Mental Health Research Review 2, February 1995

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We welcome comments about the content of the Review and would appreciate notification of problems with the electronic version.

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Established in 1974 at the University of Kent at Canterbury, the Personal Social Services Research Unit is now the largest social care research unit in the UK, with some 40 staff members. Its work is funded by the Department of Health, and other government departments, the Economic and Social Research Council, charitable trusts and international social welfare organisations.

PSSRU research focuses on needs, resources and outcomes in social care and mental health care: its concerns are resourcing, equity and efficiency from the perspective of users, agencies and others. A distinctive analytical framework called the ‘production of welfare approach’ has been developed by the Unit to illuminate such research. The PSSRU applies the approach in studies of a wide range of areas. Most of its work has been on what is loosely described as ‘community care’, but it has also worked on other areas such as in-patient health care, housing, income maintenance, criminal justice services, and the voluntary sector.

The PSSRU Bulletin is available free from Maureen Weir (01227 827555) at the Unit, who will also be glad to send lists of PSSRU books, monographs and discussion papers.

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The Centre for the Economics of Mental Health was established at the Institute of Psychiatry in November 1993 with initial funding from the Bethlem and Maudsley Research Trust. Its research and other activities are supported by the Medical Research Council, Department of Health and other funders.

The Centre promotes, conducts and disseminates health economics research in the field of mental health, broadly defined. With its central focus on mental health economics, staff at the Centre are very well-placed to make disciplinary contributions as well as applying the economist’s evaluative techniques to the topic of mental health.

The current range of topics researched at the Centre include drug therapies and compliance, child and adolescent psychiatry, old age psychiatry, psychotherapy, care management and residential care.

For a full list of Working Papers, please contact Sandra Semple at the Centre.

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‘Madmen in Authority’ and ‘Academic Scribblers’
Martin Knapp

Irreverent or irrelevant?

‘This dismal science’ — economics, as Thomas Carlyle saw it — is behind much of the research reported in this Review, and it may be appropriate to begin with a discussion of some unflattering views of the discipline.

One of my favourite quotes comes from Ronald Reagan — whose recent ‘outing’ of his Alzheimer’s disease is a welcome sign of a greater willingness on the part of major public figures not to distance themselves from mental health problems — an economist sees something working in practice and then asks if it will work in theory.

Neither of these remarks about economics is entirely irrelevant. Economics can appear dismal if it is driven only by a seeming desire to cut costs. But economic evaluations or other studies are rarely so restricted or so dull, and no self-respecting economist would advocate cutting the costs of mental health or other services without looking to see what the effects would be for user or patient health and quality of life.

Reagan’s definition is interesting as well as a little unkind. We must not gloss over the complexities of ‘practice’, but sound theoretical principles are essential. To decide policy or to intervene in practice without them would be folly. Each of the articles in this second issue of the Mental Health Research Review describes research which is either addressing the theoretical basis for evaluating mental health provision or policy, or is reporting empirical findings of research conducted on such a basis. The theoretical baseline is not just taken from economics. Indeed, it should be clear from reading these articles that research conducted at the PSSRU and CEMH draws on theories and empirical methods developed in a range of disciplines. Almost every study cited here is conducted in collaboration with individuals and teams whose intellectual roots are in other social or health sciences.

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The Mental Health Research Review No. 2

This second issue of the Mental Health Research Review is jointly published by the Personal Social Services Research Unit (PSSRU), University of Kent and the Centre for the Economics of Mental Health (CEMH), Institute of Psychiatry. It describes research in the mental health field currently underway at one or both sites. The aim is to present research objectives, methods and findings in a concise and readable form. The Review also serves as a reference point for the concepts and tools which are frequently employed in PSSRU and CEMH studies of the economics of mental health.

The Review is sent free of charge to local authorities and health authorities and to interested individuals in the UK. Further copies can be ordered from Sandra Semple at the CEMH (0171 919 3198) or Maureen Weir (01227 827555) at the PSSRU. CEMH Working Papers and PSSRU Discussion Papers cited in this Review can be purchased at a cost of £5 (post paid) from the appropriate centre or unit.

Enquiries about individual articles should be made to the authors concerned. General comments on this issue of the Review can be addressed to the co-editors: Daniel Chisholm at the CEMH and Alan Stewart at the PSSRU. Enquiries about PSSRU and CEMH research programmes in mental health should be addressed to Professor Martin Knapp at either address. The views expressed are not necessarily shared by bodies funding the research.
Developments and initiatives

The twelve months since publication of the first Mental Health Research Review have seen a number of changes. Many new research projects have started. Several people writing in this Review hold appointments which straddle the PSSRU in Canterbury and the CEMH in Denmark Hill. Everyone has participated enthusiastically in joint seminar and workshop programmes, and in the exchange of ideas, data, experiences and frustrations.

Our base at the Institute of Psychiatry gives us the opportunity to collaborate with experts in psychiatry, psychology and associated disciplines. At the University of Kent, we have access to social policy and other academics, both in the PSSRU and elsewhere. In the most recent auditing of British universities’ research standards, the Institute (as a single unit of assessment) and Kent’s social policy group both gained the highest rating.

In May and June we are holding one-day introductory courses on the economics of mental health (see page 20 for details). We intend to follow these with courses in specialist areas: for example, in relation to child psychiatry, the care of elderly people and community re-provision. I would be delighted to hear from people interested in these courses, or from anyone wanting to propose other special topics.

Another significant development for us in 1995 will be the publication of a new book, The Economic Evaluation of Mental Health Care. The twelve chapters, all but one written by PSSRU researchers, introduce the principles and methods of economic evaluation, and illustrate their application in a number of areas. Much of the empirical material in the book has not been published before, and the principles and methods have been carefully tailored to meet the needs of mental health decision makers.

Those ‘madmen’ and ‘scribblers’

There have been relatively few good economic studies of mental health care in Britain. Recently, many new studies have been commissioned, quite a few of them from PSSRU and CEMH. The result is that policy and practice initiatives of the future will be more likely to be able to call on reliable economic evidence to inform key decisions. Arguments and actions should be informed by all the available evidence; and this evidence should include economic evaluations.

Will economic evidence be available in sufficient quantity and quality, and will it be used responsibly by those whose decisions affect the lives of millions of people with mental health problems? Let me fall back on another quote, from Britain’s greatest economist, John Maynard Keynes. The language of the 1930s may be gender-specific and politically incorrect, but these words from the final paragraph of Keynes’ General Theory of Employment, Interest and Money vividly portray the opportunities and dangers often associated with economics:

The ideas of economists and political philosophers, both when they are right and when they are wrong, are more powerful than is commonly understood. Indeed the world is ruled by little else. Practical men, who believe themselves to be quite exempt from any intellectual influences, are usually the slaves of some defunct economist. Madmen in authority, who hear voices in the air, are distilling their frenzy from some academic scribbler of a few years back.

Whatever the influence of the ‘academic scribbling’ in this Review on those in authority, or on others, I am certain it will be both interesting and helpful.
The reforms introduced by the 1990 National Health Service and Community Care Act are bringing about the most far-reaching changes to the provision and funding of health and social care in the UK for 50 years (Box 1). For the foreseeable future, however, health and social care remain dominated by public funding and public provision.

Box 1
Changes prompted by the 1990 Act
- Market forces and decentralised purchasing are receiving an enormous boost
- Responsibilities are being shifted between public sector agencies
- Non-public bodies are increasingly active
- Public sector primary care physicians can control their own budgets
- Secondary care provision has been partly moved into a quasi-market
- Cross-service coordination of care is emphasised
- Users and family carers are more likely to be involved in decision making

What are effects of these reforms on mental health services? Have the 1990 reforms brought about the improvements in consumer choice, systems efficiency and service development and innovation which the government hoped? We recently completed a paper that discusses the fundamental sources of difficulty that characterised the pre-reform health and social care systems, the changes brought about by the reforms and the issues that may continue to dog the development of good mental health provision in the UK (Kavanagh and Knapp, 1995). Here we summarise some of the arguments.

Structural challenges

The pre-reform care systems harboured a number of widely-recognised inadequacies. (These are discussed in relation to people with schizophrenia in Kavanagh et al., 1995.) The balance of care, treatment and support for people with serious mental health problems was characterised by a multiplicity of organisations providing inputs into a number of (often incorrectly defined) activities that failed to coincide with any particular organisation. Thus a vulnerable group of people with little sovereignty as ‘consumers’ frequently confronted complex service boundaries and gaps.

Resources were targeted at care facilities rather than individuals. Although most mentally ill people do not need to be resident in hospital the majority of funding and provision was concentrated there. Progress in the development of community mental health care was slow, leaving the balance of care more expensive and less effective than was necessary. Despite the focus on deinstitutionalisation most of the difficulties facing care planners did not come from former long-stay patients discharged into the community but from those who, in previous years, would have been admitted to long-stay hospital care. Many such people were either not
Then, as now, the majority of people with mental illness received treatment from primary care services and a significant minority of people with 'serious' mental illnesses — such as schizophrenia — received their care solely from GPs. Furthermore, while GPs tended to refer people with serious mental health problems to specialist services, these people remained in contact with their GP, perhaps still imposing heavy demands. Policy attention may have been diverted from primary care because, despite its importance, it accounted for a relatively small proportion of the cost of mental health care.

The was a general lack of coordination between health, social services and housing agencies; and between the public, private and voluntary sectors. Too often, people with serious mental health problems seemed to be 'falling through the net'. Another failing was the limited involvement of users and carers, who had relatively little influence or choice. The old arrangements were therefore argued to be inefficient, inequitable and in need of reform.

Reforms and reversals

There are good reasons for believing that the 1990 reforms will reap benefits for mental health care systems, services and users. There are also likely to be drawbacks and continued failings. For example, spending more on the support of people with mental health problems should bring benefits, but it is equally important to develop the broader policy and systems contexts so that those resources are used appropriately. This involves creating the correct resource environment of structures and incentives so that people can access coordinated, timely, high-quality services.

