

LEARNING POINTS



As mental health trusts across England are gearing up for the introduction of payment by results, a University of York study has highlighted lessons that can be learned from other countries. The university's Maria Goddard (left) and Anne Mason report

THE USE OF casemix-based funding mechanisms in healthcare is increasing internationally. This approach can help improve efficiency and quality of care and support patient choice. However, to date the application of this approach to mental healthcare has been limited and there is no long-term experience to inform policy and practice.

From an economics perspective, there are three areas of central importance to establishing casemix funding:

- The choice of a classification system to define the activity to be funded
- The identification of the resources or costs associated with each activity
- The conversion of costs into an appropriate price.

All of these represent considerable challenges in healthcare generally but arguably are even tougher to address for mental healthcare.

In England, the Department of Health plans to extend the scope of payment by results to mental health. The Care Pathways and Packages Clusters comprise a set of 21 'care clusters' that together form currencies or units for contracting and commissioning mental health services.

Each cluster describes a group of service users who are relatively similar in their care needs and therefore resource requirements. The testing and refinement of the currencies and investigation of their resource implications are under way to inform their future use in commissioning and benchmarking, using local prices agreed between commissioners and providers.

Options for moving to a national tariff have not yet been clarified and our research, which was commissioned by the Department of Health, aimed to examine the feasibility of this

development from an economic perspective, informed by a review of international experience on payment mechanisms for mental healthcare services.

Our study, *Payment by results in mental health: A review of the international literature and an economic assessment of the approach in the English NHS*, has five main recommendations:

1 The new system should be implemented gradually. England is already pursuing a gradual approach to the implementation of PBR in mental health and the Care Pathways and Packages Clusters approach has been developed in an iterative fashion. The currency (clusters) has been developed and refined and costing pilots are under way. The next step is to begin commissioning using local tariffs. If a national PBR tariff is introduced, carefully designed pilot evaluations would be a sensible first step. These could help assess financial risks for providers and potential efficiency savings at the NHS level. The occurrence of any unintended consequences, such as cost-shifting, in other

parts of the healthcare system or non-healthcare sectors should also be monitored.

2 Flexibility must also be built in. If the extension of PBR into mental health is meant to be cost-neutral – which appears to be the stated aim – then flexibility in the methods used to calculate the tariff and in its implementation will be required.

Experience in primary care, where the GP quality and outcomes framework (QOF) resulted in higher-than-expected provider income, may be relevant for mental health. Primary care and mental health specialist care share a similar clinical focus (on chronic conditions with acute exacerbations) and in both the new funding system involves the introduction of new data reporting systems.

Reasons for the large increase in primary care expenditure included a failure to assess baseline activity prior to the introduction of the QOF and the absence of a cap on total provider income. As the intention is to introduce mental health currencies nationally, baseline activity assessments can inform expected income and help set the appropriate level for national tariffs. Furthermore, the Department of Health could build regular reviews of adjustment factors into the tariff methodology to mitigate cost pressures on primary care trusts.

3 We recommend the Department tackle unwarranted financial instability. While one intended consequence of the tariff would be to redirect income to providers that are efficient and high quality at the expense of less efficient providers, some instabilities may be less warranted. Although some of the 'losers' may be able to reduce inefficiencies, adjustments for unavoidable costs at provider level are needed to ensure the payment system is fair and to avoid 'skimping'.



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Phasing in the new system over several years, guaranteeing a minimum percentage income for all providers during the early phase and making appropriate compensation for outlier cases will all help to stabilise provider income. These centrally administered adjustments could be funded by top slicing the total mental healthcare budget.

4 Choose appropriate ‘currencies’. The chronic nature of much mental illness and its unpredictable prognosis means that the choice of payment unit is critical. Our understanding is that, under the Care Pathways and Packages Clusters approach, costs are to be calculated for each cluster episode defined by review dates. If a unique fixed tariff applies to each cluster, regardless of its position in the treatment pathway, this may fail to adjust for the higher initial cost incurred in the admission phase.

For example, cluster 11 (ongoing recurrent psychosis – low symptoms) occurring at the onset of the treatment pathway may be associated with higher costs than the same cluster occurring at the end of the treatment pathway.

If that is the case, then failure to reflect this in the tariff could incentivise inappropriate admission and discharge behaviours.

5 The Department should use the classification system to standardise and improve quality of care. The Care Pathways and Packages Clusters classification system addresses both clinical and non-clinical needs. Care pathways have been mapped, although the degree of clinical consensus for these is unclear. Nonetheless, they offer a starting point from which to develop consensus. The English approach will require a more systematic approach to data collection and reporting. This offers an opportunity to collect additional data on resource use and

EXAMPLES FROM INTERNATIONAL EXPERIENCE*	
Gradual implementation	<ul style="list-style-type: none"> The US, Canada and Netherlands adopted stepwise implementation. Progressive movement of providers from old to new systems reduced the risk of short-term financial instability in these countries.
Flexible approach	<ul style="list-style-type: none"> Budget neutrality was a statutory requirement of the US Medicare psychiatric inpatient payment system. Tariff adjustments were incorporated to allow flexibility. For example, as improved coding of comorbidities was an expected consequence of the new funding system, a ‘behavioural offset’ adjustment (2% reduction to tariff) was made, with the right to change this if budget neutrality was threatened.
Minimise unwarranted destabilisation	<ul style="list-style-type: none"> In the US, 70% of income under old system was guaranteed for all providers during the transition phase.
Choose appropriate payment units	<ul style="list-style-type: none"> The US and Netherlands linked funding to length of stay, rather than using a simple episode-based approach; this is also the intention in Ontario (Canada). The Ontario system separates length of stay into three parts that vary by their resource intensity: admission phase (days 0 to 5), post-admission phase (days 6 to 730) and long-term phase (more than two years). Both the US and Canadian systems adjust payments for interrupted stays. The Dutch DBC system, which applies only to the first year of medical care, separates tariffs for length of stay from those for treatment.
Use classification system to make improvements elsewhere	<ul style="list-style-type: none"> In the Netherlands, the DBCs used for inpatient medical care combine diagnostic and treatment specifications. These payment units are focused and well defined. To complement this approach, care packages (ZZPs) have been developed to address broad patient need, covering psychological problems, functioning, cognitive and social problems. In Ontario (Canada), the focus is on inpatient care only. Like the Dutch system, the Ontario approach specifies both diagnosis and staff input, although interventions are less explicit than the Dutch DBCs. In Australia and NZ, the classification system was used to study variation in costs and provision, although the casemix payment mechanism was not ultimately introduced.
<p>* The most relevant experience for England came from the five countries mentioned here, although our main report also reviews many others.</p>	

process or outcome measures that can help evaluate quality and cost-effectiveness and so inform the debate on what constitutes best clinical practice.

These recommendations derive from consideration of each of the three challenges for establishing activity-based funding in mental health outlined at the start of the article, and informed by our review of international experience.

The approach taken by the Department so far has been cautious and incremental, which is well-advised given the significant issues that mental health presents for the design of an appropriate funding mechanism.

The key challenge is to clarify the central aim of policy in this area. Is it to reward low-cost

providers? To reward high-quality providers? To contain overall costs? To encourage best practice? To shift activity to the community? To align services more closely with societal preferences? The design of the system may need to be tailored differently in order to address these questions. ■

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