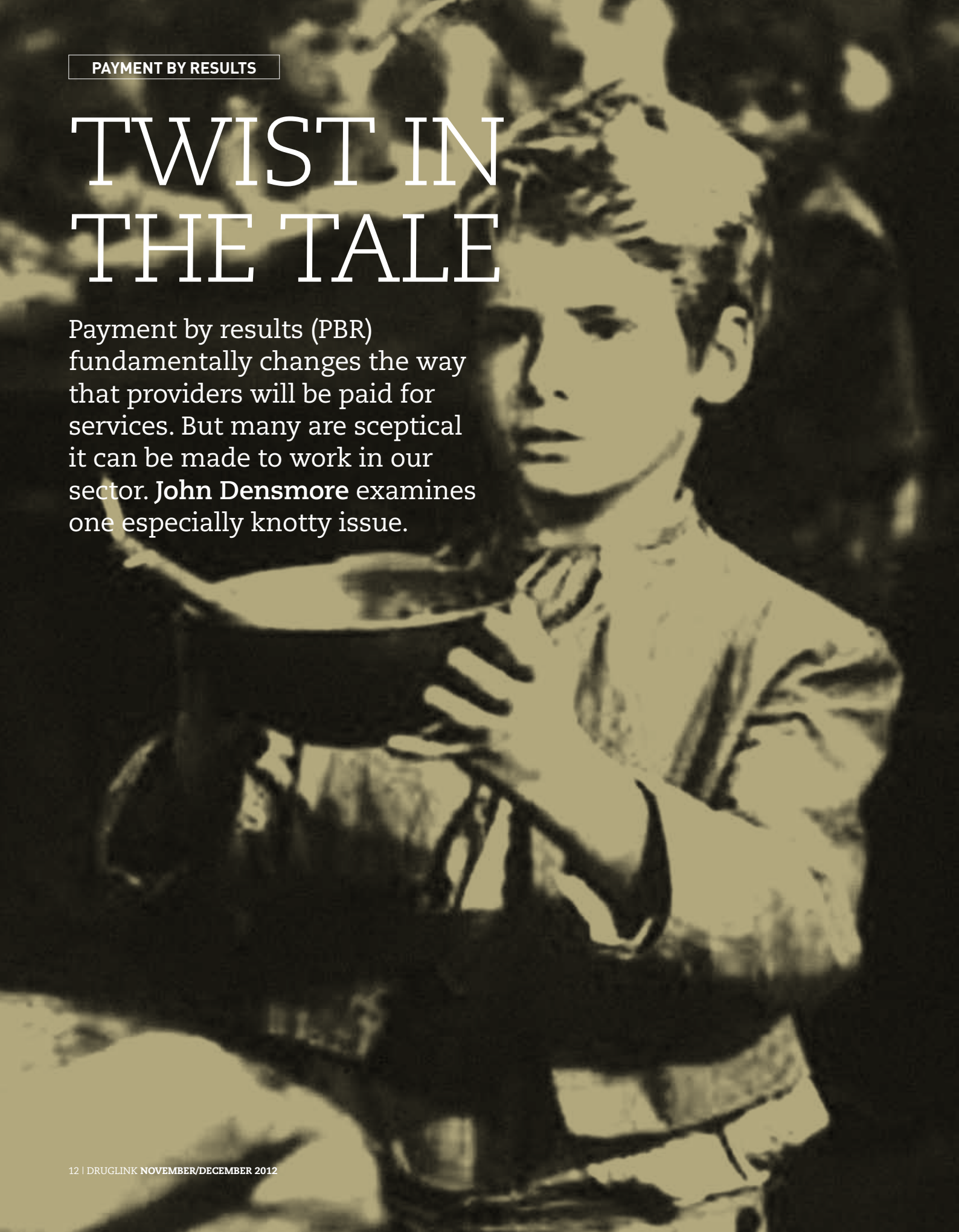
TWIST IN THE TALE

Payment by results (PBR) fundamentally changes the way that providers will be paid for services. But many are sceptical it can be made to work in our sector. **John Densmore** examines one especially knotty issue.



PBR will change the funding of service provision by providing payment for an agreed outcome, such as abstinence, instead of the traditional way which pays upfront for an activity, such as treatment or counselling. The idea is to 'incentivise' service providers into focusing on the results of their interventions and to let market forces sort out who does it best at the best price. How the service provider achieves the result is up to them. The hope is that enterprise and initiative will find innovative ways of achieving outcomes, cutting bureaucracy and costs. PBR could also provide interim payments for milestones along the way to the final outcome, such as drug free urine samples from service users who are on a substitute prescription but who cannot yet claim abstinence from all drugs. The appeal to the coalition government is that PBR seems to tick all the boxes – application of market forces, the transfer of risk to the provider instead of the funder, a promise of efficiency and hoped-for reduction of cost, and even the use of private rather than public money. It looks good on paper but how will it work in practice?

