The Sainsbury Centre for Mental Health

POLICY 4

POLICY PAPER 4

Payment by Results: what does it mean for mental health?

The results of SCMH research and analysis, presented and interpreted clearly and concisely to inform and influence policy and practice.

Executive Summary

- 'Payment by results' is a new way of paying for NHS hospital and community health services that will replace the present system of block contracts and locally agreed prices. It is planned to apply in time to all services, including mental health, and to be fully operational in 2008.

- Under payment by results, hospitals and other providers will be paid according to the quantity of work done, as measured by the numbers and types of cases treated. The amount paid for each type of case, as determined mainly by diagnosis, will be the same everywhere and fixed in advance through a national tariff.

- The introduction of payment by results will substantially change the pattern of financial incentives and associated risks in the NHS and must therefore be expected to have significant effects on the provision of care. The precise nature and scale of these effects will depend on how the system is designed.

- There are good reasons for supposing that, across the NHS as a whole, payment by results will have positive effects. It will give stronger incentives for providers to increase activity and efficiency and to respond to patient choice. Commissioners will be encouraged to seek out lower-cost forms of care, and the use of a national tariff will reduce transaction costs in the negotiation of contracts. These conclusions are supported by a body of evidence from relevant international experience going back over 20 years.

- Payment by results will be easier to apply and more likely to succeed in some parts of the NHS than others. It will work best in areas like elective surgery, where the conditions being treated and the services being supplied are such that it is relatively straightforward to classify cases into homogenous groups and to apply a uniform set of prices at little risk.

- Mental health care is at the other end of the spectrum and the design of a workable system of payment by results for these services is still some way off. Reasons include the long-term and often episodic nature of mental health problems, the diversity of services and the wide range of factors in addition to diagnosis that influence the costs of care. These and other features of mental health care all make it difficult to classify and group cases for payment purposes at acceptable risk.

- Payment by results also requires good information, particularly on activity and costs. Mental health services lag behind the rest of the NHS in the development of their information systems, in their use of IT and in the quality of information they produce.

The Sainsbury Centre for Mental Health (SCMH) is a charity that works to improve the quality of life for people with severe mental health problems.

We carry out research, development and training work to influence policy and practice in health and social care. The Sainsbury Centre was founded in 1985 by the Gatsby Charitable Foundation, one of the Sainsbury Family Charitable Trusts, from which we receive core funding. The Sainsbury Centre is affiliated to the Institute of Psychiatry at King's College, London.

- ❖ Payment by results is widely used in other countries for funding services in acute general hospitals, but in none is it yet applied to mental health care. Relevant work has been done on some of the building blocks, but otherwise there is no relevant experience to build on. The effects are therefore difficult to predict.

- ❖ These considerations do not invalidate the arguments for reform. They support a case for incremental change. For mental health care, there are too many unknowns to justify moving to a full-blown system of payment by results in a single step. Gradual implementation will reduce the risks of change, including possible adverse effects on the quality of care and on financial control. It will also allow time for supporting measures, including the improvement of information systems, the development of quality assurance mechanisms and a strengthening of the commissioning function for mental health services in primary care trusts (PCTs). All of these are needed to maximise the benefits of improved incentives associated with payment by results and to minimise the costs of increased risk.

Not for the first time, the mental health system is being required to implement a major reform designed primarily for other parts of the NHS. This is not to say that payment by results is inappropriate for mental health care, but rather that there remains a wide range of unresolved questions about the design of the system for this sector. The main aim of this policy paper is to highlight and discuss these questions to encourage better understanding and wider debate on a policy whose importance may not yet be fully acknowledged by those involved in mental health care.

What is payment by results?

As a way of remunerating hospitals and other providers, payment by results has three central components:

1. *Activity-based funding*

Activity-based funding means that hospitals and other providers will in future be paid for the volume of work that they undertake. This is in contrast to present arrangements under which services are largely commissioned and purchased through block agreements – a method of paying for health care in which there is no clear link between the actual amount of work done and the income received. The new arrangements will establish a direct connection between activity and funding – more work will generate proportionately more income for the provider, and conversely less work will mean proportionately less income.

2. *Healthcare resource groups (HRGs)*

For payment purposes, the amount of work done by hospitals and other providers will, in the first instance, be measured by the number of patients treated. It is well established that the costs of treatment vary substantially between patients, according to such factors as diagnosis and the associated complexity of care, so allowance will also be made for the type or mix of cases. For instance, bone marrow transplants cost a lot more than varicose vein procedures – indeed, over 100 times more on average. Every general acute hospital admission will therefore be allocated to one of about 500 'healthcare resource groups' or HRGs (more usually referred to as diagnosis-related groups or DRGs in other countries).

In essence, HRGs are groupings of individual cases which are both clinically similar and require similar amounts of resources for their treatment. They are based on internationally recognised categories of diagnosis and also take account of procedures, patient age, complications and co-existing illnesses. Each individual HRG will carry a different price tag.

Diagnosis-based classification systems were first developed in the USA in the 1970s and are now widely used elsewhere. Systems vary in detail between countries, but all seek to provide a

coherent and manageable way of classifying the mix of cases treated within a hospital. Payment by results is therefore sometimes described as a system of casemix funding.

3. ***Payment according to a national tariff***

Commissioners will pay providers a fixed, non-negotiable price for every patient treated. In other words, there will be a standard national tariff, with the price tag for any individual HRG being based on the average cost of treating that type of patient across the NHS.

For commissioners, the use of a national tariff means that they will be able to purchase services from any provider, anywhere in the country, at the same charge, without any need to haggle over price. Contractual negotiations between commissioners and providers will instead focus on access and quality of care and on the quantity of each service to be supplied.

For providers, the national tariff means that there will be no longer be any direct link between income received and costs incurred. Adjustments will be made for unavoidable cost differences between providers, in the form of geographical variations in wages and property prices, but otherwise the price received per case will be the same for every hospital in the country, irrespective of how much it actually costs to treat that case in any individual organisation. Providers whose costs are above the national average will therefore need to improve their efficiency so as to avoid making losses, while those with below-average costs will make financial gains, to be used for such purposes as improving service quality.

