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Activity-based funding and mental health: a rejoinder

Dear Editor,

De Jong's article (Activity-based funding in mental health: a disastrous path, 13 July 2017) missed several key points.

There have been 32 statutory inquiries into mental health between 2006 and 2012 alone, most summarising the situation as being in crisis.[1] Funding remains low (6% of the health budget) in comparison to the burden of disease (13%), rates of access to care remain unacceptably low, particularly for some key groups and investment in alternatives to hospitalisation is meagre.[2] States and Territories have failed to lift the rate of access to mental healthcare.[3] Block funding has done nothing to foster mental health reform in Australia.

De Jong's concerns about overspending are also misplaced. Both the initial Victorian application of activity-based funding (ABF)[4] and current reforms[5] are capped to limit financial exposure, and issues of 'gaming' can be overcome with audits.[6]

But the real issue here is about service-quality improvement. Before being used for payment, ABF depends on the deliberate construction of a taxonomy by which to describe the services, treatments and therapies provided to people. Some health service providers may recoil at this level of transparency.

However, it offers a level of accountability far beyond simplistic block-funding arrangements, where a service just gets what it got last year, plus or minus a bit, with no regard for the mix of services or clients it sees.

ABF delivers a clear line of sight to enable the comparison of things like length of stay, readmission rates and waiting times for groups of patients with similar characteristics (or 'casemix').

The challenge of applying casemix technology to mental health is acknowledged and ABF is not the only policy needed to drive reform. But there is several decades worth of evidence now about the positive impact ABF can have on efficiency, volume, length of stay, access and quality healthcare.[7]

Holland may have applied an unintelligent approach to payment, but this is no reason to ditch casemix in favour of dumb block funding.

More important than the issues raised by De Jong is the need for proper examination of the concept of 'phase of care' which underpins the new Australian mental health classification. Any payment systems must also align with the goals of the 5th National Mental Health Plan: early intervention, community care and hospital avoidance. De Jong was right in highlighting that poor payment systems can entrench undesirable models of care.

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On the importance of focusing on family and parent factors in multilevel analyses regarding psychopathology of adolescents with an intellectual disability who present to general hospital services

The study of adolescents with an intellectual disability who present to general hospital services and who demonstrate psychopathology can include numerous emotional, cognitive, and demographic factors of the adolescent, as well as of the parents, but future research should have to focus more on the importance of family and especially parents' emotional characteristics.

A plethora of parent-related factors affect mainly help-seeking behaviour,[1,2] as well as the established relation between family functioning, stress exposure, and internalizing symptoms in youth. This suggests that poor parenting practices, low structure, and low emotional cohesion activate psychopathological symptoms in youth exposed to chronic and frequent