Playing the game

There is general agreement that 'gaming' can undermine any PBR scheme. This is the process whereby providers might play the system for financial advantage. Even those who support PBR appreciate that gaming is inevitable. To prevent or reduce gaming, the Department of Health (DH) set up the independent Gaming Commission on Drug and Alcohol Recovery PBR Pilots in August 2011. They were given a short period to report and had a limited brief "to identify gaming opportunities within the Drug and Alcohol (D&A) pilot schemes, and to recommend how these might be eradicated or minimised". They reported the possibility of "creaming" (deliberately choosing service users who they think are likely to achieve a payment for reaching a target), "parking" (providing a minimal service to those who they think will not achieve a payment) and other methods of gaming. The Commission was not asked to find definitive responses to gaming but they did suggest two principal responses. The first is an independent Local Area Single and Referral Services (LASARS) which will make the initial assessment and refer on to the most appropriate service, which they hope will prevent "creaming" and make a more objective assessment of the complexity of a case (which could extract a higher payment) than is likely to be achieved by the service provider. The second is a robust auditing service within the local area to keep an eye on the claims of service providers in extracting payments.

WHO IS MOST LIKELY TO ACHIEVE PAYMENTS FOR ABSTINENCE QUICKLY – AN OCCASIONAL PROBLEMATIC CANNABIS USER WHO USES ONLY CANNABIS OR AN INJECTING HEROIN USER OF SEVERAL YEARS?

Both of these responses have major problems, some of which have already been identified by the Commission. Will LASARS have the expertise to make an accurate assessment? Often new clients may not tell you everything that is relevant until they think they can trust you. Many new service users come in saying "I've come for a script" and when asked how long they think they will need it, the answer is often optimistic, either from lack of experience in achieving and maintaining abstinence or possibly because they think that is what you want to hear. Without continuing contact with the client, how will LASARS workers learn from their experience?

Auditing will be almost impossible in individual cases where the claim is for abstinence, because of the difficulties and time required to find former service users, abstinent or not, 12 months after the end of treatment. The best that can be done is to audit on a statistical basis. Auditors should certainly become suspicious of claims of increases in abstinence of 15 or 20% in only a year but will have no way to check these claims. In addition, the new LASARS and auditors will be expensive, using money that could be used for service provision.

Defining outcomes

A first attempt at defining outcomes and how they will be achieved was made by the DH in their recent *Recovery Payment by Results Pilots – Final Outcome Definitions*. Trying to be fair and trying to respond to the concerns of treatment providers, the DH devised a system which nevertheless risks being bureaucratic and possibly unworkable. The payment outcomes for the PBR pilots started last year are grouped into three domains:

Domain 1 Free from drug(s) of dependence
Domain 2 Offending
Domain 3 Health and wellbeing outcomes

Domain 1 will have 4 levels. Each level is defined and also has eligibility criteria. All drugs are treated equally – opiates, cocaine, cannabis, alcohol and so forth. This already presents a significant anomaly. Who is most likely to achieve payments for abstinence quickly – an occasional problematic cannabis user who uses only cannabis or an injecting heroin user of several years? It takes no account of "recovery capital", so someone with a good education, no criminal record, a good job and family support will earn the same payment as someone who has a long criminal history, no family, never in regular employment, little education and homeless. No prizes for predicting the client who is most likely to produce the highest payment.

There are two stages within the first domain: abstinence from all presenting substances in any two TOP reviews will receive a payment as will planned exit from the treatment component of the recovery journey. The big financial prize will be for "discharge from treatment successfully (free of drugs) of dependence and does not re-present for treatment or within the criminal justice system (taken onto the DIP/ prison caseload) in the following 12 months". But is the service user really abstinent? Did he go out and score after the last appointment? Was he arrested and jailed in another town the next week and did not return for help for that reason, or maybe he just moved? Has he changed to internet drugs – legal or not? What about alcohol – is he now alcohol dependent? If he is, how do you know? What happens about relapse? Do service users get only one chance to achieve these milestones; how many relapses are they allowed? What about a benzodiazepine prescription from a GP? The questions go on indefinitely, the system becomes more and more complex and more information is required.