As noted above, the national tariff will be based on average costs per HRG across the NHS. Lags in data collection and processing mean that the latest year for which full cost information is available will always be two years behind the year in which the tariff is used. Prices in the tariff will therefore also incorporate assumptions about expected health service pay and price increases, the effects of new technology and increases in efficiency.

These three elements cover the key design features of payment by results, but a wide range of other, more detailed elements of the new funding regime also have to be planned and implemented. Much of this discussion centres on payment by results as it applies to acute hospital inpatients and day cases but, as noted earlier, it is planned that in time the new system will cover all commissioned services in the NHS. Work is therefore in hand to develop activity-related payment mechanisms for other forms of care such as outpatients, accident and emergency, and community health services. Each of these raises its own specific set of problems, as does the design of suitable arrangements for funding very specialised services which do not fit easily into the HRG framework and for covering non-patient-related costs such as teaching and research. Further information on these and other detailed design issues can be found in the documentation on payment by results available on the Department of Health (DH) website at www.dh.gov.uk.

Why is payment by results being introduced?

The Government has put forward a number of arguments in support of the new policy. Box 1 sets these out under two broad headings.

Box 1: Justifications for payment by results in the NHS

That payment by results is desirable in its own right:

- Compared with other funding methods such as block budgets, payment by results gives stronger incentives for providers to increase the level of their activity and to improve the efficiency of their operations.
- Payment by results gives an incentive for commissioners to seek out lower-cost forms of care, as they can retain and re-use the money saved.
- Payment by results is inherently fairer than other methods of remuneration because it rewards providers for the amount of work done and the same price is paid for the same service. It is also more transparent.
- The use of a national tariff reduces transaction costs in the negotiation of contracts and allows commissioners and providers to concentrate on the quantity and quality of care rather than price.
- Payment by results requires providers to improve their information systems, and this will produce wider benefits. For example, information on casemix has a variety of uses in health care management and provides a ready way of linking activity with other aspects of performance such as efficiency, effectiveness, appropriateness and outcomes.

That payment by results supports the wider NHS reform agenda:

- A central objective of the current programme of NHS reform is to develop more personalised and responsive care, particularly through the introduction of explicit patient choice. Payment by results supports this by ensuring that money flows to providers in line with the choices made by patients.
- It is also an objective of policy to promote more responsive, innovative and efficient provision of services by increasing the diversity and plurality of supply. Care for NHS patients will be available from an increasingly wide range of providers in NHS hospitals and foundation trusts and in the independent and voluntary sectors. Payment by results underpins this reform by putting in place both a payment mechanism and a set of prices that will apply uniformly across the full spectrum of supply.
- A related thrust of policy is to devolve more power and responsibility to local organisations, again with the aim of increasing responsiveness and innovation. The bulk of the NHS budget is now held at PCT level and allocations for PCTs are set for three years at a time. Payment by results, based on fixed prices with in-built incentives for efficiency, supports decentralisation by giving local organisations more certainty for planning and more flexibility.

The evidence for payment by results

The international experience with activity-related funding adjusted for casemix goes back to 1983, when diagnosis-related groups (DRGs) were first introduced as the basis for paying for acute inpatient services under Medicare, the centrally financed programme of health care for elderly people in the United States. Since then, an increasing number of other countries have developed their own versions of casemix classification and used them to pay hospitals and other providers. A recent review by the Ministry of Health in Denmark describes the use of casemix funding in 15 countries (Danish Ministry of Health, 1999). Evidence from this international experience can be drawn on to assess the possible impact of payment by results in England and on the whole the conclusions are reasonably encouraging.

First, the international evidence supports the view that activity-related funding tends to promote greater cost efficiency in the provision of acute services. For example, in the USA there have been significant falls in average length of hospital inpatient stays compared with other payment methods and conversely more use of day surgery and outpatient care. Studies in Sweden and in Australia suggest that costs per case are about 10 per cent lower in localities that use casemix payment compared with those that do not (Docteur and Oxley, 2003).

Second, there is also evidence from a number of countries that activity-related funding raises the level of health service activity, sometimes significantly. This is particularly important in the context of government policy for reducing waiting times. A major study by the Organisation for Economic Co-Operation and Development (OECD) has recently found that countries are less likely to have problems with waiting times for elective surgery if they rely mainly on activity-related funding for hospitals rather than block budgets. The difference is statistically significant after allowing for other possible influences on waiting times such as the overall level of spending on health care, hospital capacity and numbers of doctors (Siciliani and Hurst 2003).

And third, there is also evidence, particularly from the USA, that following the introduction of casemix funding hospitals improve their management information systems, particularly medical coding (Coffey,1999). The scope for such improvement in this country is illustrated by the fact that according to the Audit Commission 14 per cent of NHS trusts have 3 per cent or more of their activity uncoded – under payment by results they would not receive any payment for this activity (Audit Commission, 2004b).

Achievement of these benefits cannot necessarily be taken for granted. As noted earlier, the introduction of payment by results will substantially change the pattern of financial incentives and associated risks in the NHS, with a range of possible effects. The overall impact of the reform will depend on how the system is designed so as to minimise the extent of adverse outcomes as well as to promote the positive ones noted above.

The risks of payment by results

The experience of other countries also highlights possible risks associated with casemix funding. The main examples are shown in Box 2.

All of these are genuine risks, but the international experience suggests that the appropriate response is not to abandon or reject payment by results but to build countervailing measures into the system to deal with specific threats. In relation to the risks identified, these measures might include: protocols to regulate admissions and quality of care; the independent audit of coding data; and risk-sharing agreements between purchasers and providers, including limits or ceilings on the level of hospital activity.

Overall, the international evidence supports the view that, carefully designed and monitored, payment by results will be a positive change in the NHS, certainly in the acute hospital sector.

