ECONOMIST IMPACT

Incentivising access: reaching equity in mental health

A case study by Economist Impact

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Without incentives, change won't happen

Healthcare systems with incentive to improve healthcare equity do so. Without incentives, there is no reason to change. A report by Economist Impact, sponsored by ViiV Healthcare, looks at how to achieve equity in healthcare, assessing the roles of a broad range of health and non-health stakeholders. In this case study, we focus on how to incentivise change within a health service, looking specifically at UK mental health services and the Improving Access to Psychological Therapies (IAPT) programme.

For decades, mental health services in England underwent little meaningful systemic change. Beginning in the 1950s, discussions of reform envisaged a shift away from inpatient care towards community-based services. Nonetheless, the Victorian era asylum system existed into the 1980s, and funding consistently favoured physical health services. In addition, inconsistent, inefficient data use hindered attempts to assess services and plan for the future. Even though the need for change had been recognised for much of the 20th century, incentives to break decisively from the status quo were clearly insufficient.

Suboptimal access to mental health services is linked to disparities

Access is a key driver of successful mental health outcomes. If people cannot access mental health services as early as possible, for whatever reason, they risk suboptimal consequences, such as being hospitalised or requiring other crisis care.

People experience significant disparities in their ability to access mental health services, due to factors such as age, sociodemographic status, ethnicity, housing, substance use and learning disability. For example, in the UK, people from minority ethnic groups are more likely than other patients to:

- seek help once a problem has become a crisis and be treated in emergency departments,
- be admitted to hospital with a mental health problem,
- experience poor outcomes from treatment, and
- disengage from mainstream services.[1]

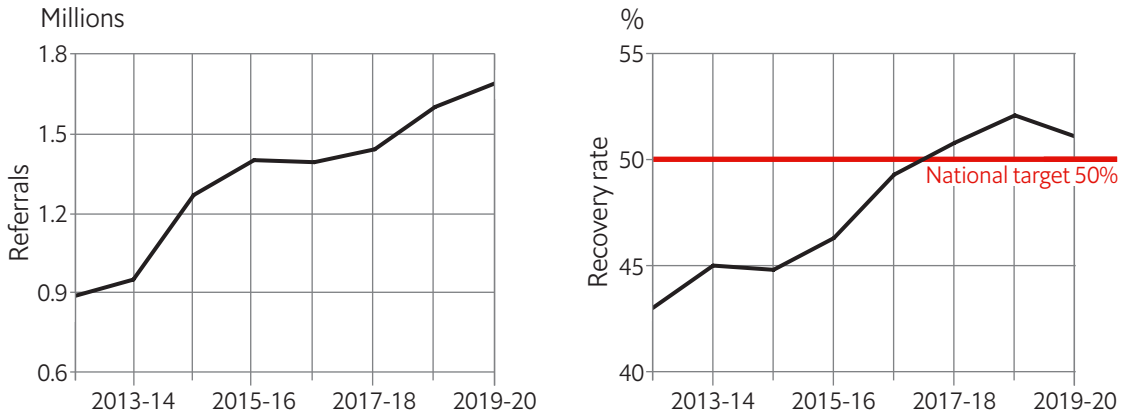
To progress towards easy, equitable access to mental health services in England, the National Health Service (NHS) implemented the Improving Access to Psychological Therapies (IAPT) programme in 2008.

What is IAPT?

The IAPT programme aims to improve access to psychological therapies through the NHS by reducing waiting times and improving recovery. Its specific goal is equity of access and recovery. The programme offers access to a range of interventions, from counselling for low-level depression to inpatient care for people with more acute mental health needs. People accessing IAPT services are offered interventions that are appropriate for their specific needs, but they can access more intensive services if needed (a "stepped care" model).

IAPT is on target to provide 1.9m people with access to the service by 2023-24 (1.7m people were referred to IAPT in 2019-20, up from 1.6m in 2018-19).[2,3] It has exceeded its own targets: more than 50% of patients move towards recovery (see Figure 1) and 90% attend their first appointment within six weeks of being referred by their GP or via self-referral.[4]

Figure 1: People referred through IAPT, and IAPT recovery rates, 2012-13 to 2019-20



Source: IAPT Annual Reports, https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services

Data on the impact of disparities is often lacking, but IAPT bucks this trend

Clear demonstration of the scale and specific impacts of health disparities should easily motivate change, but such clarity depends on the quality and quantity of data available. Challenges with data range from whether it is recorded effectively and accurately to whether systems allow data to be segmented in ways to articulate nuances of the problem.