What, then, were the underlying weaknesses in the pre-reform structures, and how successfully has the new system overcome them? We can distinguish perhaps five interconnected groups of weaknesses: information inadequacies, production relations, boundary disputes, perverse incentives and inequitable allocations.

1. Information difficulties. Information has been a long-standing concern — there is not enough of it, and what there is, is not much used. In particular, data on needs and outcomes are rarely available, and cost information is patchy. The 1990 Act addresses some of these problems, in both health and social care, but raises its own difficulties. For example, contracts between purchasers and providers open the possibility of better specification of user characteristics, quality of care and outcomes, but if block contracts are relied on — which is still generally the case in mental health — there are not the same incentives to improve data holdings. And, in general, mental health needs and outcomes remain poorly specified.

2. Production relations. The links between resources, needs and outcomes — the production relations — are rarely fully identified, and the cost implications of user-level and system-level decisions are rarely teased out. The greater the information deficiencies and the less that is known about production relations, the greater the reliance that must be placed on professionals acting as agents for users, providing advice and guiding choices. The pre-reform systems were argued to permit the development of too much professional power, with users disenfranchised.

The reforms are shifting the balance away from supply-led decisions towards needs-led and user-influenced decisions, but people with mental health problems
are still not often given the opportunity to see their preferences making a difference. The undesirable consequences of professional power — particularly negligence (failure to give proper attention to a case) and skimping (deliberate under-treatment to save time or expense) — could still arise, with few safeguards in the new arrangements to enfranchise the user. Moreover, the new systems may have replaced professional power with manager power and bureaucracy.

3. Boundary disputes. Most people with serious mental health problems need support from a number of public and other agencies. One of the failings of pre-reform health and social care was the difficulty faced by many of these people in accessing services across the agency boundaries, and also boundaries within agencies such as the NHS. Roles and responsibilities are now being clarified, but boundary disputes remain.

For example, there is still enormous tension in some localities between the NHS and social services departments, and the ‘purchasing buck’ is still being passed back and forth, with community care and other budgets running out of money before the year’s end. The coordination of primary and secondary health care should be improved by GP fundholding, which has provided an increased incentive to improve the quality of primary care services in order to avoid expenditure on secondary care services. Sectorisation should also help to integrate primary and secondary care. However, GP fundholding may perpetuate the hospital/community boundary because fundholders are not responsible for the costs of inpatient care and has introduced a new boundary due to the often incompatible purchasing strategies pursued by fundholders and health authorities.

4. Perverse incentives. Boundaries create incentives to agencies to seek to shift funding or other responsibilities onto others. These incentives become ‘perverse’ if they result in costs or outcomes for the system as a whole which are worse than would result from mutual and informed multi-agency collaboration. Hospitals which cut lengths of stay save themselves money only at the expense of community care budgets, and users may be discharged so early that their health and social care needs in the community require much greater intervention. Or, under the pre-reform arrangements, community health and primary care providers might have referred people too readily for secondary care. The private and voluntary residential care and nursing home sectors expanded rapidly on the strength of the open-ended availability of social security funding. There were many other perverse incentives, some vividly illustrated by the Audit Commission (1986).

The 1990 Act sought to address these incentives at the macro level (introducing multi-agency needs-based planning, the purchaser/provider split, collaborative commissioning and so on) and at the micro level (for example, through care management and the care programme approach). But some difficulties persist. We have already commented on the health/social care boundary and its continued capacity for ‘buck-passing’. There are also perversities introduced by GP fundholding, some related to their own funding (‘referral inflation’ in the year prior to entering the scheme, because secondary care budgets were based on historical referral patterns), some to the risks of ‘cream-skimming’ (choosing not to accept patients who are intensive service users onto lists, or not to keep them), and some to the spectre of ‘cost-shifting’ (since GPFHs only pay for a selection of the services used by their patients).

5. Inequitable allocations. The other area of difficulty is more deep-seated and certainly pervasive. There have always been inequities — injustices — in Britain’s health and social care systems. Has the 1990 Act righted them? The NHS may offer universal coverage, but rationing of available resources is by no means equitable. The allocation formulae for funding regional health authorities and
local authorities have been criticised, the former most recently for denuding inner city areas of inpatient and other resources.

At a local level the distribution of both health and social care resources often relied on a combination of historical provision, the political power of care professionals and practice variations.

The reforms did little to address the inequities of the pre-reform systems of care directly. Nevertheless, the process of change has illustrated certain inequities, for example the use of historical referral patterns to determine the size of GP fundholders’ secondary care budgets highlighted the widespread variations in referral and treatment patterns. It remains to be seen whether moving the purchasing of care closer to patients will improve the targeting of resources or lead to a lack of strategic purchasing. The increased role for social services departments and their ability to levy user charges may cause underutilisation by lower income groups.

Gloom or boom?

Does the 1990 Act and its associated policy guidance (such as the Health of the Nation strategy) herald a bright future for mental health care? Or are these various and persistent difficulties a cause for gloom?

There is no doubt that media criticism of community mental health care is building up a head of steam, with debate focusing on the ‘politics of the latest incident’. There can also be little doubt that mental health services are under-provided in some localities — acute inpatient beds in London are a prime example — and that the local authority housing and social services inputs to community care are still too few and too uneven in coverage.

On the other hand, the full impacts of the 1990 Act are yet to work their way through, and there is no doubt that some of today’s tensions, for example, between health and social care purchasers, or between primary and secondary care are the result of these various groups trying to secure better joint working arrangements or the better targeting of resources on needs. Over the next few years PSSRU and CEMH research programmes will be addressing these issues.

References


PSSRU and CEMH policy on Discussion Papers and Working Papers

We aim to disseminate our findings as widely as possible, but both PSSRU and CEMH have to charge for papers. Therefore, if a paper is also published as a journal article, we advise interested readers to obtain that publication. Other papers are available from Lesley Banks (PSSRU, 01227 827773) and Sandra Semple (CEMH, 0171 919 3198).
Health Economics and the Pharmaceutical Industry
Alan Stewart

Introduction

Last year the Secretary of State for Health welcomed (DH, 1994) the introduction of guidelines for the economic evaluation of pharmaceuticals. These joint DH / ABPI (Association of the British Pharmaceutical Industry) guidelines are intended to assist decision-making by doctors, nurses, pharmacists and other health service staff, people who are already bombarded with information from drug companies exhorting them to prescribe new products. Even without the Secretary of State’s encouragement, clinical data are now often supplemented by economic evaluations arguing the relative cost effectiveness of using innovative (and often high price) drugs. Why do the companies want to produce this type of information and why is it important? Or at least why is it perceived at ministerial level as being important?

The size of the problem

Pharmaceuticals account for around 10 per cent of total NHS health care expenditure. While this may seem to be a relatively small proportion, in cash terms it amounted to almost £3.5 billion in 1992, a sum more than double the previous year’s total capital spending by all English Regions, Districts and SHAs (DH, 1992). Pharmaceutical costs have been growing at 12 per cent per annum, but the proposed overall increase in the health care budget for future years is no more than 2 per cent per annum, illustrating the manner in which pharmaceuticals have been absorbing a growing share of health care expenditure. And the expenditure on some categories of psychotropic drugs has become a large figure:

- in 1989 GPs in Great Britain issued almost nine million prescriptions for antidepressants, making this the fourth largest prescription item by volume within the central nervous system (CNS) therapeutic class;
- antidepressants are the largest prescription item by cost, within the CNS therapeutic class, with cash sales of about £55 million in 1990 (West, 1992).

Such expenditures partly explain the developing interest in the economics of health, of depression and of antidepressants.

Policy responses

The drug bill has become a prime target in efforts to curtail NHS spending, as discussed in the Department of Health’s document ‘Improving Prescribing’ (DH, 1990) and as implemented with the introduction of the Prescribing Analyses and Cost (PACT) system to monitor doctors’ prescribing practices. The focus on drug spending arises partly because it is visible and easily identifiable, but also because many health service practitioners complain that much of current demand for drugs is driven by the marketing imperatives of the industry.

The primary sector. Cutting prescription expenditure in the primary sector (GPs and other non-hospital services) has been the main target. This is hardly surprising since 80 per cent of NHS pharmaceutical expenditure occurs in this sector, where it accounts for 50-60 per cent of total costs. Since April 1991 most GPs have been allocated indicative drug budgets which amount to personalised

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targets for expenditures on medicines. Prescribing reports generated by the PACT information system are increasingly being used to analyse GP prescribing behaviour.

The secondary sector. In the secondary sector most hospitals now have formulary lists, drawn up by Drugs and Therapeutics Committees, indicating which drugs doctors are recommended to use. With wider availability of economic evaluations and the promulgation of guidelines on this matter, there may be increasing use of information on the cost implications of a drug before it secures a place on a formulary list. At one level this can already be seen in operation in Lothian where, in the second edition of their formulary (Lothian Liaison Committee Prescribing Group, 1989), only one ulcer healing drug (SmithKline Beecham’s Tagamet) was included. Glaxo’s blockbuster product Zantac was excluded with the explanation that ‘Although [Zantac] has fewer side effects, it is much more expensive and should be reserved for those rare patients who have side-effects with [Tagamet]’.

The impact of the reforms. The NHS reforms have also significantly changed the financial environment in which public health care is provided. For example, the creation of the purchaser / provider split has focused attention on exactly how money is being spent and exactly what services should be purchased. The establishment of trusts has devolved some budgetary responsibility to clinical directorates in each specialty, with each directorate free to allocate their own funds and set their own pharmaceutical budget. GP fund-holders are in a position to do likewise. Both trends create greater incentives to minimise pharmaceutical spending, since any savings realised can be allocated to other parts of the directorate or fund-holding practice. GP fund-holders have 3-4 per cent lower drug costs than non-fundholders (Barrowcliffe, 1993): this finding

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**Figure 1**

Medicines and NHS spending

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may constitute evidence that drug budgets are already being cut, however it does not indicate how the diverted funds are being used, or if they are being used effectively.

