

DRAFT

Does the NHS give sufficient priority to Mental Health?

How the funding system penalises Mental Health

1. Definitions of Mental Health Funding

International comparisons are made of the per capita expenditure on Mental Health Care. These comparisons need to be qualified by significant variations in the definition of what is included in Mental Health Care. The following are examples:

- Dementia – in the UK treatment and care of dementia in the NHS is generally included under psychiatry; in many other healthcare systems it falls under neurology and can, therefore, be included within the definition of acute healthcare expenditure. The overall cost of dementia in the UK (including its impact beyond health services) is estimated at being over £17 billion per annum and is estimated to increase by 85% by 2030 based on demographic changes.
- The interface with the Criminal Justice System – in the UK the costs of providing forensic mental health care are included within the definition of overall mental health spend; this varies from country to country. In the United States, the single largest provider of inpatient psychiatric care is the federal penitentiary system rather than the health care system. The magnitude of the impact of this can be very significant in areas where there is high psychiatric morbidity and a high level of offending. For example, in South East London in 2002 it was calculated that 25% of the total expenditure on specialist mental health care (and 5% of the total expenditure on all secondary and tertiary health care) funded 365 patients in high and medium secure hospital beds out of a total population of 750,000.
- The boundary between health and social care funding responsibilities for people with mental illness varies from country to country, such that long term care of inpatients with chronic mental illness can fall largely under social care funding or under health care funding or as a mixture of both.

2. Making comparisons within the NHS – local variation in Mental Health Funding

Comparisons are frequently made within the UK of mental health expenditure as a proportion of total health spend on a given population – most recently through the use of ‘Programme Budgets’. Expenditure on mental illness is usually described as being the largest single component of any such comparison, though this of course disguises the fact that there are many different mental illnesses, whereas expenditure on physical illnesses is generally broken down to describe separately cardiovascular disease, cancer, diabetes etc. There are a number of important qualifications that need to be made to such analyses.

- The first is the history of the distribution of funding on mental health care in relation to populations. When the mental health care system was developed in the UK, it concentrated on the provision of large asylums usually on the periphery of major towns and cities which served segments of population, not always related to their immediate locality. In the 1970s and 80s, this system was gradually dismantled and a community based model of care established but the direction of resources was largely determined by where patients from the asylums moved to in the new community based services, resulting in an unevenness of coverage. By contrast, at the same time, the distribution of acute hospital beds was subject to a centrally planned analysis of ‘bed norms’ which ensured a relatively even distribution across the range of clinical specialities in relation to the populations they served. Thus by the 1990s there was quite significant variation in mental health expenditure from population to population (and variation in the distribution of the populations who had moved from the large asylums and who required ongoing care in community settings) but relatively even distribution of resources across most acute physical health care provision.
- To an extent this reflected real variations in the pattern of morbidity. There are parts of inner cities which have six times the national average incidence of schizophrenia, a degree of variation which is seen in very few physical illnesses with the possible exception of infectious diseases, sexually transmitted diseases and HIV and AIDS. The big difference is that schizophrenia constitutes between 60 to 80% of the total costs of care within secondary mental health services and as such is a far more significant component of the total than any physical illness.
- Just as the boundary between health and social care funding varies internationally, so there are local differences between the extent to

which mental health services are supported by NHS funding and local authority funding. This is particularly true in relation to the development of the local voluntary sector which can play a significant role in supporting people receiving treatment in the community and thus on the options available as an alternative to hospitalisation. Charting this pattern of funding is notoriously difficult but its impact is nevertheless obvious, particularly where mental health providers span a number of different local authority areas.

- The impact of non 'health' factors in driving the consumption of resources devoted to mental health care has already been noted in international comparisons and these factors are highly susceptible to local variation. The most obvious is rates of offending which tend to be much higher in urban areas, and where a 'broad' view of mental health care is taken (as in the UK) which encompasses the treatment of mentally disordered offenders, these can become a significant distorting factor which is outside the direct control of both health care commissioners and providers. No such similar factor exists in relation to physical health care and offending is only one of a number which have an impact on mental health care (others might include, for example, homelessness, and refugee or asylum seeking status).