In the fragmented US health system, says Lisa Fitzpatrick, a clinical professor at George Washington University School of Medicine and founder of Grapevine Health, "it's very hard to look at the data across sites and make sense of it when different states and institutions are all collecting different variables and have different processes for collecting information." Our report on eliminating health disparities highlights the need to improve data-sharing practices.

Despite the centralised nature of the NHS in England, a recent NHS report described inconsistent data quality and reporting as "a major factor behind unwarranted variation across mental health services".[4] The report noted IAPT as the exception.[4] The programme routinely collects and publishes data on service usage and outcomes. IAPT data include details on service users (including race and ethnicity, age, gender, and so on) and publish the data online monthly, quarterly and annually. Clinical Commissioning Groups (CCGs—the organisations responsible for commissioning local NHS services) can use these data to identify unmet needs and hold the service accountable on a local and national basis.

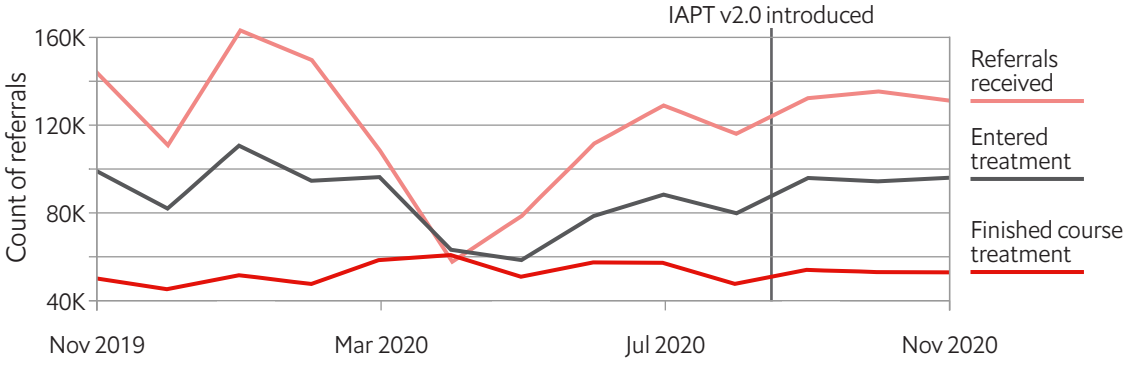
Equity is built into IAPT's incentives—a catalyst for action on disparities

The NHS has also specifically tied targets concerning equity of access and outcomes in IAPT services to its "Quality Premium" reimbursement programme. CCGs are essentially provided with a financial incentive to achieve equity-linked targets—specifically on improved recovery rates for Black, Asian and minority ethnic patients and increased access for older people.[5]

IAPT services were affected by the onset of the covid-19 pandemic. Referral and recovery rates dipped in March-May 2020, but both rapidly returned to pre-pandemic levels (see Figure 2).[6] Given the huge mental health impacts of the pandemic, that IAPT was able to bounce back quickly underscores its importance in accessing mental health care.

Other health services have also taken notice: since the programme's implementation, IAPT-like services have been established elsewhere, including in Canada, Norway, Sweden and Australia.[7]

Figure 2: IAPT referrals and treatment rates amid the covid-19 pandemic (Nov 2019-Nov 2020)



Source: NHS Digital (https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/november-2020-final-including-a-report-on-the-iapt-employment-advisers-pilot).

Key takeaways

The scale and the specifics of the challenge must be demonstrated.
All health-disparity stakeholders need clear evidence of the issues in order to be motivated to act. The data collected by IAPT provide a full picture of overall access and outcomes, as well as detailed analyses of service users (and how successful their treatment is). These data demonstrate both the successes and the challenges at national and local levels—including blind spots. Our report identifies data-sharing practices as an area of action; IAPT demonstrates the importance of these practices.

Accountability breeds trust.
Crucially, IAPT makes its data available to all, which enables better planning. This transparency also improves trust among potential service users that they will receive the help they need, encouraging them to seek treatment. Although our report is clear that health service users are not responsible for disparities in care and access, demonstrating progress towards set goals (as we outline in a separate case study) should inspire confidence in the services' intent to improve care for all.

Success must be incentivised.
Our report is clear in stating that the broad range of health and non-health stakeholders need strong incentives to take steps to eliminate disparities. IAPT's link to the Quality Premium programme incentivises local providers to improve equity of access to mental health services. Incentives stretch beyond the purely financial, but even in a socialised health service such as the NHS, financial rewards can motivate local providers to adopt specific equity-based targets.

For further information from this research, visit:
https://impact.economist.com/perspectives/Achievinghealthequity

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