**The role of economic evaluation**

All this has happened at a time when there are large numbers of new pharmaceutical products, many of which have similar clinical characteristics. Economic evaluation, whether by independent bodies or by the pharmaceutical companies, can differentiate between seemingly similar drugs, or at least the Secretary of State hopes that it can. Furthermore the costs of producing new drugs are spiralling, with one study estimating that, at 1987 prices, every new chemical entity reaching the market cost $231m (DiMasi et al, 1991). Many of these new drugs will be produced in areas where substitutes or close alternatives already exist. Hence there is increasing pressure on pharmaceutical companies to demonstrate the value of, and the need for, new drugs, particularly if they appear to be more expensive than existing alternatives. Economics can also assist licensing authorities and pharmaceutical companies in pricing negotiations, establishing why a new drug should be more expensive, or possibly why it does not justify a high price. Such approaches are already taken in some other health care systems, such as France and Australia.

**Economics and clinical budgets.** But what about clinicians struggling with a tightly defined budget? What can they gain from expanding promotional information to include economic data? Economic evaluation can identify drugs which, although having a higher unit price, can actually generate cost savings to health care providers as well as improving many patients’ quality of life. For example, one study compared the use of an SSRI and a TCA for antidepressant therapy, showing possible cost savings for prescribers by switching to the more expensive SSRI, despite its higher packet price (Jönsson and Bebbington, 1994). Although it should be noted that other research has disagreed with this and advised that general claims about SSRIs should be treated with caution at the moment (Stewart, 1994).

**Whose responsibility?** But while such analyses may benefit clinicians, how reasonable is it to expect health economics to be added to an already wide range of skills demanded of modern practitioners? If they are interested, there are many texts available providing an introduction to the area, but probably there are more long term benefits from looking for the expertise to be provided by specialists in this area. Such changes are coming in, with many purchasers, providers and other health care organisation acquiring economists to advise the medical practitioners. And there is undoubtedly a role for the pharmaceutical companies in providing more and better information on the economic implications of using new, and often very expensive, products.

**Benefits, resources and ‘rational prescribing’.** By comparing a drug with all alternative treatments available, economic appraisals can identify potential benefits and consequent resource implications of using a particular drug. They can justify allocation of resources to a specific drug within a given budget and provide evidence to increase a budget to allow prescribing of more expensive drugs if they identify savings elsewhere within the health service. This wider view focuses on the benefits to society available from improved use of the total health care budget. Such analysis will ensure that worthwhile drugs are placed on formulary lists and promoted as examples of ‘rational prescribing’, rather than finding their way onto limited lists where their benefits will be denied to patients.

An earlier version of this paper appeared in *Health Service Journal*, 1 December 1994.
References


Department of Health (1994) Press release 94/251


Other publications by PSSRU staff on the economics of pharmaceutical products


Decision trees

Many studies of pharmaceutical and other treatments are now using decision tree analyses to track or predict costs and outcomes. This mode of analysis incorporates elements of the economic theory of expected utility, and represents given clinical problems using a fairly standard diagrammatic representation and notation.

Decision trees, their contributions to economic evaluation and their drawbacks, are discussed by Alan Stewart in ‘Decision analysis and mental health evaluations’, chapter 10 of Martin Knapp (ed.) The Economic Evaluation of Mental Health Care, Arena, Aldershot, 1995.
Psychotherapy and the NHS

Psychotherapy has been described as ‘a nebulous term referring to a seemingly infinite variety of ‘talking cures’ of differing intensity, duration and theoretical sophistication.’ (Fahy and Wesley, 1993). Brown and Pedder (1991) classify psychotherapy along a spectrum of specialisation. At one end of this spectrum is psychotherapy practised in a generalised form by non-specialists within the context of the agency relationship between patient and doctor (see Balint, 1957). At the other end of spectrum, and of more relevance from an evaluative perspective, is the practice of psychotherapy as an explicit psychological intervention, using both psychodynamic and cognitive-behavioural principles aimed at the alleviation of a wide variety of mental disorders.

Sandwiched in between are counselling services provided by a variety of individuals and organisations. Although counselling might be considered as a form of psychotherapy, Farrell (1993) suggests that counselling deals specifically with psychiatric problems of an acute nature arising out of specific traumatic life events such as bereavement, assault, rape or contraction of illness. In contrast, he views psychotherapy as a response to psychiatric impairment of a more chronic nature, independent of any traumatic life event.

Psychotherapy did not become an established medical specialty until 1975. In 1987 there were 84 consultant psychotherapists in Britain, a number which grew to 114 in 1990 with the availability of an additional thirteen posts (Psychiatric Bulletin, 1991). Trained counsellors operating in the NHS are more numerous. Farrell estimated that in 1993 there were between 500 and 1000 counsellors working within primary care settings, with an additional 1000 counsellors, including nurse therapists, practising elsewhere in the health service. The NHS is only one potential source of supply of counselling and psychotherapeutic services. People with emotional difficulties and mental health problems utilise the therapeutic skills of private practitioners, voluntary groups (e.g. the Samaritans, marriage guidance counsellors, counselling services for HIV/AIDS sufferers) and public sector professionals (e.g. social workers).

Recent organisational changes in the NHS have placed value for money in service provision near the top of the policy agenda. Health authority planners and GP fundholders have become increasingly aware of the opportunity costs in terms of health improvements forgone from spending their budgets on relatively ineffective and expensive treatments. In this climate there will be growing demand for evaluative evidence on the benefits and costs of introducing or expanding the routine provision of psychotherapy services in the treatment of specific health problems.

Psychotherapy and value for money: the evidence

After conducting an extensive search of the UK literature, we found only limited evidence on the cost-effectiveness of psychotherapy compared with other treatments for specific patient groups. Four studies reported true cost-effectiveness evaluations; the others were concerned either with the impact of psychotherapy on service utilisation or descriptive analyses of the cost implications of providing specific services. Box 1 summarises these studies.
Box 1
Cost studies of psychotherapy

Cost-effectiveness studies


All these evaluations were based on RCTs, with the exception of Ginsberg et al (1977) who conducted a before and after study. All four studies were concerned with the evaluation of psychological therapies within a primary care setting. On balance, the introduction of these services was found to be cost-effective in terms of improvements in clinical outcome and the achievement of overall cost savings. Results provided by Scott and Freeman were the exception. They concluded that the psychological treatment of patients offered no significant gains in clinical outcome with additional costs associated with the introduction of specialist care compared with routine patient management by a GP.

Service use evaluations

Koch (1979); Earl and Kincey (1982); Dick and Woof (1986); Menzies et al (1993)

With the exception of Earl and Kincey, who conducted an RCT, these studies adopted before and after experimental designs. Koch, Earl and Kincey, and Dick and Woof concentrated exclusively on the effects of therapy on health service utilisation and clinical outcome. Koch and Dick and Woof found significant improvements in patient outcomes and reductions in service use for those patients evaluated. Menzies et al costed the impact on service use of in-patient psychotherapy for people with personality disorders. Their analysis focused on the implications of therapy for both NHS and prison service costs. It was concluded that psychotherapy would realise significant cost savings to both the health and prison services after a four year period.

Descriptive cost studies

Wankowski (1979); Watson and Ryle (1992)

These studies were not concerned with the explicit evaluation of specific psychotherapy or counselling services. Wankowski estimated the potential financial savings that would accrue to the government and universities from the introduction of student counselling services. Significant cost savings were projected if counselling services prevented the drop-out of 60 per cent of referred students. Clearly, this study is of limited applicability to the health service. Watson and Ryle examined the potential health service cost implications of providing psychotherapy in a secondary care setting to all patients referred from an inner London catchment area and defined as in need of psychological treatment. Not surprisingly, the authors conclude that salary costs will crucially depend on the number of therapy sessions provided per patient.
Policy implications

To varying degrees the studies reviewed were found to suffer from a number of methodological failings:

- **Experimental design** — Only four out of the ten studies reviewed were based on randomised controlled comparisons of psychotherapy versus other types of care. Three out of the 4 service evaluation studies were based on uncontrolled before and after study designs. If evaluations are to be of any relevance to policy, services under evaluation must be compared with their relevant alternatives (even if the relevant alternative effectively means doing nothing). Randomisation is then required to add scientific rigour to the evaluation. It should be noted, however, that an economic evaluation based on an RCT should be treated with caution given the potential discrepancy between treatment efficacy and effectiveness. A more naturalistic approach to the evaluation of psychotherapy within specific service settings may prove to be the more pragmatic option.

- **Comprehensiveness** — Where patients included in an evaluation are suffering from a chronic mental impairment it is important to recognise that they may be in receipt of a variety of statutory and non-statutory support services outside the NHS. Analysis of service utilisation and costs should therefore take into account the impact of psychotherapy and other interventions on resource use in these areas.

- **Costing methodology** — Studies that provided cost estimates varied in the extent to which the true opportunity cost of service provision was measured. The treatment of an additional patient will involve a variety of resource inputs that will require costing (therapist time, buildings, equipment, administrative resources). A number of the studies reviewed concentrated only on running costs, and failed to consider the opportunity cost of capital.

- **Benefit measurement** — The underlying approach to benefit measurement concentrated on the potential resource savings that could be achieved with the implementation of programmes of therapy for specific patient groups. Whilst these financial savings are a legitimate secondary benefit from health care interventions, the programmes of care should be evaluated in terms of their effects on the welfare of service users and society in general. In line with economic evaluation in mental health services generally, welfare measurement amongst psychotherapy users has been narrowly based on clinical indicators of patient outcome. As global quality of life instruments in psychiatry are developed there will be greater scope for analysing the extent to which psychotherapy and its alternatives improve those aspects of health most valued by service users. Explicit valuation of the benefits from psychotherapy has focused on the human capital effects of service receipt. This approach within a health care context is, however, methodologically and ethically unsound.