3. How the mental health funding system has worked and how it has come to differ from the system for funding physical health care

Prior to 1990 when the 'purchaser/provider split' was introduced, funding for mental and physical health services was directed through local health authorities using a population based funding formulae and then allocated to individual service provider organisations on the basis of historic funding arrangements amended on an incremental basis taking account of service developments and cost pressures. As a general rule, mental health services were separately organised, though in some instances they were sub-divisions of hospitals providing physical health care. As indicated above, the historic pattern of expenditure was largely shaped by the way in which the Victorian asylums had been transformed into community based services.

With the advent of the purchase provider split, the vast majority of mental health providers retained a 'block' contract arrangement whereby they received a fixed sum of funding to provide a mental health service for a given population based on the historic level of spending which was reviewed annually against expectations of efficiency improvement, inflationary uplift and service developments and reductions. Physical health care provision, principally in hospitals, moved gradually to a 'cost and volume' contract system whereby a relationship was established between the numbers of patients treated and the funding received.

Originally this was not subject to any national direction and a variety of local currencies and tariffs flourished.

The other key difference which emerged between physical and mental health care service funding was the introduction of risk management arrangements. The block contract system funded a given capacity of mental health service to meet the demands of the particular population. If the demand exceeded that capacity, e.g. in the requirement for inpatient beds, then additional provision had to be made available. In some instances, the costs of this were picked up by commissioners who generally bought additional bed capacity purchased at a fixed price for a daily rate from independent sector providers who expanded rapidly to meet the demand. This was particularly noticeable as the demand for additional medium secure inpatient accommodation grew very swiftly following the publication of the Reed Report in 1992 which confirmed the policy of care for mentally disordered offenders being provided by the NHS rather than the Criminal Justice System and resulted in a significant and sustained transfer of work from prison to secure hospitals.

In some cases, the risks associated with meeting this additional demand was transferred to mental health service providers, initially for local psychiatric services but over the course of the last ten years, increasingly including the costs of secure psychiatric provision. The rationale for this was that service providers were in a better position to manage individual patients progress down a clinical pathway than commissioners who lacked the specialist clinical expertise or authority to make such decisions. The providers were, therefore, in a better position to get value out of the expenditure entailed.

This created a clear incentive for providers to manage demand within the overall envelope of resources available and so to minimise the extent to which the more costly forms of inpatient care were required and to transfer patients back to primary care at the earliest opportunity. By contrast, the system for acute physical health care, particularly following the introduction of a national tariff based system over the last decade, created incentives for providers to maximise the consumption of health care interventions. This is not surprising as the acute PbR model was based largely on experience in elective surgery, where the aim was to increase the number of operations undertaken in order to reduce waiting lists. When applied to the treatment of long term physical health conditions, where the aim is generally to maximise patients' ability to flourish outside of hospital, the incentive is paradoxically to increase the number of treatments and admissions.

Nevertheless over the same period, which was generally one of growth, there was an increase in the range and scope of service capacity available for mental

health care. This tended to be through specific tranches of block funding for the development of particular additional capacity, for example, the development of home treatment teams, assertive outreach teams and early intervention in psychosis teams in the light of the National Service Framework for Mental Health, the development of IAPT services and most recently the development of memory clinics following the National Dementia Strategy. In some cases the original funding plans for funding these developments were reduced and much of the additional capacity was resourced by savings elsewhere in the mental health system, so for example, home treatment teams were often funded, at least in part, by the reductions in acute inpatient bed capacity that they facilitated.

Over the last three or four years, as a more explicitly market orientated approach has been adopted, the approach to funding has turned against this model of service and capacity development, but at the same time there has not been in place an adequate national mechanism for responding to changes in demand for services using the volume based method of acute PbR. Where it has taken place (for example, where additional medium secure provision has been required) it has generally been within the context of the old risk management arrangements.

It is true that more recently steps have been taken to reduce the scope for acute physical health care providers to grow their income without restraint by generating additional activity, most notably through the imposition of an historic cap on emergency admissions with penalties where that base line is exceeded, and through the introduction of deflation to national tariffs and best practice tariffs. Nevertheless there is still not the expectation that providers of physical health care services will manage the demand from a given population within a fixed resource envelope.