Box 2: The risks of payment by results

❖ ***'Cream skimming'***
Because hospitals are paid the same for every case in a given diagnosis-related group, they may try to avoid having to treat the more severely ill patients, whose costs are likely to be above average, and conversely to seek out easier and cheaper cases.

❖ ***'Quicker and sicker'***
Hospitals may attempt to make financial gains by cutting back on the quality of care, thus pushing their costs below the price obtained for each case; in particular, they may discharge patients inappropriately early.

❖ ***'DRG creep'***
Hospitals may try to manipulate patient coding, so that cases are progressively pushed into higher-priced groups.

❖ ***'Cost spiralling'***
Providers may respond to the incentive to increase activity to such an extent that overall expenditure control is put at risk.

The timetable for implementation

The Government's decision to reform the system of financial flows in the NHS and introduce payment by results was first announced in *Delivering the NHS Plan*, published in April 2002 (DH, 2002a). This has been followed by a number of consultation papers, guidance documents and other publications, all available on the Department of Health website at www.dh.gov.uk.

The introduction of payment by results began on a small scale in 2003/04 and, according to the Department of Health's most recent announcement, the new system "will be fully implemented in 2008" (DH, 2004b). It is intended to cover all services, including mental health care, and all providers, including those in the private and voluntary sectors supplying services to the NHS on contract.

For acute hospital services, two distinct processes of transition are involved. First, there will be a move from block agreements between commissioners and providers to more detailed contracts that specify the number and type of cases to be treated. Second, there will be a shift from locally determined prices to the national tariff.

The second of these is planned to proceed on a slower timescale than the first. This is primarily to minimise the risk of financial instability, particularly among NHS trusts whose costs per HRG are significantly higher than the national average. There will therefore be a transition period during which these providers will be paid above the standard tariff while at the same time being expected to make gradual year-on-year efficiency savings to bring their costs into line with the national average, consistent with full tariff implementation in 2008.

For commissioners the move to the national tariff will happen sooner, taking effect from the start of the 2005/06 financial year. From April 2005 every PCT will pay the same price for every patient of a given type, wherever the treatment takes place. Financial allocations to PCTs will be adjusted so that the effect of the switch on their purchasing power is initially neutral.

The transition period between now and 2008 will also be used to bring services other than acute inpatients and day cases within the scope of payment by results. For example, it is planned to include outpatients, accident and emergency, and critical care from 2005/06 onwards.

As far as mental health is concerned, the Department of Health has recently stated that "we cannot yet indicate with any precision when a national tariff for the commissioning of mental health services will be issued, but are optimistic this may be possible from 2007/08", although it is also noted that "much remains to be done" to achieve this objective (DH, 2004b).

The mental health context

It has been recognised from the outset that payment by results is much less easily applied to mental health than to the acute hospital sector. For example, the Department of Health document *Reforming NHS Financial Flows: Introducing Payment by Results*, published in October 2002, stated: "By 2005-06 the new system is expected to cover most inpatient, daypatient and outpatient activity, including both elective and non-elective services in surgical and medical specialties. We recognise that, in some areas, particularly services for patients with chronic illness and services that have a strong community service component, such as mental health and learning disabilities, suitable measures of service are particularly challenging to develop. A lot of development work is needed on the tools underpinning commissioning in these areas" (DH, 2002b).

Similarly, in *Payment by Results: Preparing for 2005*, a consultation document published in August 2003, the Department said: "We are also considering how to include mental health and community health services in the medium term. At present, costs are collected at a broad level using a number of currencies and classifications. These classifications have been developed from a pragmatic perspective rather than the more detailed statistical and clinical development of HRGs. We have analysed the currently available information and concluded that it is not yet robust enough to use" (DH, 2003). In other words, payment by results cannot be applied to mental health at an early stage because some of the key building blocks are not yet in place. Chief among these is a 'robust' patient classification system.

The lack of building blocks partly reflects the underdeveloped state of wider information systems in the mental health sector. The shortcomings have been forcefully described in a report by the NHS Information Authority on the development of mental health groupings: "Mental health services comprise a large part of the NHS. However, in comparison with other parts of the NHS, it is largely unquantified in terms of activity, resources used, appropriateness and effectiveness. Planners can't plan, commissioners can't commission, providers don't know how much it costs and clinicians can't tell whether their work is effective. There is little information about how services vary

within or between providers across the country" (Carthew *et al.*, 2003). Similarly, in a recent review of progress on improving information systems in the NHS, the Audit Commission has noted that: "In some areas, specifically mental health, there has been less progress than we would have hoped. For largely historical reasons there seem to be particular problems in this sector and there is an urgent need for focused action to improve the reliability of information" (Audit Commission, 2004a).

The weakness of information systems is clearly a major practical constraint, but other, more deep-seated reasons why payment by results is difficult to apply to mental health also need to be considered. These relate to the underlying nature of mental health problems and the associated characteristics of treatment and care. For more information, see Box 3.

Box 3: Difficulties of applying payment by results to mental health care

- ❖ Mental health service users have diverse needs. The course of illness even for the same initial diagnosis is often very variable.
- ❖ Patients frequently have other, co-existing conditions that may complicate treatment and add to costs independently of their mental health diagnosis.
- ❖ Mental health problems are often long-term and episodic or intermittent.
- ❖ Services are frequently supplied by more than one agency, creating complex 'care pathways'.
- ❖ Professionals often make quite different decisions about which treatments or interventions are most effective for which patients.
- ❖ Care is often provided in different settings which may be close substitutes.
- ❖ Informal care is very important. For many service users the costs of support by the statutory services may be determined as much by the availability of family and social support as by the diagnosis and severity of their illness.