The limited quantity and quality of research into the costs and benefits of psychotherapeutic interventions within specific patient groups and disease categories places serious limitations on its usefulness as a decision-making tool. Without more rigorous evaluative work, those who advocate the use of psychotherapy will find it increasingly difficult to secure its inclusion within a purchaser’s list of priorities. In the interests of the overall health of their respective populations, the costs and benefits of psychotherapy cannot and should not be considered in isolation of the value for money offered by other psychiatric and non-psychiatric interventions.
References


Further details

A paper by Andrew Healey and Martin Knapp, Economic Evaluation and Psychotherapy: a review of UK evidence (Centre for the Economics of Mental Health, Working Paper 30, 1995) gives further details. After revision, this paper is likely to be published by the Department of Health. The authors are also preparing a chapter for a book to be published by the US National Institute of Mental Health in 1995.

The CEMH is carrying out economic evaluations for the MRC Social and Community Psychiatric Unit in the related areas of family therapy for schizophrenia, partner therapy for depression and cognitive behaviour therapy in the treatment of psychosis; and is collaborating with other research groups at the Institute of Psychiatry and elsewhere on other evaluations of psychological therapies.
Rationale

The development of measures of outcome capable of recording improvements in health-related quality of life does not only reflect a shift away from reliance on mortality and morbidity as indicators of the success or failure of medical intervention. It also represents a departure from the clinical orientation of much outcomes research in psychiatry, with its emphasis on psychopathology as opposed to the impact which care has on quality of life.

One approach within this overall quality of life movement in health care evaluation that has received particular attention is the quality-adjusted life year (QALY). The QALY combines data on the ‘utility’ of health states with data on life expectancy, to give a single measure of achievement or output. What this enables, in a form of economic appraisal called cost-utility analysis (CUA), is the comparison of cost per unit of (conflated) outcome for different clinical procedures or even different social problems. At the level of the health purchaser, or indeed the government, this ability to assess the worthiness of different treatments is one important objective of outcome measurement, since it assists and informs allocation decisions across programmes about how to achieve the greatest or greater health gain out of the finite amount of resources available.

Examples of CUA in the mental health sector are rare. Wilkinson et al (1990) describe an early attempt at a CUA of a community mental health service in order to test the usefulness of the QALY. Small differences in QALY scores between entry and one year later were found but were not statistically significant, with the estimated cost per QALY being lowest (£6,000) for people with schizophrenia and highest (£25,000) for those with neurotic disorders. Drummond et al (1991) offer a CUA evaluation within an RCT that examined the effect of a community support programme targeting support for caregivers of people with dementia. The score differential between control (standard patient care) and experimental (targeted carer support) groups was not found to be statistically significant between the groups.

Some problems with constructing QALYs

While there is widespread acceptance of the need for measures of outcome capable of reflecting quality of life in different client groups and for alternative interventions, no such consensus has been reached concerning the preferred methodology to be adopted. QALYs in particular have been fervently debated and widely criticised on a number of technical, as well as ethical grounds, none of which shows any clear sign of being readily or speedily resolved.

Which dimensions to include in QALYs?

Quality of life (QoL), the concept that QALYs attempt to measure, covers the actual or perceived level of fulfilment across physical, psychological and social aspects of individuals’ lives. The dimensions employed to capture this concept commonly revolve around mobility, pain, distress and functional capacity. The Rosser and Kind (1978) valuation matrix that is commonly used to derive QALYs contains seven categories of disability and four of distress which, together with the states of being unconscious and dead, provide relative valuations of 30 health states.
A basic conundrum of measuring quality of life, however, is that it can mean very different things to different people, and measuring the quality of life of people with mental health problems is no exception. Wilkinson et al. (1990), for instance, point out that the Rosser-Kind matrix is biased towards physical disability, and that distress and social disability are the two dimensions of most concern in the measurement of mental health outcome. In the development of the SmithKline Beecham Quality of Life instrument (SBQOL), Dunbar and Stoker (1992) asked a small sample of psychiatric patients suffering from moderate-severe anxiety or depression to rank in order of importance ten domains selected as important in the measurement of QoL. Their results underline the importance of psychological wellbeing in assessing QoL for people with mental health problems. Yet this domain is not explored in any depth in the QALY formula, nor in measures of quality of life generally. Likewise, individuals’ likings, preferences and feelings are often dealt with in one question, when it would be desirable to break down this side of quality of life into several elements for different groups (Huxley, 1986). Other important aspects of life that get overlooked are the spiritual and cultural dimensions, which may be a vital source of strength and support in individuals’ lives.

Whose values should count?

The values used in the construction of a QoL index raise other issues. Doctors’ perceptions of what factors are important in assessing health-related QoL will not necessarily coincide with the perceptions of patients, who for certain aspects of QoL may be the best judges of their own welfare. Hunt and McKenna (1993) argue that individuals’ contacts with mental health services are influenced by their subjective views about their mental health. These views may or may not coincide with clinically-defined need. Thus, whilst demand is based on the patient’s own (or carer’s) preferences for health care, clinically-defined need constitutes a judgement made on their behalf by a ‘better informed’ specialist who endeavours to act in the patient’s interest.

In mental health care it is the psychiatrist and other mental health professionals who act as ‘agents’ and thus have the most formative impact on assessing need and thereby influencing the specification and valuation of QoL. Huxley (1986) argues that there should be room for the reliance on the preferences of service users along dimensions where they can be expected to be the best judges (e.g. happiness and mood). Resort should be made to the judgements of mental health professionals only in areas where the patient may be less well-informed.

The outlook for QALYs in mental health care

The QALY provides decision-makers with a set of precise-looking statistics. In so doing it is contributing enormously in the UK by concentrating clinicians’ and managers’ minds on the thorny issues of resource allocation and priorities. However, it harbours difficulties and dangers. Indeed, if mental health care evaluations use generic QALY measures they run the risk of including irrelevant, ‘mis-valued’, insensitive and (in instrument opportunity cost terms) expensive questions. In this respect, the generic QALY is inappropriate as a mechanism for the allocation of mental health resources. Moreover, the complexities and drawbacks of a specific mental health QALY might be large. But if mental health evaluations fail to use QALYs, they run the risk of marginalisation in the increasingly QALY-influenced budgeting mechanisms and priority-setting exercises used in the NHS. For QALYs to be a useful method in mental health care decision making, a number of key questions need to be resolved:

- Getting the balance right (objective vs subjective valuation): Who chooses or
dictates the dimensions and scales to be used? How can different perspectives be reconciled?

- **Getting the level right** (specific/detailed vs general/summary): What does one want to get out of a QoL measure? Does the advantage of having a unitary dimension of outcome compensate for the loss of detailed outcome information? Is the generic QALY usable or should mental health care evaluators develop their own?

- **Establishing the trade-offs** (quality vs quantity of life): Should years of life gained be valued equally with the QoL of those years? Given that many mental health care interventions are not life extending, and therefore stand to fare poorly on strict efficiency grounds in ‘league tables’ and the like, will distributional considerations overshadow any attempt to derive a composite index for comparative purposes?

**References**


Huxley, P (1986) *Quality Measurement in Mental Health Services; Good Practices in Mental Health*.


**Further details**


Research is also under way at the CEMH that seeks to explore wider quality of life issues, in particular its conceptualisation and measurement in relation to people with mental health problems from diverse cultural groups.

**Drug dependency — the NTORS**

The National Addiction Centre, Institute of Psychiatry, has been funded to conduct the National Treatment Outcomes Research Study (NTORS) of modes of treatment for drug dependency. The CEMH is collaborating on the parallel health economic evaluation. Research started in early 1995 and continues for two years. Please contact Andrew Healey at CEMH (0171 740 5322) for further details on the economic evaluation.
Mental Health Economics: Introductory Short Courses

The Centre for the Economics of Mental Health, Institute of Psychiatry, in conjunction with the Personal Social Services Research Unit, University of Kent at Canterbury, is running two one-day courses in May and June 1995 in central London. The courses will introduce and illustrate the principles of economic evaluation.

The courses will be relevant to managers, researchers, clinicians and other mental health professionals. Each will equip participants with the knowledge and skills to understand the principles of mental health economics evaluations and to apply those principles to their own areas of expertise. The two courses may be taken separately or in sequence.

**Course 1**

**Introduction to Mental Health Economics Evaluation**

Thursday 11 May 1995

repeated on

Wednesday 24 May 1995

Course 1 will introduce and illustrate the principles of mental health economics evaluations. Topics will include: policy and practice contexts for evaluations; the ‘production of welfare’ and supportive frameworks; definition and measurement of costs and outcomes; criteria for evaluation; types of economic analyses; introduction to applications and study design.

**Course 2**

**Using Economic Evaluations of Mental Health for Policy and Practice**

Thursday 15 June 1995

Course 2 will introduce some more advanced concepts of economic evaluation. Most of the course will be devoted to the application of economic evaluative methods to key policy and practice issues in today’s mental health services, including community reprovision following hospital closure, prescribing patterns, predicting longer-term costs, and altering the balance of care for people with dementia or schizophrenia.

To book, please complete and return the form below, or a photocopy

**BOOKING FORM**

Please register me for the following course(s)

**Course 1** Thursday 11 May 1995  [ ]  **Course 2** Thursday 15 June 1995  [ ]  

**Course 1** Wednesday 24 May 1995  [ ]

I enclose my cheque for £______, payable to the Institute of Psychiatry.

Cost per course, including refreshments, lunch and course materials:

£211.50 (including £31.50 VAT), for private sector employees; £152.75 (including £22.75 VAT) for others

Name  
Post held  

Organisation  

Address for correspondence  

Postcode  

Telephone  
Fax

Please return this form, with your cheque, to: Sandra Semple, Centre for the Economics of Mental Health, Institute of Psychiatry, De Crespigny Park, London SE5 8AF  
Telephone: 0171 919 3198  Fax: 0171 701 7600  E mail: cemh@ucl.ac.uk

Please book no later than two weeks before the course
New Publications

A full list of mental health research publications can be obtained from the PSSRU Librarian, Lesley Banks, on 01227 827773, or Sandra Semple at CEMH, on 0171 919 3198.

