά των φορέων παροχής υπηρεσιών συνδέονται με νέους κινδύνους, ενώ η μη επιδίωξη της μεταρρύθμισης ενός συστήματος σε κρίση επίσης εγκυμονεί κινδύνους. Ο ανταγωνισμός μπορεί να αποφέρει αποδοτικότητα αλλά ενδέχεται και να αποδυναμώσει τη συνεργασία μεταξύ των παρόχων, όπως επίσης και τη διαφάνεια. Από την άλλη πλευρά, είναι δύσκολη η εφαρμογή της απαραίτητης διακυβέρνησης και ελέγχου χωρίς να επιδεινωθεί η γραφειοκρατία και η αναποτελεσματικότητα. Η επιδίωξη της αποτελεσματικότητας της αγοράς είναι ιδιαιτέρως αμφιλεγόμενη στην ψυχική υγεία, όπου πολλοί επαγγελματίες κρατούν αμυντική στάση σε σχέση με τους κινδύνους που ελλοχεύουν για τους ευάλωτους ασθενείς και τις παραδοσιακές μορφές επαγγελματικής εργασίας. Οι εξελίξεις και οι συζητήσεις που λαμβάνουν χώρα στο Ηνωμένο Βασίλειο ενδέχεται να είναι διδακτικές και αλλού. Κλείνουμε το άρθρο με μια σειρά ερωτήσεων που μπορεί να τροφοδοτήσουν τη περαιτέρω συζήτηση και την αξιολόγηση των υπηρεσιών ψυχικής υγείας διεθνώς.

Λέξεις ευρετηρίου: Υπηρεσίες ψυχικής υγείας, ανάθεση υπηρεσιών, παροχή υπηρεσιών, Ηνωμένο Βασίλειο (UK).

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