These characteristics create a range of problems for the design and operation of any system of payment by results for mental health. In particular, they imply that there is no straightforward link between diagnosis and service use, which obviously hampers the classification of patients into groups that are both clinically similar and require similar amounts of resources for their treatment. They also make it difficult to define an appropriate unit of activity or work done for payment purposes (for example, over what period of time is a "case" defined?). And they require payment by results to be applied over a wide range of providers and services, in the community as well as in hospitals, to avoid perverse incentives for the inefficient use of options that may have higher costs or worse outcomes than the possible alternatives.

It is generally acknowledged that casemix funding works best in areas such as elective surgery, where the characteristics of patients and their care are very different from those just described for mental illness. Thus for patients requiring a form of treatment such as hip replacement, the great bulk of costs are usually incurred in one relatively short episode of care, provided in a single setting; there is relatively little variation in costs between different providers, as the nature of treatment is well established; and there is also relatively little variation in costs between individual patients (and such variation as does exist may largely be explained by readily measurable patient characteristics such as age). Taken together, these features imply that payment by results for elective surgery is not only relatively straightforward to design but also unlikely to carry significant financial or other risks, whether for purchasers, providers or patients. Such an outcome cannot be assumed in the case of mental health. For elective surgery, payment by results is about grouping and pricing a reasonably well-defined set of standardised products; for mental health, it is about designing a system for products or services that are complex, unpredictable in duration and variable in nature both between patients and between providers. Such characteristics are also found to a greater or lesser extent in some other health conditions, particularly those of a chronic or degenerative type, but are particularly pronounced in the case of mental illness.

The international experience in casemix funding for mental health

Attempts have been made in other countries to develop and apply casemix funding for mental health care. We analyse the experience of three countries for this purpose: the United States, Australia and New Zealand. As will be seen, only limited progress has been made in these cases and this is typical of the wider experience. Indeed, as far as we know, no country in the world can claim to have in place a fully operational system of activity-related funding adjusted for casemix in the area of mental health.

The United States

The Medicare scheme finances health care for elderly people in the USA. It is the largest publicly funded health programme in the USA and in many ways acts as a market leader, not just for other public programmes but for the private health insurance industry as well. As noted earlier, a system of payment for acute inpatient services using a DRG-based tariff was introduced by Medicare in 1983 and this form of payment, known in the USA as prospective payment (in contrast to the previous system of retrospective cost reimbursement), rapidly spread to all acute inpatient services, whether funded by other public sector agencies or by private insurance.

Prospective payment for acute inpatient treatment under Medicare has been followed over the years by the introduction of similar arrangements for acute outpatient services, inpatient rehabilitation services, long-term care hospitals and home care services. Psychiatric inpatient facilities have, however, been exempt throughout and continue to be paid on the basis of hospital-specific actual costs, subject to a limit on annual rates of increase. A budgetary measure passed by Congress in 1999 mandated the development of a new prospective payment mechanism for these services, but – as will be explored later – this has still not been introduced and, when it is, it will be relatively modest in scope.

There are two main reasons why psychiatric inpatient services have so far been exempt from prospective payment under Medicare (and elsewhere in the US health system). The first is the lack of a satisfactory method of classifying or grouping cases, whether based on diagnosis or other patient characteristics. As a report for Congress prepared by the Prospective Payment Assessment Commission (PROPAC) in 1992 noted:

"The key component of any prospective payment system is a reliable and useful patient classification system… psychiatric DRGs have not sufficiently explained the cost and utilization variations occurring in inpatient psychiatric care for Medicare beneficiaries. Despite several attempts to classify psychiatric conditions, a meaningful case mix classification system has not been identified. Unless a valid patient classification system is developed, a prospectively-based payment system cannot be successfully implemented for psychiatric facilities" (PROPAC, 1992).

For psychiatric inpatients, diagnosis has thus been found to be a poor predictor of resource use. Depending on the stage and severity of illness and other factors, one patient might require 20 days in hospital while another with the same diagnosis might need a stay of only three days. Paying the same rate for both cases would clearly be inappropriate, with associated risks of under- or over-provision. According to a review published in 1990, "numerous studies have shown that the explanatory power of DRGs and other classification groups is weak, explaining only 5-10 per cent of the variance in the cost of a psychiatric hospitalization" (Taube *et al.*, 1990).

The second reason why prospective payment has not been applied to psychiatric inpatient services under Medicare is a concern that its introduction would lead to systematic financial gains and losses for different groups of providers. Psychiatric inpatient services in the USA are provided by both public and private hospitals, but there is a clear tendency for public hospitals to take on the more severely or chronically ill cases, irrespective of diagnosis. On average, such patients have substantially longer lengths of stay and therefore impose higher costs than inpatients in private hospitals. Paying all providers the same amount per case by diagnostic group would lead to substantial windfall losses among public hospitals and equivalent windfall gains among private hospitals. Such gains and losses would be unrelated to differences in efficiency and therefore of no economic or other benefit.

Notwithstanding these concerns, the continuing use of retrospective cost reimbursement for psychiatric inpatient facilities was seen as increasingly unsatisfactory, leading in time to the 1999 Congressional directive. This mandated the introduction of prospective payment by October 2002, with the key feature that payments adjusted

for casemix should be made not per case but per day. This largely avoids the risks noted above but clearly falls some way short of a fully-fledged system of payment by results. For example, it provides little incentive for hospitals to take on more cases (as they can just as easily increase income by treating existing cases for more days) or to improve efficiency by reducing length of stay. It does, however, put pressure on hospitals whose daily costs are above average to make savings.

Despite the limited nature of the change, the deadline for introducing the new system was not met and it was only in November 2003 that the Centers for Medicare and Medicaid Services (CMS) published details of the proposed arrangements, which still await final approval and implementation (CMS, 2003). As required by statute, the proposal is for per day prospective payment, with various adjustments to the standard daily rate. Box 4 shows the breakdown of these adjustments.

The new payment system will not change the overall budget for psychiatric inpatient services under Medicare which is allocated by Congress. It will lead to some redistribution of the total between providers and between different parts of the country, but the extent of this reallocation is not expected to be large, reflecting the relatively modest nature of the change.