**Care in the Community — Five Years On**

**Antidepressant pharmacotherapy: cost comparisons of SSRIs and TCAs**

**Service use and costs of home-based versus hospital-based care for people with serious mental illness**

**The health economics of schizophrenia treatment**

**Reduced-list costings: examination of an informed short cut in mental health research**

**Programme-level and system-level health economics considerations**

**Policy and finance for community care: the mixed economy**

**Community mental health services: towards an understanding of cost-effectiveness**

**Residential care as an alternative to long-stay hospital: a cost-effectiveness evaluation of two pilot projects**

**The costs of accommodation and care: community provision for former long-stay psychiatric hospital patients**

**Economics and mental health**

**Predicting costs from needs and diagnoses: community mental health care for former hospital in-patients**

**Costing the care programme approach**

**Costing changes in the balance of dementia care**

**Predicting the downstream costs of psychiatric treatment: the DLP and standard hospital-based care**

**Community psychiatric nurse teams: cost-effectiveness of intensive support versus generic care**
Mental Health and the Value of Employment

Justine Schneider

The value of work

Meaningful occupation is a human need recognised universally and throughout the ages. Indeed, some societies see work not merely as a practical necessity but as a social imperative. In this respect, however, people with severe mental health problems (like those with other forms of disability) are at a disadvantage, being much less likely to be in paid employment than people with no form of disability.

For our purposes ‘productive activity’, ‘occupation’, ‘employment’ and ‘work’ are used interchangeably, following a definition given by Walter Neff (1988): ‘Work is an instrumental activity carried out by human beings, the object of which is to preserve and maintain life, which is directed at a planned alteration of certain features of our environment.’

Whenever service users are consulted about community mental health care, there is agreement that, once basic needs for shelter and treatment are satisfied, employment is of paramount concern (Hatfield et al., 1992; Thomason, 1989; McCollam, 1994).

In the UK large asylums have always offered a range of work for patients. Initially this was as much to help them pay their keep or to run the hospital as to aid recovery. After the NHS was founded, therapeutic justifications came to the fore and a 1957 Ministry of Health circular Rehabilitation in the hospital service and its relation to other services, endorsed the provision of work with realistic terms and conditions. Changes to psychiatric care brought about by the introduction of major tranquillisers and a new emphasis on the social aspects of mental health care, together with the 1959 Mental Health Act, fostered new forms of employment rehabilitation. By 1967, Wansborough and Cooper found that 100 out of 122 hospitals circulated had some form of Industrial Therapy Unit (ITU). Nowadays, community care reforms have led to a reconsideration of the role of employment for people with long term mental health problems.

While employment for people with mental health problems has a long history, it has hitherto been almost entirely hospital-based. As a result, staff were inexperienced in business skills, and the enterprises depended largely on the hospital for accommodation, investment and other essentials. The progressive closure of hospitals has meant that many work opportunities have also disappeared, and new alternatives based in non-hospital settings have developed. The shift in responsibilities for providing care from a monolithic psychiatric hospital to a disaggregated and less organised set of community providers means that the role of purposeful and productive activity for patients has sometimes been overlooked.

Key issues

While users who have gained influence over services do demand meaningful occupation, pressure to obtain value for money in health care makes it necessary to address some complex issues surrounding work for people with long term mental health problems. Five aspects are discussed here.

1. The relationship between work and mental health or illness is not straightforward. Work can have ill effects and may in some instances precipitate a relapse in someone who is vulnerable to stress, for example. On the other hand,
we also know that for the general population unemployment is associated with poor mental health and suicide (Office of Health Economics, 1993), so it would be reasonable to infer that unemployment could be detrimental to some people with mental health problems. A balance needs to be struck between the demands of the job and the needs of the individual, with flexible work settings to accommodate fluctuations in mental state.

2. It may seem unrealistic to expect people with disabilities to compete in a market where jobs are scarce. Specialist schemes such as ITUs respond to this need. Their workforces are large to compensate for low productivity but relatively low-paid. Still there is a danger of implying that people with long-term mental health problems are not capable of anything other than sheltered work, whereas the first option for most would be to obtain open employment at a fair wage.

3. There is also the problem of stigma, or public perceptions of mental illness. This can severely restrict the opportunities offered to individuals. Strategies aimed at managing disabilities at work (Floyd et al., 1994) can overcome practical problems, but attitudes of suppliers, customers and others are often intransigent. It may be held that people with mental health problems need rest, protection or patronage rather than challenging opportunities to use their abilities.

4. The benefits system creates disincentives to work for people with mental health problems. Earnings may be taken into account in calculating entitlement to benefits. At present 'Therapeutic Earnings' are the most flexible means of overcoming this obstacle, but they are not available to all. It is not yet clear whether the proposed ‘jobseeker’s allowance’ will be adaptable to the needs of people who are disabled through mental illness or who may have intermittent periods of sickness.

5. Employment for people with mental health problems will in most cases require financial subsidies. Social security, health services, local authorities and voluntary organisations are the commonest sources at present, but their respective responsibilities are not clearly demarcated.

Promoting work opportunities

Planners, purchasers and providers of mental health care in the community need to take account of these factors and weigh them up in the light of the demand on the part of service users and their carers for meaningful occupation. If productive activity can be developed as an integral part of community care this should benefit both the self-esteem and the social status of people with mental health problems living in the community. It may also contribute to maintaining people outside of hospital. It would certainly be a clear sign of the influence of service users in shaping mental health care.

References

Thomason, C. (1989) ‘What do you do for a living?’ A study into the employment and training needs of people from Haringey who have been involved with the psychiatric services, Haringey Economic Development Service and Tottenham Unemployed Network, London.

Related research

The PSSRU is currently conducting research for people with severe mental health problems. Angela Hallam and Justine Schneider are studying 150 people in seven work projects of various types. The research explores the costs of work schemes in relation to other forms of community care, and the workers’ satisfaction with their quality of life. This study is funded by the Department of Health as part of the PSSRU programme of research The Economics of Mental Health, which is directed by Martin Knapp.

Discussion Paper 1052/2 The Value of Employment in Mental Health Care, is available now from the PSSRU (price £5 including p&p), and the final report on the research is due at the end of 1995.

Current DH-funded Research at the PSSRU

The Department of Health has commissioned the PSSRU to conduct research on:

- analysis of the OPCS Survey of Psychiatric Morbidity, looking in particular at service utilisation, costs (both descriptive and predictive), and funding and the mixed economy (contact: Shane Kavanagh and Martin Knapp)
- the role of employment and meaningful occupation for people with severe mental health problems, a study of the costs and short-term benefits of several different work schemes (contact: Angela Hallam and Justine Schneider)
- monitoring the development of the mixed economy of mental health care, new providers, new funding and new incentives (contact: Martin Knapp and Justine Schneider)
- long term follow-up of former long-stay patients; the costs after five years in the community, linked to the TAPS study (contact: Jeni Beecham and Angela Hallam)
Mental Health Needs and the Costs of Residential Care
Daniel Chisholm and Jack Astin

Policy context

There has been widespread concern at a policy and operational level that the need for mental health residential care is currently not being met. This concern has been heightened in the light of two key changes in the provision of residential services: 1) the move away from hospital to more community-based care, which although welcomed as a positive shift in provision, has resulted in long-stay hospital places being reduced at a faster rate than community or hostel places being made available; 2) the allocation of lead responsibility for community care to social service departments, which has reduced the emphasis on long-stay needs, and also altered the links between the public sector and voluntary and private sector community-based facilities, since many of these services are no longer paid for out of social security benefits. Thus, and in short, there is concern regarding the misprovision as well as the underprovision of mental health residential care.

Residential care is also by far the most costly element of many care or support packages for people with mental health problems (it represents an estimated 80 per cent of hospital and community services and a substantial proportion of personal social services expenditure on mental illness), and yet the information base upon which many policy and practical decisions are made remains poor.

Aims and objectives

With these concerns in mind, the Centre for the Economics of Mental Health added an economic component to an NHS R&D funded project to examine and predict the mental health needs of populations in eight DHAs. The overall purpose of the main study, which is being carried out by the Research Unit of the Royal College of Psychiatrists, is to provide and test simple methods of determining needs for high-cost residential mental health care, based on data for all residents and facilities in a representative sample of eight District Health Authorities (DHAs). The purpose of the CEMH economic component is to build up a comprehensive picture of the true costs associated with both the service utilisation of residents and the service provision of facilities within the eight DHAs. The principal benefit of the study will be the ability to predict with greater precision the likely need for and cost of mental health residential care. The study will also characterise the services being used and provided in facilities (in terms of levels of dependency and disability; organisation, structure, size and cost), and in so doing will be able to estimate the level of unmet need for residential care and also the appropriateness of placement.

Data collection

In order to build up a comprehensive picture of service provision and use associated with mental health residential care, it is necessary to obtain data on the characteristics of facilities or establishments offering residential care and the characteristics of the residents themselves. To this end, two main instruments for collecting these data were designed and employed in this study:
- the Facility Profile, which captured data on the type of establishment, services offered, professional inputs and staffing levels, plus an estimate of the average
the Resident Profile, which provided data on residents’ placement, psychiatric history, mental/behavioural problems, personal functioning, income and service use. This latter section included use of services other than residential care (e.g. day care, community nursing, hospital out-patients, etc.), since these represent the bulk of the overall level of resources directed at care for this group of people.

Resources that are consumed in the provision or use of mental health residential care provide one indication of the level of inputs into this sector. In economic terms, however, a more useful indication can be gained from placing unit costs on these consumed resources, since this will convert all resources into a common unit of measurement (\(£\)) and by so doing can provide total or average costs of mental health residential care. These costed resource inputs combine with non-resource inputs such as the characteristics of care environments (not costed) to generate the ‘production of welfare’ and its final output, namely changes in the health, welfare and quality of life of clients (Davies and Knapp, 1988).

