
Correspondence

Health economics in mental health

Sir: The two timely articles on economic evaluation in mental health (*Psychiatric Bulletin*, November 1997, **21**, 684–686, 687–691) omitted to mention the important issue of cost of illness economic analysis.

Cost of illness analyses are important when specific disorders are considered as opposed to modes of treatment and service delivery (Shah, 1995; Smith *et al.* 1995). This approach attempts to measure the economic burden of disease in terms of resources used to treat the condition, the occurrence of premature mortality, and the morbidity and disability falling on sufferers and carers. These studies measure direct costs of treating the disorder and indirect costs due to loss of productivity from early mortality and disability and the financial strain on the carer. Cost of illness studies can be used to identify avoidable costs in the successful development of primary prevention or early detection and treatment resulting in secondary and tertiary prevention.

If, by using the cost of illness approach, disorder A is more expensive than disorder B, treatment and research can be directed towards the more expensive disorder (Croft-Jefferys & Wilkinson, 1989). If treatment and research resources directed at the economically more significant disorders can result in primary prevention or early detection and treatment with secondary and tertiary prevention then it has real policy implications because the cost of treating established illness will be saved. The amount of cost-saving would depend upon the effectiveness of prevention and early detection/treatment strategies. Moreover, this would also bring about changes in life expectancy and the quality of life in individuals who would have otherwise died or suffered from distress and disability. However, the risk of cost of illness studies is that economically less significant disorders will be neglected.

CROFT-JEFFERYS, C. & WILKINSON, G. (1989). Estimated costs of neurotic disorders in UK general practice 1985. *Psychological Medicine*, **19**, 549–558.

SHAH, A. K. (1995) The measurement of the economic burden of psychiatric illness in old age. *Australian Journal of Ageing*, **14**, 3–5.

SMITH, K. SHAH, A. K., WRIGHT, K., *et al.* (1995). The prevalence and costs of psychiatric disorders and learning disabilities. *British Journal of Psychiatry*, **166**, 9–18.

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Authors' reply: Shah suggests that failure to discuss cost of illness studies was an important omission from our recent articles on economic evaluation. Economic evaluation is the comparative analysis of alternative actions in terms of costs and consequences (Rovira, 1995) to inform health-care resource allocation decisions. Cost of illness studies, as Shah points out, measure the economic burden of disease. They do not examine alternative responses to reducing the burden of disease and they do not compare costs to consequences. We therefore left cost of illness studies out of our short series because they are not forms of economic evaluation as economists conventionally define it.

This is not to say they are not useful forms of analysis. Some authors have suggested they are not (Shiell *et al.* 1987), but this view is contested (Behrens & Klaus-Dirk, 1988; Hodgson, 1989). Cost of illness studies can reveal unexpected distributions in the burden of disease; bring together data on the total current costs of meeting disease in ways which routine health and social service data, arranged on a service or specialty basis, can not; suggest the *potential* for resource savings through effective prevention or other forms of early intervention; and highlight disease problems which demand action of *some kind* because of the health burden they impose on both the population and the formal and informal caring services (Knapp, 1997).

However, cost of illness studies cannot, in themselves, indicate where treatment resources should be directed. It may be neither effective nor cost-effective to treat the more expensive disorders referred to by Shah. The expense of the existing response may reflect an inefficient use of resources, the circular argument referred to by Shiell *et al.* (1987), rather than a need which can be effectively and efficiently met. Cost of illness studies in themselves are not therefore an appropriate basis for resource allocation decisions. A significant burden of disease suggests a pressing need for health-care resources, but the priority attached, in terms of resources allocated, to meeting that need should reflect the effectiveness, cost-effectiveness and cost-benefit of the alternative treatments available, information generated through economic evaluation. Cost of illness studies are complementary to but distinct from economic evaluation.

BEHRENS, C. & KLAUS-DIRK, H. (1988) Cost of illness studies: no aid to decision making? Reply to Shiell *et al.* *Health Policy*, **10**, 137–141.

- HODGSON, T. A. (1989) Cost of illness studies: no aid to decision making? Comments on the second opinion by Shiell *et al.* *Health Policy*, **11**, 57-60.
- KNAPP, M. (1997) Costs of schizophrenia. *British Journal of Psychiatry*, **171**, 509-518.
- ROVIRA, J. (1995) Economic analysis and pharmaceutical policy. *Anaesthesia*, **50** (suppl.), 49-51.
- SHIELL, A., GERARD, K. & DONALDSON, C. (1987) Cost of illness studies: an aid to decision making? *Health Policy*, **8**, 317-323.

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Members of a community mental health team

Sir: Lucas concludes that his study of community mental health team members' activity should inform service planning (*Psychiatric Bulletin*, September 1997, **21**, 547-549). There are however limitations to a study that only counts the number of staff-patient face-to-face contacts and classifies each as 'assessment', 'ongoing' or 'group' and cross tabulates these by discipline.

Lucas does not describe the data collection method in any detail and the reliability of the data appears not to have been established (e.g. through case-note or diary audit). Lucas makes no comment on the remarkably low contact rate of 1.4 patients per full clinical day. In our experience of collecting staff activity data, mental health professionals' compliance with even very clear data collection protocols is variable. Such data collection requires continuous and careful attention to detail if meaningful conclusions are to be drawn.

The paper's most serious problems lie in the interpretation of the data. Lucas' claim that "the CMHNs [Community mental health nurses] had the most face-to-face contacts followed by the consultant . . . Psychologists and occupational therapists . . . social workers then junior doctors" is only true if one ignores the number of staff from each profession. For example there are 5 whole time equivalent whole (WTE) CMHNs and only 1.4 social workers (WTE). When we calculated and ranked the number of contacts (WTE) per week from Lucas' data a very different picture emerged. The consultants see the most patients (18.5) followed by psychologists (12.1), social workers (11.8), junior psychiatrists (8.2) and occupational therapists (6.2). CMHNs have the least number of contacts (5.2).

Lucas' assertion that a team geared towards assessments ought to maximise psychiatric staffing (although possibly true) is not supported

by his data. In one of his study teams the half-time consultant sees 40% of those being assessed. In the other the fifth-time consultant sees none. Decisions about team staffing must be based on firmer evidence than the current practice in one of two study teams.

Lucas did not measure duration of contact. His statement, therefore, that "CMHNs spent more than 50% of their time with [patients with severe mental illness] . . . while social workers spent less than 20%" can only be speculation.

There is no doubt that team composition is a vital component in community mental health services and Lucas is right to assert that there is currently little information to guide service planners in this respect. However, it is important that the research evidence that forms the basis of service planning is of high quality.

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Author's reply: I am grateful to Flander *et al* for highlighting some of the limitations of this kind of study, both in terms of collecting staff activity data and interpreting it. They suggest that staff compliance with activity data collection may be poor. This arises from their experience, but it is difficult to comment on this when it is just that. For the teams studied, the activity data collected formed part of the contracting process with the purchasers (and samples were validated by them). The data were distributed on the trust network and were thus a means of communication, and it was used for case-load monitoring within the teams, so there were considerable pressures for professionals to comply.

Perhaps the most substantial point they raise does need clarifying; all the figures do already allow for the number of posts in each profession. Clearly it would be nonsensical to draw conclusions about professional roles by comparing the work of one part-time social worker with that of three full-time community psychiatric nurses.

Despite the limitations mentioned in the article and by Flander *et al*, the study does begin to address the question of who should be in a community mental health team, and should form a basis with which to compare further, and perhaps more refined, results in this area.

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