Box 4: Adjustments to the proposed Medicare daily rate for psychiatric inpatient care

- Geographical differences in wages and higher daily rates for rural providers and teaching hospitals
- A 13 per cent increase in the standard daily rate for patients over 65.
- Diagnosis: all patients must be allocated to one of 15 DRGs, with a difference of 39 per cent in the daily rate between the highest- and lowest-priced groups.
- A further set of adjustments for co-morbidities: there are 17 categories of co-morbidity, increasing the daily rate by up to 17 per cent.
- An allowance for the higher costs associated with the first few days of an inpatient stay: the daily rate is increased by 26 per cent for the first day, 12 per cent for days 2-4 and 5 per cent for days 5-8. A discharge and subsequent readmission within five consecutive days is to be treated as a continuation of the original stay and the length of stay adjustments applied accordingly.

Australia

Casemix funding was first used for acute hospital services in Australia in 1993, when a DRG-based system was introduced in the state of Victoria. Similar systems have subsequently been implemented in most other states. As in the USA, mental health was excluded from the coverage of these systems from the outset and this continues to be the case. There has, however, been considerable interest in the development of improved casemix classification for mental health services which might in time underpin new funding arrangements.

The main publicly financed initiative on casemix was the Mental Health Classification and Service Costs (MH-CASC) project, a large study undertaken between 1995 and 1998 as part of the Australian National Mental Health Strategy. This aimed to develop the first version of a national casemix system, with associated cost weights, for mental health services. The study collected detailed clinical, socio-demographic and service utilisation data on 18,000 service users attending specialised mental health services in both hospital and community settings. The sample was large, covering 25 per cent of Australia's mental health services, and service use data were collected by about 4,500 staff who kept daily diaries of all activities over a three-month period. According to the official report describing this project, "the scale and complexity of the study has no international precedent" (Buckingham *et al.*, 1998).

In essence, the study sought to determine whether patient-related clinical factors explained service costs and whether these could be used to develop a system of classification for assigning service users to groups that were both clinically meaningful and similar in resource use. Clinical measures were selected to cover not only diagnosis but also severity of illness, level of functioning, legal status and other attributes.

An important conceptual development in the MH-CASC study was to define an appropriate unit of activity for casemix classification purposes, the key concept being seen as the episode of care. This was defined on the basis of two criteria:

a) Treatment setting: two settings were distinguished (hospital inpatient and community), with care in each being treated as separate episodes. A service user transferring from hospital to the community would therefore be classified as starting a new episode.

b) Duration of care: a distinction was drawn between completed and ongoing episodes. The former were defined as those beginning and ending within eight weeks. A service user receiving care in the same setting for more than eight weeks would then be deemed to have started a new episode.

Episodes of care were thus defined in managerial or administrative rather than clinical terms and did not necessarily coincide with episodes of illness.

On the basis of statistical analysis using these definitions, the study recommended a casemix classification model which distinguished between 42 patient classes, including 23 for hospital inpatient episodes and 19 for community episodes. Diagnosis played a relatively minor role in the model, with more importance attaching to other variables such as age of service user and severity of illness as measured by scores on the Health of the Nation Outcome Scales (HoNOS).

The study also unearthed five other important findings:

1. Evidence was found of statistically significant relationships between levels of service use and the clinical status of patients. However, the overall capacity of the model to explain variations in treatment costs between patients was towards the low end of acceptability (lower, for example, than the explanatory power of DRGs in the acute hospital sector).

2. The explanation of cost variation proved particularly difficult for episodes of care provided in the community. This may reflect the greater complexity of community care compared with hospital inpatient services and also the influence of factors other than patient attributes such as the level of family and social support.

3. The ability of patient characteristics to explain variance in costs was also undermined, in all settings, by the different treatment methods of different providers. Indeed, provider variation emerged as a major explanatory factor for the amount of services received by any particular patient.

4. The system of casemix classification emerging from the project was found to be demanding in terms of data requirements. Some information had to be specially collected for the purposes of the study, implying that the proposed classification could not be routinely administered but would require the development of new systems for collecting and coding information.

5. The findings of the project were based on an analysis of services and costs in specialist mental health facilities, even though it was an objective of the National Mental Health Strategy to replace inpatient services provided in these sites with units located in general hospitals ("mainstreaming"). In June 1998 psychiatric beds in general hospitals accounted for 46 per cent of Australia's total psychiatric inpatient capacity compared with 27 per cent five years earlier (Whiteford *et al*., 2002). The costs of these services and the characteristics of the patients using them were not covered in the MH-CASC study, implying the need for further work if the findings were to be generalised.

A recent assessment of the Australian National Mental Health Strategy published in the British Journal of Psychiatry notes that "very little use" has been made of the MH-CASC classification for funding purposes (Whiteford *et al*., 2002). This partly reflects some of the limitations just described, but it should also be noted that the project was an initiative of the Commonwealth government, whereas the specification of payment systems for individual hospitals and other providers is in practice a responsibility that resides at state level. Individual states have not yet been persuaded that casemix funding is a workable or appropriate method of payment for mental health care.

New Zealand

As in Australia, there has been considerable interest in New Zealand in the development of casemix classification for mental health, culminating in a major publicly funded research project which reported in 2003 on the applicability of the MH-CASC model in the New Zealand context (Gaines *et al*., 2003). While the potential relevance of this work to funding issues was recognised, the main objective was to develop casemix classification as an information tool for other management purposes such as quality assurance and service utilisation reviews, benchmarking and the development of clinical protocols.

In scale and design the New Zealand study was similar in many respects to its Australian counterpart. It was based on a large and representative sample of mental health services, involving eight participating District Health Boards (DHBs) which together accounted for nearly a quarter of all spending on mental health care and which provided a comprehensive range of services. Detailed information on service use, patient characteristics and costs was collected over a six-month period for more than 19,000 episodes of care, of which around 15 per cent were inpatient-based and the remainder in the community. Based on the analysis of this data set, a casemix classification model was developed which distinguished between 42 patient classes, 20 relating to inpatient episodes and 22 to episodes in the community.