Some of the data necessary to derive unit costs for services and resource components were collected via the study instrumentation. However, it has been necessary to gain access to and collect supplementary data and information in order to build up a comprehensive picture of the costs of service receipt and provision:

- **Resident service use costs**: Unit costs needed to be derived for the items of service use listed in the Residents’ Profile. Together with accommodation costs and client living expenses, these costed services make up the constituent elements of the packages and the costs of care for residents.
- **Facility costs**: Data needed to be collected, either from the facilities themselves or their managing agencies, that related to the principal cost components of facilities, such as capital and revenue costs, in order to enable the calculation of total and weekly average cost of accommodation.

**Data analysis**

Data analysis was ongoing at the time of writing, so it is only possible to provide an initial descriptive analysis of accommodation costs for facilities. A total of 446 facilities were initially identified as meeting the criteria for the study, but of these 61 either did not meet the criteria when site visits were made or were unprepared to participate, and for a further 34 facilities costs information was unavailable. This leaves a total of 351 facilities for which weekly accommodation costs or charges per resident have been estimated.

As can be seen from Table 1, the major difference in cost is by agency, with NHS facilities significantly higher than the other agencies. For like-with-like comparisons to be made, however, this cost differential needs to be examined in the context of resident differences. The difference across districts is not so pronounced. We have taken a preliminary look to test for a ‘London effect’. Table 2a (all facilities) does not show any sign of much effect. But once the Regional Secure Units and Special Health Service Authority facilities have been taken out (table 2b), there is evidence of a significant London effect. Again, this difference has yet to be examined in the light of client characteristics.

These data on accommodation costs will be combined with the costs associated with other service use, which together will produce comprehensively costed packages of care for the 2000 residents covered by the survey. Cost function analyses can then be carried out, which will estimate the relationship between weekly cost per resident and hypothesised influences in an attempt to ‘explain’ observed variations. Potential influences that might effect the cost of residential care are...
Table 1
Mean accommodation costs of facilities by sector and district

<table>
<thead>
<tr>
<th>District</th>
<th>Health</th>
<th>LA</th>
<th>Private</th>
<th>Voluntary</th>
<th>Total</th>
<th>Significance</th>
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<td>6</td>
<td>5</td>
<td>27</td>
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<tr>
<td></td>
<td>N Mean s.d.</td>
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<td>223</td>
<td>156</td>
<td>97</td>
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<tr>
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<tr>
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<td>103</td>
<td>170</td>
<td>142</td>
<td>154</td>
</tr>
<tr>
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<td>7</td>
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<td>223</td>
</tr>
<tr>
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<td>208</td>
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</tr>
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<td></td>
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<td>300</td>
<td>368</td>
<td>234</td>
</tr>
<tr>
<td>5.</td>
<td>19</td>
<td>14</td>
<td>12</td>
<td>35</td>
<td>80</td>
<td>221</td>
</tr>
<tr>
<td></td>
<td>N Mean s.d.</td>
<td>852</td>
<td>218</td>
<td>228</td>
<td>221</td>
<td>197</td>
</tr>
<tr>
<td>6.</td>
<td>10</td>
<td>7</td>
<td>0</td>
<td>7</td>
<td>24</td>
<td>203</td>
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<tr>
<td></td>
<td>N Mean s.d.</td>
<td>766</td>
<td>450</td>
<td>0</td>
<td>203</td>
<td>158</td>
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<tr>
<td>7.</td>
<td>9</td>
<td>14</td>
<td>13</td>
<td>5</td>
<td>41</td>
<td>173</td>
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<tr>
<td></td>
<td>N Mean s.d.</td>
<td>759</td>
<td>485</td>
<td>301</td>
<td>173</td>
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<tr>
<td>8.</td>
<td>16</td>
<td>3</td>
<td>20</td>
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<td>55</td>
<td>202</td>
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<tr>
<td></td>
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<td>1067</td>
<td>136</td>
<td>134</td>
<td>202</td>
<td>61</td>
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<tr>
<td>Total</td>
<td>88</td>
<td>65</td>
<td>109</td>
<td>87</td>
<td>351</td>
<td>390</td>
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<tr>
<td></td>
<td>N Mean s.d.</td>
<td>886</td>
<td>263</td>
<td>216</td>
<td>209</td>
<td>165</td>
</tr>
</tbody>
</table>

Significance: 0.0241 0.000 0.0160 0.074 0.0456

Please note that these figures may be amended after further analysis.

Table 2
Mean cost (and s.d.) of London versus non-London facilities

<table>
<thead>
<tr>
<th></th>
<th>Location</th>
<th>Cases</th>
<th>Mean (s.d.)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) All cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Cases</td>
<td>Mean (s.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>105</td>
<td>400 (326)</td>
<td>0.649</td>
<td></td>
</tr>
<tr>
<td>non-London</td>
<td>244</td>
<td>380 (382)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Excluding RSUs and SHSA facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Cases</td>
<td>Mean (s.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>105</td>
<td>400 (326)</td>
<td>0.009</td>
<td></td>
</tr>
<tr>
<td>Non-London</td>
<td>229</td>
<td>310 (271)</td>
<td></td>
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</tr>
</tbody>
</table>

Please note that these figures may be amended after further analysis.
care include the characteristics of staff, residents, the homes themselves and their location, and non-residential services (Darton and Knapp 1984).

References


Related research

As part of the King’s Fund Fair Shares for London Research Grants Scheme, CEMH is undertaking additional analyses of the disaggregated data collected as part of the Royal College of Psychiatrists study, in order to observe any ‘London effect’ and to consider in depth the implications of this effect on overall service provision in the capital. Elucidation of the extent to which needs are being met, and improved specification of the cost implications of meeting those needs in different settings, will be of considerable value to both purchasers and providers of community health and hospital services for people with mental health problems in London.

Findings from the King’s Fund programme will be published in autumn 1995. Please contact Daniel Chisholm for further details of the CEMH research, or Dr Ken Judge, Director of the King’s Fund Institute, for details of the full programme.

Nineteenth century cost-effectiveness?

‘We take then the reports as they come to hand, and here, to begin with, in a fat pamphlet, almost like a blue-book, is the report of the oldest and richest of these institutions, Bethlem, with its income of £29,091 per year. A noble institution indeed, conducted in a spirit of the most enlightened liberality, and able to boast of the most satisfactory results in a percentage of cures of 66 …’

Journal of Mental Science, volume VI, 1860, number 34, page 496
Affording Community Care: Lessons from the Friern and Claybury Psychiatric Reprovision Programme
Angela Hallam

The move to replace Victorian psychiatric institutions with community-based facilities has been part of government policy in England for more than thirty years. Yet it was not until the mid-1980s that the number of mental hospitals began to decline appreciably (Davidge et al., 1993). At that time there was little research evidence to indicate either how much the reprovision of hospital services was likely to cost, or which services would be needed to provide care in the community. Consequently, the acceleration of the closure programme has been shadowed by a rising level of concern that vulnerable people are wandering the streets of our cities and not receiving any form of care at all.

Stories which appear in the media chart a desperate trail: underfunded services, deficiencies in planning and coordination, unmanageable staff caseloads, lack of compliance and, inevitably, tragic consequences. In addition, a wider, potential threat underlies the individual case history, owing to the use of a set of images from the world of the gothic horror film. Deplore the system and pity its victims, reader, but also beware the ‘beast,’ the ‘human timebomb,’ resisting medication or dazed under the effect of a ‘liquid cosh’ (at any rate not responsible for subsequent actions), and heading for a street near you.

It is plain that some people are being failed by existing health and social care services. Certainly, isolated events indicate there are lessons which must be learned if a coherent, flexible and multidisciplinary approach to care is to serve the people who need it most, as and when their needs are greatest. However, because the failures are reported so memorably, while examples of good practice rarely receive press coverage, it is easy for the picture of service provision in the community to become distorted.

The Friern and Claybury reprovision programme

For the past nine years, the PSSRU has been conducting an economic evaluation of the closure programme of two large psychiatric hospitals in North London. We work in association with the Team for the Assessment of Psychiatric Services (TAPS), who undertake detailed assessments of the study clients before they leave hospital and at regular intervals once they have moved to the community. Our remit is to describe and cost the package of services received by individual former long-stay patients one and five years after their discharge from Friern or Claybury hospitals. These ‘packages of care’ are then examined alongside the clinical outcomes evidence.

The evaluation is important for a number of reasons. First, the reprovision programme has been well planned and funded by the regional health authority, which has had implications for both the level and range of service provision. Second, the move from hospital to community has been monitored by the two research teams since its inception in 1985, and results have been widely reported and published. Finally, and perhaps most importantly, we know that the former long-stay patients are still receiving services in the community. TAPS report that only seven of the 671 study clients were lost to follow-up one year after leaving hospital and, of these, four had been vagrant in previous periods of their lives (Leff, 1994).
Accommodation arrangements

To date, the PSSRU team has costed the service packages received by seven successive annual cohorts of leavers. We have found that 87 per cent of the total cost of community care is accounted for by costs relating to the accommodation facility. It is important to emphasise the way that responsibility has shifted since the health authority paid and provided for the Friern and Claybury residents. Now, although much of the purchasing power is retained by the health authority, a variety of providing agencies are being paid to support the former long-stay patients. For example, voluntary organisations, housing associations, and local authority social services departments are important providers of accommodation.

This mixed economy leads to a wide range of provision and different intensities of care. Some former inpatients have moved to large units, where 24-hour care is provided by qualified nursing staff; others are now living in small houses, with two or three other people, and staffing is provided on a peripatetic basis. In addition, 12 per cent of the study clients live completely independently, usually in housing rented from the local authority, and the health authority is no longer responsible for any of their accommodation costs.

Service use by study clients

When planning the closure of an institution, it must be remembered how many functions the hospital serves. If reprovision as a policy is to be successful, a complete network of services is required to replace the hospital model. One of our principal concerns when monitoring the relocation of services from Friern and Claybury has been that the study clients are, in fact, receiving services which relate to the many areas of their disparate health and social care needs. The accommodation unit may provide all or most of these, but it is more usual — and more desirable (see, for example, Goffman, 1961) — for people to visit different settings and participate in relationships with service professionals and others which are not defined within the context of the residential unit.

