DELAYING THE IMPLEMENTATION OF PAYMENT BY RESULTS IN MENTAL HEALTH: THE FAILURE OF THE QUASI-MARKET

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Extended Abstract

Research background: Payment by Results, the English version of Diagnosis Related Groups (DRGs), is a prospective payment system under which different tariffs/prices are set against clinically classified groups in which patients share similar health care needs. It is based upon the assumption that cases for treatment can be classified into a finite number of categories based upon the likely costs of providing for them. First introduced in acute services since 2003/04, PbR was expected to control health care costs, enhance the provider's capacity, and create an incentive for the development of quality through paying providers at a cost-and-volume basis instead of the original block payment method (Department of Health, 2002). An expansion of PbR into mental health was initially planned to come into effect by 2013, but at the time of writing (July 2015), it had yet to become the definitive framework for funding NHS secondary mental health services. Also, the terms "dangerous" and "unintended outcomes" have been employed by key figures to describe the rush to implement PbR in the mental health service (Lintern, 2013). By February 2015, a changing political landscape appeared to have moved this debate even further, with focus shifting from PbR as a core feature of competitive tendering to an emphasis upon a "system-wide approach" (Keohane, 2015).

Purpose: To explore the issues surrounding a long planned expansion of PbR into mental health commissioning in England and identify the factors responsible for the delays.

Methods: This study adopted a three-stage analysis process based on the triangulation concept. Stage 1 theoretically analysed the feasibility of applying market theories to the mental health sphere. Stage 2 conducted 12 semi-structured interviews with actors from different interest groups (commissioners, hospital managers and frontline clinicians) to inform how this policy is being implemented in practice. Stage 3 conducted online surveys to testify the corresponding findings. Results from the empirical data were triangulated with the literature.

Results: The following barriers to implementation were identified: 1) Mismatches between the market theory and public services in the current context; 2) Complex nature of mental disorders; 3) Inaccurate data from (a) the Mental Health Clustering Tool classification system, (b) defining care packages, (c) Lack of nationwide guidance, (d) variations in clinical practice; 4) Unintended consequences: side-effects of targets and 'gaming' behaviors.

Conclusion: Implementing PbR policy in mental health services failed to serve the purpose of controlling cost and improving efficiency given the fundamental problems of the commodification of mental health services together with the corresponding difficulties in defining the mental disorder that the patient is suffering and designing care packages at clinical level. The corresponding recommendations were proposed subject to the improvement of Mental Health Payment by Results.

Keywords: Mental Health and Quasi Market.