The model had many similarities to the Australian version but also some differences; for example, the inclusion of a variable for patient ethnicity was found to improve the overall ability of the model to explain cost variations. Other relevant findings include:

1. As in the Australian study, it proved possible to develop a coherent classification of episodes on the basis of observed associations between patient characteristics and service use, but variation between providers was also an important determinant of costs and such variation appeared to be random.

2. Diagnosis was found to be a poor predictor of costs. Indeed, in the final classification, it played no part at all as a variable for grouping episodes of care among adults. It did, however, feature as a predictive variable in the classification of hospital inpatient episodes among children.

3. It proved more difficult to explain cost variation for episodes of care in the community than for episodes in hospital. Indeed, the model could explain only about 15 per cent of variation in community-treated cases, although it should be noted that the overall extent of cost differences both within and between the various classes of community episodes was relatively small.

4. The project brought to light a number of problems with the availability and quality of data. For example, there were inaccuracies in the assignment of some costs – over 20 per cent of total staff contact time with service users in the community could not be allocated to specific episodes, because of poor record-keeping. On the other hand, it was found that information on all the variables included in the final casemix classification model was already available or capable of being collected at low cost.

It was not an objective of the New Zealand study to develop a funding model. The final report on the project does, however, comment that the results could be used "to inform funding decisions", particularly on the overall level of DHB spending on mental health services. But, as the report also notes, "The Ministry of Health has advised that there are no immediate plans to introduce purchasing on a casemix basis for mental health services" (Gaines *et al.,* 2003). In other words, it is not at this stage intended to move to a system of payment by results along the lines planned for the NHS.

The challenge of designing a system of payment by results for mental health

The introduction of payment by results for mental health care in the NHS will be something of a leap in the dark. There are a number of reasons for this:

- ❖ There is little relevant international experience to build on, in contrast to the position for acute general hospital services.
- ❖ Casemix classification for mental health care is still at a relatively early stage of development, notwithstanding the progress made in Australia and New Zealand (and in one or two other countries, notably the Netherlands).
- ❖ Taking into account the general characteristics of mental illness and its treatment and also the international evidence on provider variation, there remains concern that mental health services are insufficiently structured and uniform to support a system of activity-related funding based on casemix. There may simply be too much variation to capture in a manageable set of prices.

A further consideration is the poor state of information systems for mental health services in this country. Among other things, this makes it very difficult to predict the effects of changing the payment regime. For example, little is known about the extent of variation in costs per case or per episode of care between individual providers, but this is essential for assessing how far payment by results based on a national tariff might result in financial instability, particularly among high-cost providers. In the case of psychiatric inpatient care, the NHS Reference Costs published each year by the Department of Health (DH, 2004a) provide some information on unit costs by hospital, but this is presented in terms of cost per day not cost per case and it is not broken down by diagnostic group or any other patient characteristic. The Reference Costs show wide variations in cost per day between individual mental health providers (even after allowing for geographical differences in input prices), but in the absence of detailed information on casemix, length of stay and other factors, the reasons for these variations remain largely unexplained. In addition, the Audit Commission recently found that as many as 70 per cent of mental health trusts had a level of inaccuracy of 5 per cent or more in their Reference Cost submissions (Audit Commission, 2004b).

A possible conclusion to be drawn from this analysis is that the Government should abandon its ambition to apply payment by results to all services and all providers in the NHS and should instead follow the lead set by Medicare over 20 years ago and grant a long-term exemption for mental health care (and perhaps some other services). There is, however, no reason to suppose that the Government is thinking along these lines. In addition, a wholesale rejection of the system for mental health care would be hard to justify. The broad arguments in favour of payment by results remain strong. We suggest a more realistic and constructive approach, as outlined in Box 5.

Box 5: Recommendations for preparatory measures to introducing payment by results in mental health services

❖ ***Risk assessment***
First, it is clear that payment by results for mental health entails a number of risks as well as potential benefits. The key requirement at this stage is to analyse in more detail the nature of these risks, to assess whether they can be avoided or mitigated by the design of the payment system.

❖ ***Developing a timetable for gradual implementation***
Second, depending on the findings of that risk analysis, a timetable should be developed for a phased introduction of reform and evolutionary change. There is no need for a 'big bang' approach and gradual implementation would provide opportunities to learn from the experiences of other parts of the NHS.

❖ ***Improving systems to aid implementation***
Third, action should be taken to improve wider management and information systems in the mental health sector, so as to support payment by results and improve its chances of success.

Managing risks and rewards

The introduction of payment by results for mental health brings many implications for service users, commissioners and providers. The key risks are listed in Box 6. They provide a checklist for assessing proposed actions.

Some combination of risk and reward is inherent in any system of payment for health services. Payment by results should not be compared with some hypothetical risk-free model but with a real-world alternative, most obviously the present system of predominantly block budgets. This entails a different pattern of

Box 6: The risks of payment by results for mental health

- ***Treatment decisions***
  Will payment by results run the risk of encouraging under- or over-provision of services? Are there likely to be any adverse effects on the quality of care for individual service users, such as inappropriately early discharge from hospital?

- ***Service settings***
  In cases where there is scope for substitution between different service settings (e.g. hospital or community), will the system encourage cost-effective choices? Will there be risks of inefficient substitution, for example if some services are covered by payment by results while others are not?

- ***Patient selection***
  Is there a danger that providers will seek to avoid taking on complex cases, for example because the payment system sets the same price for the treatment of patients with widely varying costs?

- ***Expenditure control***
  What are the likely effects of payment by results on the overall volume of activity? Will the incentive for providers to increase activity, particularly hospital admissions, pose a threat to the management and control of NHS budgets?

- ***Financial stability***
  How will payment by results affect the financial position of individual providers? Are there likely to be large potential gains and losses? Can these be managed by greater efficiency by providers? Even among those providers with relatively low average costs, will payment by results cause financial instability because of variations in cost between individual patients that are not reflected in the pricing system? What will be the impact on providers in the independent and voluntary sectors which supply services to the NHS on contract?