Over the seven years that we have been examining service receipt by the study clients, we have recorded contact with a total of 48 different services. Certain services were used by almost all clients: for example, 82 per cent of our sample saw a general practitioner. In other instances, there are rare reports of contact. Only two study clients have served prison sentences since leaving hospital and only a small percentage of each group of leavers had contact with police officers. This evaluation has shown that when money is invested in the reprovision programme and spent on a wide range of hospital- and community-based health and social care facilities, responsibility for former long-stay hospital patients need not fall to the police and prison service by default.

While the old hospitals provided a range of services, the care packages received by long-stay patients were fairly standard. Community provision allows far more flexibility. We have recorded a wide variety of daytime activities, for example: everything from social clubs to sheltered work, training and contact with High Street job centres. There is also a place for alternative therapies to supplement conventional health care. This does not imply that any one person will receive more than five or six different services, (only seven services, including accommodation, were used by more than 25 per cent of the sample). But every contact contributes to the picture of support required by the study clients and the costs associated with that support.
Hospital and community costs

How does the cost of community care compare with the cost of looking after those same people while they were resident in Friern or Claybury? An answer may be reported fairly easily, but we advise caution when looking for a direct correlation. Clearly, any sort of comparison made after the reprovision patients began to move would not be valid: staff were in the process of being relocated, general maintenance activities were being run down and, in general, the hospitals were not representative of stable, long-stay and acute care settings.

To obtain an approximation to ‘steady state’ hospital costs, we used data from 1985-86, the year in which the first cohort of leavers moved to the community. As shown in figure 1, the mean cost per patient per week at that time was £551 in Claybury and £578 in Friern (at 1993-94 price levels). Costs are likely to have been higher than this average in acute wards, therefore lower in the less well-staffed long-stay wards where the study clients were living. In comparison, the mean cost across the seven cohorts followed up after one year in the community (a total of 584 clients) was £539 per person per week, at 1993-94 price levels, and (for the first three cohorts after five years) £562 per week. The service packages of those clients most difficult to place in the community have yet to be included in our costs data, so it is probable that the eventual mean total cost of care for the former Friern and Claybury populations will be slightly higher than the figures quoted here.

Figure 1 makes it clear that good community care is not a cheap option, although it may be considerably less costly than hospital-based care for some people. Ultimately, although the hospital/community comparison is important, it is costs associated with the different community arrangements that are more relevant to policy makers and planners.
Costs and service use after five years in the community

We can now examine the longer term implications of the reprovision programme, as we have costs data relating to 139 people in the first three cohorts, five years after they moved from the study hospitals. Findings to date yield interesting data on service use, which have wider policy implications. For example, when we compared service packages received by the same people at the two time points, we found a dramatic fall in contact with social workers, both in numbers using the service (28 in the first year, 10 in the fifth) and a 13-fold drop in the length of visits. It is likely that this change reflects scarcity of resources rather than reduced levels of need.

Although there was no change in the proportion of the sample using hospital inpatient services (approximately 13 per cent), the weekly cost of this component of users’ service packages rose from £96 to £153 per week, indicating that the average hospital stay is lengthening. In addition, as the psychiatric institutions disappear, inpatient episodes usually take place in acute, general hospitals, at a cost which may be four or five times greater (Hallam et al., 1995). It is important to ensure that community-based facilities and service professionals are adequately resourced so that they meet more of the care needs of these clients. In the long-term this will represent a cost saving.

Conclusions

If the reprovision of long-stay hospital services is funded by transferring all of the money released from hospitals to effectively targeted community-based services, it is affordable. The challenge for NHS purchasers and community care planners is to reallocate funds equitably between agencies, so the needs of individual people with severe and enduring mental health problems are appropriately addressed.

The research reported in this article was undertaken with Michelle Asbury, Jennifer Beecham, Andrew Fenyo and Martin Knapp, in association with the Team for the Assessment of Psychiatric Services (TAPS) and its Honorary Director, Julian Leff. Grateful thanks also to the staff and users of each service.

References


Other publications from this study

The costs of accommodation and care: community provision for former long-stay psychiatric hospital patients


The costs of community care for people with long-term mental health problems


Predicting costs from needs and diagnoses: community mental health care for former hospital in-patients

The Daily Living Programme Phase II
Martin Knapp and Jane Wolstenholme

‘Sound community care is a fragile plant. It withers quickly if policies do not ensure secure funding which omits perverse incentives that impair good care’ (Audini et al., 1994). Although several randomised controlled studies have found more benefit from a community care setting for severely mentally ill individuals than from the traditional in/out-patient care, no controlled study has examined for how long these advantages can be sustained. The Daily Living Programme (DLP) Phase II study thus offers a unique opportunity to examine longer-term costs and effects.

The chance to carry out the investigation came about at the end of DLP Phase I. The DLP is an intensive community-based service, based at the Maudsley Hospital, for people who are seriously mentally ill. Instead of ending the DLP for all patients, a ‘controlled withdrawal study’ was conducted. From January 1990 to December 1992 (30 months after admission), 50 per cent of the original DLP cohort were randomised to continuing DLP care, while the remaining 50 per cent became the new control group using standard psychiatric care. Patients who had originally been randomised to the control group continued this into Phase II, and were followed up at 45 months (on average).

The outcome measures used were: number and duration of in-patient admissions, ratings of clinical and social function, and patients’ and relatives’ satisfaction. Detailed data on service use and accommodation provided the basis for the costing over three further component evaluation periods (26-30 months after admission; 31-34 months; 35-45 months). The techniques and methodology utilised in the costing of Phase II adhered closely to those used in Phase I (Knapp et al., 1994). In costing the service receipt from the Daily Living Programme, the contact time of the DLP staff with 16 extra referrals and 19 control group clients (who insisted on receiving DLP care in Phase II) was taken into account.

Cost-effectiveness results

The outcomes evaluation proved to be disappointing, since the clinical and social gains present at Phase I were generally lost during Phase II. The only positive result was greater patient and relatives satisfaction with the DLP compared with standard psychiatric care (Audini et al., 1994). By contrast, the cost gains attained after 20 months of Phase I were sustained after 45 months of DLP care, with standard psychiatric care significantly more costly than DLP care. The total weekly costs (all service, living and accommodation costs) are shown in Figure 1.

DLP weekly costs were consistently lower than the DLP control group weekly costs — significantly different in the first period of Phase II (31-34 months; p=0.014) and marginally lower in the second (35-45 months, p=0.080). DLP costs were also lower than the original control group costs in the latter period (p=0.025). There is thus a continuing cost-effectiveness advantage to the community-based treatment, even four years after control group members had left in-patient care.

Cost variations

One major caveat is that only the average costs are displayed. Although the weekly costs are lower for the DLP group on average, this result does not apply to every client. We therefore explored the reasons for cost differences. These more detailed analyses were conducted for both Phases I and II and revealed some interesting linkages between the personal, social and clinical characteristics at
admission and their costs downstream. The results are presented elsewhere (Knapp et al., 1995).

**Conclusion**

The aim of the Daily Living Programme Phase II was to examine whether the superior outcome results and lower costs of DLP care attained during Phase I could be sustained for a further two years. The cost gains attained during Phase I after 20 months were sustained after 45 months of DLP care, with standard psychiatric care significantly more costly than DLP care.

The DLP is a particular form of community care and it is not easy to generalise from these results to other community-based models of provision. Nevertheless, these results are encouraging in the context of today's policy emphasis on alternatives to in-patient hospital treatment.

The research described in this article was conducted whilst Jane Wolstenholme was an MSc health economics student (University of York) on placement at CEMH; she is now at the University of Nottingham. Other people contributed to this research, especially Bernard Audini, Jack Astin, Jennifer Beecham and Isaac Marks.

**References**


Introduction

The difficulties of undertaking international psychiatric research are legion and have been rehearsed from many perspectives by many writers. From the perspective of health services research these difficulties are further compounded. In each country, responses to mental health problems are governed by central and local politics and by policy-makers, planners and practitioners, so the context in which services operate is very different (see, for example, WHO, 1987; Munday, 1993). Berting (1979) cites two further problems in comparative research; data which are insufficient or which cannot be compared and lack of clarity in concepts or definitions.

Staff at the PSSRU and CEMH are currently involved in both ad hoc and purposively-planned studies comparing mental health care within the UK and between the UK and other European countries and North America. Not surprisingly each of these studies involves economic evaluation, but when we start thinking about international costs studies more problems are uncovered. How can we account for differential levels of resources allocated to mental health, the very different funding arrangements and the different currencies used in each country? In looking at AIDS/HIV treatment and care, Tolley and Gyldmark (1993) suggest international cost comparisons require the development of a standardised framework which defines the cost categories to be included, the methods of data collection on service use and the measurement of unit costs. Each of these issues is addressed briefly in this article and the final section examines three approaches to attaching unit costs to service receipt information and the implications for analysis and interpretation.

Cost categories

For the ideal and fully valid cost-effectiveness study, we would advocate collecting data from every study member on all support services, accommodation facilities, employment and income and all inputs from other health, social care and informal sources. In the mid-1980s, and building on previous PSSRU work, we developed the Client Service Receipt Interview on which all elements of support and service use could be recorded (CSRI; Beecham and Knapp, 1992; Beecham, 1985). We advocate the use of trained interviewers to best tease out the peculiarities of each individual’s care package. First, interviewers require some knowledge of costing methodologies to better understand the importance of obtaining the correct data. Second, they require an appreciation of how different social policy elements link together at the national level and how the health and social care systems operate at the national and local level.

With the perfect vision that hindsight often brings, we have suggested a short-cut to calculating the costs of mental health care which reduces the data collection exercise and provides a list of service categories which, as the minimum data-set, should be included. Statistical analysis of previous data-sets allowed us to isolate the five main service components of care packages which together comprised 95 per cent of total care costs: accommodation and living expenses; hospital in-patient admissions; hospital out-patient attendances; and day care provided by both the health and social care sectors (Knapp and Beecham, 1993). Other services, however, should be included where they provide a major contribution to care in any country or where they have particular policy or practice relevance.
The resulting costs data should be suitably adjusted to reflect total costs.