Even now drug workers groan under

the weight of recording information. They need to keep up to date with NDTMS (National Drug Treatment Monitoring System) which will become more onerous as more data is added in November this year, and, if they work in the criminal justice sector, CRAMS (Case Recording and Management System). Everyone has to complete TOP forms for each service user, a system which still lacks credibility among many workers.

EVERYONE WILL WANT THE NEW SYSTEM TO WORK – POLITICIANS, FAMILIES, SERVICE USERS, SERVICE PROVIDERS AND COMMISSIONERS. YET THOSE WHO HAVE POWER TO INFLUENCE THE SYSTEM WILL BE UNDER VERY CONSIDERABLE PRESSURE NOT TO ROCK THE BOAT

Cash for questions

Under PBR, treatment agencies will need to wait until their service users have achieved their outcomes before they receive a significant part of their payment. This will be difficult for the interim payments and very difficult for the final abstinence payment – at least 12 months. How will service providers pay their staff during this time? The government is hoping that the financial industry will come to the rescue in the form of Social Impact Bonds (SIBs). These are investments from a financial institution which will 'invest' in a particular service and only get a return if the intervention improves outcomes, leading to lower government spending for that individual over the longer term. Government will pay out only if there are identifiable savings. Most investors in SIBs will want a premium rate of return on their investment, money which might be better used directly by service providers. In these financially difficult times are hedge funds, banks and hard headed investors really willing to put their money into SIBs when even profitable businesses are being starved of funds?

In any event, the notion of PBR is having a hard time. Recently, the finance industry has been criticised by the Financial Services Authority for massive failures and mis-selling of their products as a result of paying bonuses based on results. A4e, a private employment contract agency on payment by results contracts has been accused of fraud by whistleblowers, and "gaming" to maximise payments. Why this same system is now deemed to be the appropriate engine for change in the drug and alcohol service industry is a mystery to me.

Everyone will want the new system to work – politicians, families, service users, service providers and commissioners. Yet those who have power to influence the system will be under very considerable pressure not to rock the boat. Will commissioners, despite their good intentions, want to hear that their systems don't work or that their choice in service providers was a mistake? Will provider agencies be willing to complain about a system which they have recently signed up to? It is hoped that those service providers who have mastered the new system will maximise their payments by providing a better service which makes for better outcomes, but can we be sure that they are not making up the data or engaging in clever gaming? It will be impossible to tell. Politicians will be happy if the new system really does improve services. Some genuinely believe it will. But with the political capital invested in PBR, will they able to backtrack if evidence is produced that it does not work?

POLITICIANS WILL BE HAPPY IF THE NEW SYSTEM REALLY DOES IMPROVE SERVICES. SOME GENUINELY BELIEVE IT WILL. BUT WITH THE POLITICAL CAPITAL INVESTED IN PBR, WILL THEY ABLE TO BACKTRACK IF EVIDENCE IS PRODUCED THAT IT DOES NOT WORK?

While the government is keen for PBR to be rolled out nationally, the localism agenda will mean that local commissioners should have the final say about whether or not to implement it. I have met a few commissioners who are keen but more are sceptical and have said they will see how it works in other areas before they decide.

For those of you who have not already guessed, I'm less than enthusiastic at this development for reasons which I have already stated. However, there is another reason why I think this is a misjudged idea and the best way to explain my reasons can be found in a true story.

Several years ago I was in a supermarket and noticed a man who looked familiar but I couldn't remember his name. He stopped and asked me my name and told me his. He was a former service user I knew from years back and his story demonstrates why payment by results is misconceived. He came to our agency having left a residential rehabilitation treatment programme against advice. He started using heroin again soon after and came to us asking for a methadone prescription. He managed to reduce and was abstinent in about 4 months. I was seeing him frequently at this point and one day he failed to meet me at our normal meeting place. I wrote to him and even went to where he was living but he had gone. By chance he was offered a job in another part of the country and had to leave immediately to take up the offer. Despite a very brief relapse and a short period of heavy drinking (which he managed himself with no treatment), he made himself a new life. He has now been drug- free for 10 years, raising a family, running a business, no longer offending and paying his taxes. So, who should be paid for his success? How about the street agency who first helped him detox and get to the rehab? What about his GP who gave him his first methadone prescription? What about the pharmaceutical company which manufactures methadone? What about the rehab that gave him the confidence that he could achieve abstinence? He acknowledged that they all played a vital part but somehow the payment will be made out to me (why not him?). I treated him last and he ticks all the boxes. So, if the commissioners are reading this please make the cheque out to me.

The author has been a commissioner and provider. He is writing under a pseudonym (name supplied).

So is PBR doomed before it starts or is that an over-pessimistic view?

Write to the Editor at harrys@drugscope.org.uk