- ***Strategic behaviour***
  Will payment by results encourage or allow providers to earn more income without increasing the quantity or quality of care, for example by manipulating the information used to classify patients?

- ***Operational costs***
  Will the system require new information that is expensive to collect? What risks will be associated with inaccuracies in coding? What will be the overall impact on administrative costs?

- ***Case management***
  Will the system be acceptable to clinicians and other practitioners? Will it be compatible with existing systems of case management, including the care programme approach (CPA)?

- ***Wider policy***
  Is there a risk that payment by results will run counter to any of the wider objectives of mental health policy, as set out in the National Service Framework (DH, 1999) and other central guidance? Will it, for example, discourage continuity of care?

risks from payment by results but also a different pattern of incentives and rewards. The key issue for consideration is whether payment by results for mental health care can be designed so as to yield a net improvement on the present system, in the sense that the overall benefits outweigh the potential costs. Some increase in risk in exchange for stronger incentives to improve services and raise efficiency may well be an acceptable trade-off.

The extent to which the introduction of payment by results increases the overall level of risk in the system is in many respects a matter of choice. In other words, the way the system is designed will depend on how much risk policymakers are prepared to take.

Very strong incentives may be judged to impose an unacceptable cost in terms of additional risk, particularly where this falls predominantly on service users in the form of major potential adverse effects on the quantity or quality of care. It may, therefore, be appropriate to design and implement a system of payment by results for mental health that is based initially on relatively weak incentives, with the possibility of moving to a more high-powered system at a later date. Such a strategy might be particularly sensible given the high level of uncertainty surrounding the possible effects of the new system.

A key determinant of the extent of risk is the way in which cases or episodes of care are classified and grouped together for payment purposes. In general, the more variation in clinical needs and treatment costs between cases within any individual group, the greater the risk. If a hospital is paid the same amount for treating two patients, one of whom requires three days of inpatient care and the other 20 days, there are clearly risks that the hospital may seek to avoid treating the second patient or, if treatment is provided, to save costs by cutting back on the quality of care, for example by inappropriately early discharge.

An important means of developing a low-risk system of payment by results for mental health is therefore to explore methods of classifying cases or episodes of care in ways that minimise the extent of variation within each group. This could be achieved by using a classification that includes a large number of small but relatively homogenous groups. In turn, this might be achieved by basing the initial groupings more on episodes of individual service use than on the episodes of care proposed in the Australian and New Zealand models which bundle together all the services received over a specified period of time in a hospital or community setting. At the limit, unbundling would imply paying providers on a fee-for-service basis, for example per inpatient bed-day, per outpatient consultation, per day centre attendance, and so on. (For hospital inpatient treatment, this corresponds to the method of payment now being introduced for Medicare in the USA.) Compared with a payment system using fewer groupings, this would be relatively low-risk but at the cost of giving rather weak incentives for better performance. Depending on how such a system worked, services could be bundled into larger episodes or packages of care for payment purposes over time.

Striking an efficient balance between risk and incentives depends not only on the overall level of risk in the system but also on how it is distributed and managed. In many cases this will imply sharing risk rather than allocating it all to one party. For example, special arrangements can be made for the treatment of patients whose treatment costs are unusually high or low relative to the average of the group in which they are classified. Such arrangements might include commissioners and providers agreeing to set aside a proportion of budgeted expenditure at the start of the year and using this to pay on an ad hoc basis for cases whose costs exceed or fall short of the national tariff by a specified amount. Risks associated with variability in treatment costs would thus be shared between commissioners and providers instead of being borne solely by the latter. The extent of risk sharing could be modified over time by changing the cut-off points at which such payments are made.

The workings of payment by results will also be determined by the capacity of other management systems to offset some of the potential risks. For example, the danger that payment by results will have adverse effects on the quality of care for some patients can be lessened by making clinical guidelines or protocols that are agreed in advance between commissioners and providers a condition of payment. Similarly, the risk that providers may seek to maximise income by manipulating the classification of patients (so that more cases are pushed into higher-priced groups) can be offset by the regular independent audit of coding data combined with financial penalties or other sanctions against mis-coding.

A plan for action

While there are ways of reducing or offsetting risk, it would nevertheless be unwise to plan for early or rapid implementation of a high-powered system of payment by results for mental health. Too little information and analysis is available to predict the consequences with any confidence. There are clear risks of harming patient care and creating financial instability, and it will inevitably take time to develop and implement countervailing measures. A more cautious, evolutionary approach may be preferable, allowing opportunities for learning from experience and developing support systems.

We suggest seven key areas for further work during a transitional phase:

1. *Developing a system of casemix classification*

The first and most obvious requirement is for the development of a robust system of casemix classification. This is of course well recognised by the Department of Health and work is currently in hand on testing the feasibility of applying the Australian and New Zealand models in the English context.

This is welcome, although it bears repeating that there is no relevant experience or evidence on how these models might perform when used explicitly for funding purposes. It is also worth recalling the scale and duration of the research that went into the development of these models, indicating the complexity of the task. Finally, it needs to be recognised that, whatever system is initially introduced, casemix classifications are unlikely to be stable over time, for example because of changes in clinical practice and in patient characteristics. Any system must therefore be kept under regular review.

2. *Defining units of activity*

Particular attention should be given to exploring alternative definitions of the unit of activity to be used for payment purposes. As noted earlier, the 'episode of care' measure developed in the Australian and New Zealand studies involves considerable bundling of services, with associated risks. Consideration should be given to more disaggregated measures based on episodes of individual service use, not only because such measures are likely to be less risky in the payment context but also because they would be much easier to develop on the basis of currently available information. As suggested earlier, this would not preclude moving towards more aggregated measures based on bundled packages or episodes of care at a later date.