4. How have mental health services achieved efficiency improvements and cost reduction?

Within this overall funding system, providers of mental health services have had generally fewer opportunities to achieve efficiency gains by doing more work with the same resources as their contractual arrangements gain them no credit for the additional work whilst they do require a cash releasing efficiency saving on their overall budget. The focus has, therefore, been on improving value by more effective treatment models, better management of demand and in particular, releasing costs from those parts of the system which were funded on a basis which incentivised consumption, especially independent sector inpatient care, which is generally funded on a cost per bed day. The following are examples:-

- Reduction in acute inpatient beds through reduced average length of stay and the substitution of home treatment (in some cases for up to a third of all admissions).
- Better management of clinical pathways, particularly for secure, rehabilitation and mental health in learning disability care, where high cost patients in long term placements were more regularly reviewed and steps taken to support their recovery so that they might move to less intensive (and usually less coercive) treatment and care environments at the earliest opportunity. In order to achieve this control over the 'recovery' process, there has in some cases been an expansion of inpatient provision operated by those providers who bear the risk of managing demand at the expense of those who are funded on a cost per bed day basis.
- Sub-contracting of 'manualised' care for less complex cases to lower cost, often third sector, providers (this is most striking in the addictions field).
- Consolidation of inpatient sites. Interestingly it has proved much easier to reduce the number of hospital sites used to provide mental health inpatient services and so to achieve significant reductions in overhead costs than has been the case for physical health care where any such moves are usually accompanied by considerable political protests. In the case of my own organisation, we have over the course of the last five years, reduced from seven main inpatient sites to four. Ironically the most significant public protest has been in response to proposals to open a new inpatient unit on one of the four remaining sites!

5. What will be the effect of Payment by Results in mental health?

Whilst rather confusingly it shares the same name, Payment by Results in mental health which will start to operate next year, is fundamentally different in concept from acute PbR. There are a number of reasons for this. The first is that it is clear that the general policy direction for mental health care over the course of the last twenty years, has been away from hospitalisation as the norm and towards supporting people in their own homes with the maximum amount of independence. Any system which, therefore, created an incentive towards the consumption of particularly the most expensive health care interventions would over turn that direction, and would be particularly problematic where coercion exists as a significant feature of much inpatient care. Much of the discussion around the development of the model for mental health PbR took place against the background of the protracted debate about new mental health legislation in England.

Mental health PbR is, therefore, based on a relatively small number of 'clusters' which group together patients with a similar profile of needs and which then identifies, on a local basis, using a common 'currency', the costs associated with

providing their care and treatment over a period of time. Rather than rewarding the provider for each intervention made, the provider bears the risk of managing treatment to best effect within the funding agreed and the commissioner bears the risk of demand based on the numbers of people referred to mental health care or discharged from it.

The cost for each of these clusters is not fixed nationally (at least in the first instance) because it is accepted that there is a likely to be a wide variation in the detailed content of treatment packages available for each cluster nationally, and because all international efforts to introduce a standardised tariff based system for mental health care have foundered. There is also the small matter that when acute PbR was introduced, £700m was made available at a national level to providers and commissioners to manage the period of transition towards a standard national tariff and no such smoothing mechanism exists for the introduction of any other form of PbR.

This model is more appropriate for the management of any form of long term condition than one based on an elective surgical model, and it is possible that some of its principles may be incorporated into aspects of Payment by Results for physical illness, but until that occurs the different systems will continue to have an impact on the levels of expenditure.

Another key question is whether need for treatment for mental illness will be appropriately recognised and referred by commissioners under the new system. At the moment many mental health services offer a variety of routes in, including self-referral, referral by social workers and other professionals (often including teachers in the case of children and young people) in addition to the normal route via GPs. Those arrangements have proved manageable in a system where funding is not tied to individual cases but is more related to the overall capacity of the system but under PbR it is likely that tighter controls will be necessary by those who have the accountability for budgets under the new GP commissioning arrangements.

Experience so far is that those GPs with more mental health expertise and capacity to provide care and treatment for mental illness in their practices tend to refer more to specialist mental health services than those who have less capacity or interest in the field.

6. The funding of mental health care in general practice

So far much of this discussion has been about the funding of specialist mental health services, be they provided by NHS Trusts, the independent or voluntary sector, but it is important to remember that only a small proportion of the totality of mental illness ever finds its way to more specialist care and the majority is

dealt with in general practice. There is no specific or distinctive funding arrangement for mental health care in general practice and so it is much harder to distinguish any differences between how in practice funds are used to treat mental viz a viz physical illness. There are aspects of mental health care that are covered by the Quality and Outcomes Framework, though in both mental and physical health care, its coverage is not and is not intended to be comprehensive but rather focuses on a number of specific priorities.