Methods of data collection

Prospective data collection is an ideal but resource-consuming means of undertaking research (Knapp, 1991). The CSRI records retrospective service use and allows receipt of larger elements to be corroborated. Moreover, use of descriptive data such as staffing levels, client places or service outputs removes the confusion that service labels may generate (see also de Jong, 1993). Sheltered housing in the Netherlands, for example, is not provision of warden-assisted flats but a service more akin to residential care in the UK.

Since its initial development we have refined the Client Service Receipt Interview to ensure it represents the best compromise between allowing accurate estimation of individual-level costs and reducing the burden on the interviewer and informant. This has removed the requirement for a trained interviewer and allowed the schedule to be used in a variety of scenarios such as self-completion, postal surveys and during a clinical interview before the more personal questions are asked. A short version of the CSRI is currently being piloted in five countries under a European Union initiative and specially-designed versions are being used in Scotland, Italy, Spain and Sweden, as well as more than forty applications in England.

Calculating unit costs

Using the standardised framework described above ensures the scope of data-collection in each country is comparable but the calculation of unit costs must also follow a consistent methodology. We recommend estimation of long-run marginal opportunity costs. By grounding the calculations in sound economic theory the full cost implications of providing care can be taken into account (Beecham and Allen, 1993; Knapp, 1993). We suggest three approaches to attaching costs to service receipt information and analysing those data across different countries.

The first approach is to calculate the costs of care packages received by sample members in each country in the local currency. Our unit cost methodology is currently being used to calculate service costs in several countries including Canada, Italy, Spain and the United States (see, for example, Dickey et al, 1994). The resulting costs data are then analysed with respect to the client outcome data for that country and broad comparisons of cost-effectiveness are then drawn across all the countries included in the study.

The second method builds on this approach. Having calculated the costs of care in local currencies they can then be converted to one price base and the cost-effectiveness analyses undertaken across all study members. An indicator variable, or similar methods, should be used to identify each country to examine whether there is a 'location' effect over and above the associations found between costs, characteristics, needs and outcomes. Currency exchange rates, perhaps for US dollars or ECUs, can be used to convert the costs data to a single unit of measurement. Health purchasing power parities (PPPs) may be a more appropriate way forward and have been used in one recent US/UK comparative study (Dickey and Scott, 1995). PPPs take into account overall price levels and relative prices for specific commodities which differ across countries and seek to correct for these price differences in exchange-rate-based comparisons. For health, PPPs are the ratio of the national average health prices in one country to the corresponding average international prices for a group of countries (OECD, 1987). Development of a mental health PPP is some way down the research line...
but one which we should work towards.

The third route open to us when analysing costs data from international studies is to impose the unit costs calculated for one country on to the service receipt data collected in all countries. From our own work we have two useful sources of data. The first is a large study of residential facilities undertaken in eight health districts in the UK. Costs are estimated for all establishments where people with mental health problems live, including hospitals, 24-hour staffed facilities and those with lower levels of support (see pages 25-28). A second source of information is the annual compilation of nationally-applicable unit costs for some 40 different community care services, including community psychiatric nurses, social workers and psychologists (Netten, 1994). Using this methodology, the location variable should be retained and again the results carefully examined in the light of the circumstances in each country.

Conclusion

This paper is not intended as an exhaustive commentary on the ‘state of the art’ in either economic evaluation or international comparative studies. It does, however, aim to bring these two elements together. Economic evaluation of mental health services is a relatively new field and, like any other area of research, requires a grounding in the relevant theory and concepts (Knapp, 1995). International mental health costs research has bred yet another set of challenges and addressing these will require the development of new skills and techniques but the work undertaken to date provides a solid foundation from which to go forward.

References

de Jong, A. (1993) International Classification of Mental Health Care, Department of Psychiatry, University of Groningen, the Netherlands.
Munday, B. (1993) European Social Services, European Institute of Social Services, University of Kent at Canterbury.
Unit Costs Programme
Ann Netten

Introduction

The PSSRU has a long history of estimating and analysing cost information. In recent years, due primarily to the NHS and Community Care legislation and associated guidance there has been an increasing level of interest in this work. The book Costing Community Care (Netten and Beecham, 1993) was a response to this, drawing together work from a number of PSSRU members which identified a range of examples of the PSSRU’s work in the context of a discussion of theoretical and pragmatic estimation issues.

But a separate need for actual unit cost estimates was recognised. This need arises in a variety of forms even within the Department of Health: for example, in option appraisal and in costing the effects of demographic and policy changes for public expenditure purposes. It was in the light of these and a wider review of unit cost information that the Department asked the PSSRU, together with CHE at York, to draw together the most up-to-date information on national unit costs of community care services.

A report, Unit Costs of Community Care 1992/3 (Netten and Smart, 1993), was the first output of that exercise. A particular difficulty was presented by the fact that users of the data given in the report wanted the costs for a number of different purposes, but how costs are estimated depends on the purpose of the costing. This was resolved by providing as high a level of detail as possible. First, the individual components of costs were identified wherever possible. Second, all the assumptions behind the estimates were made clear. And third, the sources of information which were used and which were of potential interest were specified. This level of detail allows users to adjust assumptions or use more relevant material wherever it is available. Many gaps and problems were identified in the process of compiling the report, but it did provide a baseline from which to work.

Developments

Building from this baseline there are three principal objectives. The first is to extend the range of services. The second is to improve the quality of the estimates and, third, to develop methodologies – particularly for difficult-to-cost services. The second report (Netten, 1994) demonstrates how these aims are being met. It covers a variety of additional services, including a section on services for children and their families, sheltered housing and a specialist case management scheme. The quality of the estimates has been improved with the introduction of a consistent approach to estimating capital costs based on a small research exercise undertaken during 1993/4. A series of short articles is included which report on recent cost-related research including methodological issues.

The report includes a section on facility-based services for people with mental health problems and a number of generic services that are primarily used by people with mental health problems such as psychologists and community psychiatric nurses. Four of the six short articles refer to recent or ongoing work in the field of costing mental health including items on schizophrenia, dementia and reduced list costings.

Ongoing work includes methodological tasks such as developing a model for costing the assessment and care management process. Investigations into local authority and health service overhead costs are in the process of development: outputs from these studies will be used in future reports when the results of the
investigations become available.

The Unit Cost programme has a symbiotic relationship with other research, both within the PSSRU and within other research units. For example, the model of costing case management has some of its roots in discussions during an analysis of an ongoing study of a specialist case management scheme for elderly people with dementia in Lewisham; it will feed into two studies at the National Institute of Social Work, one of which is evaluating community care arrangements for older people with dementia. It will also feed into the study of community care of elderly people in ten local authorities being undertaken by the PSSRU and to work on mapping and evaluation of different models of case management. In turn these studies will generate valuable cost information which can then be fed back into the Unit Costs programme.

Conclusions

Overall, the programme brings together information from regular statistical sources and from research enhancing the value of both, and identifying critical areas where there are gaps in our knowledge concerning costs. It also provides a focus for expertise which can be drawn on within and outside the PSSRU. The aim is to identify important sources of variation in mainstream services and detailed information about innovative approaches to providing care. Comments and suggestions about useful sources of information are always welcome. What has been produced to date is far from perfect but it is hoped that, by an iterative process of revision, the report will become a valuable point of reference on service costs, a critical factor in evaluating community care.

References


New Books

Opening New Doors

An evaluation of community care for people discharged from psychiatric and mental handicap hospitals

Michael Donnelly, Sinead McGilloway, Nicholas Mays & Sarah Perry
Martin Knapp, Shane Kavanagh, Jennifer Beecham, Andrew Fenyo & Jack Astin

Published in 1994 by HMSO, London. 416 pages (paperback, ISBN 0 337 11202 9, £14.95)

The implementation of community care has resulted in a steady decline in the number of people living in psychiatric and mental handicap hospitals. In late 1989, the Department of Health and Social Services (NI) commissioned a programme of inter-related studies — the first of its kind in Northern Ireland — to monitor and evaluate community care for all former long-stay patients discharged from the six psychiatric and three mental handicap hospitals in Northern Ireland between 1987 and 1992.

This book provides a comprehensive and detailed account of the research. It explores the realities of care in the community for adults with mental health problems and learning difficulties and provides valuable insights for developing both the policy and practice of community care.

Care in the Community: Five Years On

Paul Cambridge, Lesley Hayes and Martin Knapp, with Eriko Gould and Andrew Fenyo

Published in 1994 by Arena, Aldershot. 109 pages (paperback, ISBN 1 85742 275 9, £12.95)

What are the long-term outcomes, costs and processes of community care for former long-stay hospital residents? This book looks at more than 200 people with learning difficulties who left hospital in the mid-1980s. Questions addressed include: How successful is the policy of hospital closure? How well have former hospital residents adjusted to their lives in the community? How have community care agencies responded to their needs and preferences?

The Economic Evaluation of Mental Health Care

Edited by Martin Knapp

To be published in summer 1995 by Arena, Aldershot; approximately 230 pages.

An introduction to the principles of economic evaluation, with many illustrations of their application to mental health care policies and practice.

The economic perspective: framework and principles
Martin Knapp

Economic evaluations of mental health care
Shane Kavanagh and Alan Stewart

Collecting and estimating costs
Jennifer Beecham

Costs and outcomes: variations and comparisons
Martin Knapp

Eight years of psychiatric reprovision: an economic evaluation
Angela Hallam, Martin Knapp, Jennifer Beecham and Andrew Fenyo

Elderly people with dementia: costs, effectiveness and balance of care
Shane Kavanagh, Justine Schneider, Martin Knapp, Jennifer Beecham and Ann Netten

Costing the care programme approach
Justine Schneider

Comparative efficiency and equity in community-based care
Jennifer Beecham, Martin Knapp and Caroline Allen

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