3. *Improving information systems*

The use of activity-related payments adjusted for casemix will require very substantial improvements in the coverage and quality of existing mental health information systems. This particularly applies to information on costs, which at present is both insufficiently detailed and of variable quality.

Much more detailed and more accurate information is needed, both nationally and locally, for devising and operating a tariff-based system of payments without unacceptable risks of financial instability. Such improvements are unlikely to be achieved rapidly. For general acute hospital services, there has been about ten years' experience of estimating costs in ways that will be used in the payment by results system. By comparison, mental health starts from a long way back.

4. *Developing management systems*

Work is also needed to develop and improve other management systems which have a role in supporting payment by results and offsetting potential risks. As noted earlier, particularly important in this context are systems relating to the quality of care, and relevant work might include ways of making the National Service Framework for mental health more prescriptive, in the form of national clinical guidelines or protocols. An obvious way of achieving this would be to extend the coverage of the guidance already produced by the National Institute for Clinical Excellence (NICE). All NICE guidance can be found on their website at www.nice.org.uk.

The use of guidelines and protocols would be helpful not only in ensuring the maintenance of care standards but also in reducing the variation between providers which international evidence has shown to be an important hindrance to the

development of casemix funding. Monitoring the performance of providers against the proposed guidelines or protocols would impose a further requirement for substantial improvements in existing information systems.

5. *Learning from the rest of the NHS*

A phased approach to the introduction of payment by results for mental health provides an opportunity to learn from early experience in other parts of the NHS. The impact of reform on services for other complex or chronic conditions that have some similarities to mental illness, for example stroke, diabetes and degenerative diseases, will be most relevant. Concern has been expressed, for example by the King's Fund, that payment by results may inhibit the good care management of such conditions (Dixon *et al.*, 2004). Monitoring the effects in these areas will therefore be important for mental health, so as to establish whether the predicted adverse consequences materialise and, if so, how they might be avoided or minimised.

6. *Strengthening NHS commissioning*

A major implication of payment by results is that the role of commissioners will become more demanding. In comparison with the present system of block budgeting, commissioners will bear increased financial risks, particularly relating to expenditure control, and will therefore have correspondingly increased responsibilities in such areas as planning, monitoring, demand management, quality regulation and service re-engineering. Indeed, to be fully effective, payment by results requires a substantial shift from passive to active commissioning.

It is, however, very much open to question whether the commissioning function for mental health services in PCTs currently has the capacity for this enhanced role in terms of resources, expertise and technical support. Shortcomings in the commissioning of mental health services by PCTs have been noted in a number of recent reports, including *Money for Mental Health* (SCMH, 2003), and *London's State of Mind* (Levenson *et al.*, 2003). The latter notes, for example, that: "Weak commissioning of mental health services by primary care trusts emerged as a key factor in the slow pace of modernisation of London's mental health services".

7. *Resolving boundary issues*

Finally, there remain some unresolved issues relating to the coverage of payment by results for mental health. All of the preceding discussion has focused on payment methods for the secondary or specialist mental health services commissioned by PCTs from NHS trusts, but services are also provided by PCTs themselves and by local authorities. As noted earlier, to the extent that the various services are interchangeable, a partial coverage of payment by results creates the risk of inappropriate or inefficient substitution. Further work is therefore required to resolve these boundary issues and related matters such as the operation of payment by results in the context of Care Trusts, joint commissioning and the pooling of budgets between PCTs and local authorities.

Conclusions

There are good reasons for supposing that, across the NHS as a whole, payment by results will have positive effects. These reasons include a body of evidence from relevant international experience going back over 20 years.

Payment by results has a number of potential benefits. Most importantly, compared with the present system of mainly block budgeting, it will give better incentives for providers to increase activity and to become more efficient.

On the other hand, payment by results will also create new risks, including possible adverse effects on the quality of care and greater difficulty of financial control. The detailed design of the new system will be crucial in maximising the benefits of improved incentives and minimising the costs of increased risk.

A workable system of payment by results for mental health care will be difficult to develop for a range of reasons. These include the heterogeneity of cases, the long-term and often episodic nature of mental illness, the extent of variation in treatment methods, the complexity of care pathways and the range of settings in which care is provided. These features make it difficult to find manageable ways of classifying or grouping mental health cases for payment purposes.

A further important constraint is the poor quality of existing data on mental health services, particularly relating to activity and costs. The risks of financial instability associated with payment by results are substantially increased if the information on which payments are based is inaccurate or incomplete.

Systems of activity-based funding adjusted for casemix are widely used internationally for acute hospital services, but as far as is known no country in the world yet uses a fully-fledged system of this type for mental health. Relevant work has been done elsewhere on some of the building blocks for such a system, but otherwise there is no international experience to build on. The lack of such experience underlines the complexity of the task being undertaken in this country.

The poor quality and coverage of mental health information systems in the NHS mean that it is difficult to predict with any confidence the effects of introducing payment by results in this sector. It is nevertheless clear on the basis of wider evidence that, depending on how the system is designed, there are definite risks of adverse effects, particularly on the quality of care and financial stability. Various mechanisms can be identified for mitigating these risks, but they will take time to put in place.

The difficulties of applying payment by results to mental health are acknowledged by the Department of Health and reform is being implemented in this area on a slower timescale than in most other parts of the NHS. Specific proposals for change are, however, still awaited, as is a detailed timetable for implementation.

This paper supports the case for a cautious, evolutionary approach. There are too many risks and unknowns to justify moving to a full-blown system of payment by results in a single step. The broad case for reform remains valid, but change should instead be introduced incrementally, accompanied by a programme of work designed to maximise the chances of long-term success. Key issues to address in this programme include:

- ❖ The development of a robust system of casemix classification for mental health, with particular attention to the appropriate unit of activity to be used for payment purposes;
- ❖ Substantial improvements in information systems;
- ❖ The development of quality assurance mechanisms such as clinical guidelines or protocols, to operate alongside payment by results; and
- ❖ A major strengthening of the commissioning function for mental health services in PCTs.

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