There is considerable ambiguity in the core contract for general practice as to what is the requirement for treatment of mental illness in primary care and there is significant scope for discretion by individual practitioners over what care they may provide as standard and what should be construed as an 'extra' and, therefore, funded over and above the care. It is arguable that this discretion is greater in the case of mental illnesses than for physical illnesses as a general rule. For example, some GPs will willingly prescribe anti-dementia drugs in primary care and regard it as a routine part of their normal responsibilities whilst others will not and may require them to be administered by specialist mental health services. Some GPs will consider it an integral part of their core responsibilities to deliver depot injections to patients on anti-psychotic medication whereas others will regard it as an additional responsibility for which extra training and funding is required. There is less standardisation of expectation and no ready fix on the consistency of practice or expertise.

By the same token there are some significant barriers which may make it more difficult for GPs to support people with mental illness in primary care, for example, in many cases the eligibility criteria for social care will require that individual patients are in receipt of specialist secondary mental health services when access to social care interventions may be the very thing that might enable them to avoid using specialist mental health services.

7. What are the results of this system in practice?

Example 1 – Financial investment in London

The London Mental Health Trusts examined the PCT expenditure profiles for acute, general services and mental illness services for the period 2008/09 to 2009/10. This drew on data sourced from the full accounts of PCTs, though NHS London does not agree with our analysis of the figures.

The conclusions of this analysis are that for the period between the financial years 2008 – 2009 to 2009 – 2010 (which was overall a period of substantial growth in NHS spending):

- There was a real terms disinvestment in mental health spend by 27% of PCTs in London.

- Overall mental health services received an average increase in expenditure of only 3%. This was during the period when IAPT was being rolled out which is likely to account for most if not all of this increase.
- During the same period in terms of total PCT expenditure, on average acute health services increased by 23%.

Example 2 – Decisions about commissioning priorities

There are a number of examples recently where PCTs determining commissioning priorities will use bench mark data about the percentage spend on mental health ('The Programme Budget' approach) without taking into account the extent of variations in morbidity which are well established in major mental illnesses, and sometimes without taking into account adjustment factors which are routinely used when determining physical health care spend (for example, the Market Forces adjustment Factor). More fundamentally these exercises neglect the question as to whether the average level of spend on mental health care is anything like appropriate in the first place, relative to expenditure on other diseases, let alone whether such expenditure is likely to result in relatively greater or lesser benefit to patients. This normative approach based on the historic distribution of resources superimposed on a payment system which is allowed to drive consumption in physical health care whilst restricting it in mental health care, will inevitably result in a sustained downward pressure on mental health expenditure irrespective of the needs of the population served or their potential to benefit from treatment.

8. An alternative approach

In order to achieve a more balanced approach to the funding of mental and physical health care, I propose bringing into combination two considerations.

The first is to examine the extent to which the need, by disorder in a population is met by the opportunity for treatment. For example, we know that in western developed health care systems, approximately 85% of the population with type 2 diabetes have access to treatment. Similarly, we know that on average only 25% of the population with mental illnesses, get access to treatment, though there is considerable variation between the different mental illnesses covered by that unhelpful umbrella term. We should break down the generic heading of mental illness into its individual component disorders and set out the extent to which people are able to obtain treatment, across the full range of mental and physical health care.

This should then be set against the potential to benefit from intervention in relation to the disorder. This is not always a linear relationship. For example, we know that for lung cancer, despite intensive efforts, the prognosis remains very little better today than it was thirty years ago, though there are considerable

benefits for patients from palliative and end of life care. We should, therefore, focus our investment in those areas where people stand most benefit until such time as new and more effective treatments come along which is to say in the case of lung cancer, on good palliative and end of life care rather than on ineffective treatment. Similarly we should look at the potential people have to benefit from treatment for mental illness and if there is a significant opportunity for benefit and a large gap between need and its fulfilment, there is a clear case for increasing expenditure by contrast with those areas where there is a small gap between need and its fulfilment but very little real scope for benefit. It should be noted that assessment of the value of benefit from intervention and treatment should extend beyond the realm of health care, e.g. it should encompass the reduction of re-offending or improvement in educational attainment from physical as much as mental health care interventions.

If the assessment of resource allocation to particular disorders was based on such an approach, rather than one rooted in history and skewed by differential incentive structures which inherently disadvantage those parts of health care which are more susceptible to variability, which start from an historically low base which have complex definitions and which have significant benefits outside health care, then we would stand a better chance of getting the most from the limited resources available to us and finally put the funding of mental and physical health care on an equivalent footing.

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