

The impact of different models of healthcare provision on mental health policy and services

Dr Pauline Prior
Queen's University Belfast

Aims

- To explore the impact of different models of healthcare on mental health provision
- To highlight some strengths and some issues of concern in mental health policy in NI and ROI
- To explore ideas for a future mental health care system in the context of national and international research

Models of Healthcare

- Publicly funded and publicly provided services
- Publicly funded with different providers
 - Public organisations
 - For-profit organisations (commercial)
 - Not-for-profit organisations (voluntary/charity/users)
- Parallel/separate systems of funding and provision – public and private
- Market forces - private funding and provision (individual and insurance finance)

Health services in Northern Ireland

Model:

Mainly publicly funded and provided, with an increase in independent providers since 1980s

Provision

- Public sector: Acute and long-term care hospitals, psychiatric hospitals and community services, public health system, primary care system (integrated health and social services)
- For-profit sector: 2 acute hospitals, nursing homes, residential homes, GP services?
- Not-for-profit sector: residential homes and sheltered accommodation for disabled and older people

Health services in Ireland (ROI)

Model :

Mainly publicly funded but provided by public (HSE) and independent (NFP and FP) sector

Provision

- Public sector: Acute and long-term care hospitals, Psychiatric hospitals, community care/primary care system, public health system
- For-profit sector – Acute hospitals, nursing homes, residential homes, GP services?
- Not-for-profit sector – Acute hospitals, Psychiatric hospitals, residential homes and sheltered accommodation for disabled and older people

Some financial facts

- UK (NI statistics similar in pattern) OECD 2006
 - 86% of total health spending comes from public sources,
 - 8.3% GDP spent on health in 2004
 - Per capita expend on health in 2004 E2020 (£1362)
 - 11% of population had private health insurance in 2003 (Ham 2004:75)
- ROI: (OECD 2006)
 - 80% of total health spending comes from public sources,
 - 7.1% GDP spent on health in 2004
 - Per capita expend on health in 2004 E2060 (£1390)
 - 52% of population have private health insurance (Health Insurance Authority, 2005)
 - Voluntary Hospitals
 - approx 40% of acute hospital beds, 55% day case beds (DoHC Health Stats for 2005) 90%-95% of costs borne by DoHC (Lynch, 2006: 9)

Mental health services NI

- All health and social care for people with mental health problems publicly funded and provided
 - Psychiatric hospitals
 - Psychiatric units in general hospitals (including Mater)
 - Community mental health teams
 - Approved Social Workers (24 hour service)
- Employment and housing projects provided in partnership between public and not-for profit sector
 - Day centres, sheltered housing, befriending, advice (including legal advice)
- NB: no commercial interests – Why?

Mental health services ROI

- Most health and social care for people with mental health problems publicly funded - but there is a strong independent sector
 - Psychiatric hospitals (public and private)
 - Psychiatric units in general hospitals (public and private)
 - Community mental health teams (public)
- Employment and housing projects : mainly not-for profit sector
 - Day centres, sheltered housing, befriending, advice

NB: important position of voluntary hospitals : independent (nfp) or public sector?

Strengths

- **Northern Ireland**
 - Integration of health and social services since 1970s
 - Involvement of Approved Social Workers in admissions since 1986
 - Successful programme of decarceration from hospitals - from 1980s
 - No leakage of experienced professionals from public sector
 - Strong centralised control of strategic planning
 - Strong commitment to reviewing law and services (Bamford Review)
- **Ireland (ROI)**
 - Strong independent sector – voluntary sector, users, carers, commercial interests
 - Finance available from public and private purse
 - Tradition of innovative practice within voluntary sector
 - Influence of international and European debates e.g. disability, human rights, social inclusion

Problems

■ Northern Ireland

- Variable quality of community care services
- Slow development of services for young people (children and adolescents)
- Lack of alternative to public system for those with money
- Dominance of medical model (over-reliance on pharmaceuticals) – slow development of alternative approaches/therapies
- Lower level of resources from public purse (relative to other groups)

■ Ireland (ROI)

- Over-reliance on hospital based treatment
- Slow pace of development of community mental health teams (multi-disciplinary)
- Slow pace of implementation of mental health law
- Lack of integrated approach between sectors
- Dominance of medical model - as above

Future mental health policy

■ Essential characteristics

- Easy access to a mental health professional
- Mental Health Law that applies to total population and incorporates latest legal thinking on rights and capacity
- Adequate financial resources for a range of services (community and hospital)
- Centrally guided strategy requiring co-operation between providers
- Inter-sectoral co-operation on employment and housing problems
- Real alternatives to the medical model of care/treatment
- Specialist services for children, young people, men, older people, offenders, people with substance dependency problems etc
- Advocacy services attached to every mental health team/institution

■ Desirable characteristics

- A range of non-medical services available to all users of mental health services
- Legal advice for service users, carers, mental health professionals
- Services that promote social inclusion
- A conscious 'mental health' proofing of policies related to children, offenders, employment, education, housing, income support

Models of healthcare and the question of mental illness

National and international research indicates

- Mental illness highly co-related with low socio-economic status
- Psychiatric diagnosis highly gendered
- Pharmaceutical industry very influential
- Strong parallel systems of care (public/private) lead to:
 - leakage of experienced staff
 - poor quality public services
 - low level of funding for community services
 - focus on dangerousness as a pre-requisite for treatment in a publicly funded bed

Conclusions

- Well-funded publicly-provided mental health service to form the basis of the system
- Multi-disciplinary approach to care
- 24 hour service for crises (easy access)
- Partnership between public and independent sectors to promote community based services – housing, employment, advocacy, care.
- Public resources to ensure a working legal framework that is 'rights' based
- Government strategy to incorporate independent sector in plans for future

Selected information

- A vision for change: Report of the expert group on mental health policy, 2006, Dublin: The Stationary Office
- NESF, 2006, Mental Health and routes to inclusion, Scoping paper prepared by J. Moore, for project team on mental health. (available from NESF)
- Bamford Review 2004-6 (Review of mental health and learning disability in NI). Papers available on website www.rmhdni.gov.uk
- Mental Health Commission, 2005. A vision for a recovery model: the Irish mental health services. Discussion paper. Dublin: Mental Health Commission.

14
