

Prime providers and capitated budgets: will they enable new models of care?

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In future, commissioners will have greater scope to develop integrated care pathways where this makes sense, working with a range of local clinicians, and new health and wellbeing boards will promote integration across the NHS, social care and public health. We are encouraging GPs to work with local hospitals to improve care pathways. Clinician-led commissioning will support integrated care and commissioners will have the flexibility they need to be able to bundle services together across a pathway where this makes sense.

(David Nicholson, 2011)

Ideas in good currency today

- › Prime provider/lead provider/prime vendor type models of care
- › Commissioning for outcomes of care e.g. COBIC initiative
- › Alliance contracting
- › Integrated care following the listening exercise and with Norman Lamb's interest
- › Year of care tariff

evidence for
better health care

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Commissioning integrated care in a liberated NHS

Research report
Chris Ham, Judith Smith and Elizabeth Eastmore

September 2011

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**Ideas that change
health care**

Case studies of commissioning integrated care

- › **Birmingham North and East PCT** – commissioning integrated care for people nearing the end of life
- › **Milton Keynes PCT** – seeking to contract an ‘accountable care organisation’ for a whole programme of care
- › **Tower Hamlets PCT** – commissioning outcome-based diabetes care from networks of providers
- › **Smethwick Pathfinder** – a group of GP practices holding a capitated budget for managing the care of people with long-term conditions

Case studies of commissioning integrated care (2)

- › **Cumbria PCT and practice-based commissioning** – commissioning integrated diabetes care across a county, using a new specialist care organisation
- › **Knowsley PCT** – contracting with a lead specialist provider to deliver the full range of cardiovascular care for a population with major health inequalities
- › **Somerset PCT** – commissioning an integrated COPD service from a partnership of BUPA and a company formed of local GPs
- › **West Kent PCT** – commissioning a social enterprise to deliver integrated out-of-hours primary care and emergency primary care, based in the hospital A&E

Penine MSK Partnership: a case study

- › Company limited by shares holding SPMS contract
- › Partnership delivers integrated MSK services – primary, community and secondary care
- › Funded via a ‘programme budget’ and not through PbR
- › Developed over 10 years by innovative GP specialist and nurse consultant in rheumatology

The lessons

- › How to define the scope of the service to be commissioned?
- › All care for the whole population on large (county wide) or small (locality) scale
- › Care for people with a specific disease (e.g. Diabetes) or condition (e.g. Dementia)
- › How easy is it to draw boundaries and deal with cost shifting and risk shifting?

Lessons (2)

- › How well placed are providers to act as prime providers?
- › What proportion of care can they deliver directly?
- › What proportion of care will they sub-contract to other providers?
- › Do the providers in the supply chain have a track record of working together?

Lessons (3)

- › How easy is it to define the budget for the service to be commissioned?
- › What are the risk sharing arrangements between commissioners and providers?
- › What incentives can be built into contracts to ensure high quality is delivered?
- › How will prime providers pay and incentivise providers with whom they subcontract?

Lessons (4)

- › In the new NHS, which commissioners need to be involved?
- › Does a CCG need to act with other CCGs and the NHS CB?
- › Do local authorities need to be involved too especially but not only re social care commissioning?
- › What are the means by which commissioners collaborate if this is necessary?

Lessons (5)

- › The fundamental challenge of information asymmetry in health care
- › Clinically led commissioners cannot hope to negotiate on equal terms with providers across the full spectrum of care
- › Outcome based contracts are the way forward where outcomes can be defined
- › The process of contracting matters e.g. the value of competitive dialogue

Lessons (6)

- › Competition and integration are not necessarily in conflict
- › Competition *in* the market is different from competition *for* the market
- › Stephen Dorrell talks about 'competition for solutions'
- › There are lessons from other sectors including supply chains

Where service integration and continuity of care is important to secure the best clinical outcomes, patient experience and value for money (for example, in end of life care), the intention is that commissioners will be able to go to competitive tender and offer the service to one provider or 'prime contractor'. In this model, patients would still have choice of treatment, setting or lead clinician, and potentially of provider for certain services within the pathway.

(DH, 2011)

Integration: What will the policy framework and the law allow

NONE of the following should stop you commissioning or delivering effective innovative integrated care:

- DH or NHS CB policy
- Procurement law
- Competition law
- Monitor – as economic regulator
- NHS Standard Contract

As long as you are driven by what's best for patients, are clear about outcomes and follow fair, transparent, compliant processes

“Seek forgiveness, not permission”

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Ideas that change
health care

Payment by Results

How can payment
systems help to
deliver better care?

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health care

Options for paying for care

- › PbR
- › Bundled payments
- › Episode payments
- › Year of care tariff
- › Programme budgets
- › Capitated budgets
- › Quality incentives

International experience

- › High performing integrated systems use capitated budgets for almost all care
- › Their main focus is on population based budgets not disease or condition based budgets
- › They also specify the quality/outcomes they expect to be delivered
- › Systems like Kaiser Permanente are not over-reliant on payment methods and financial incentives – other tools are also important

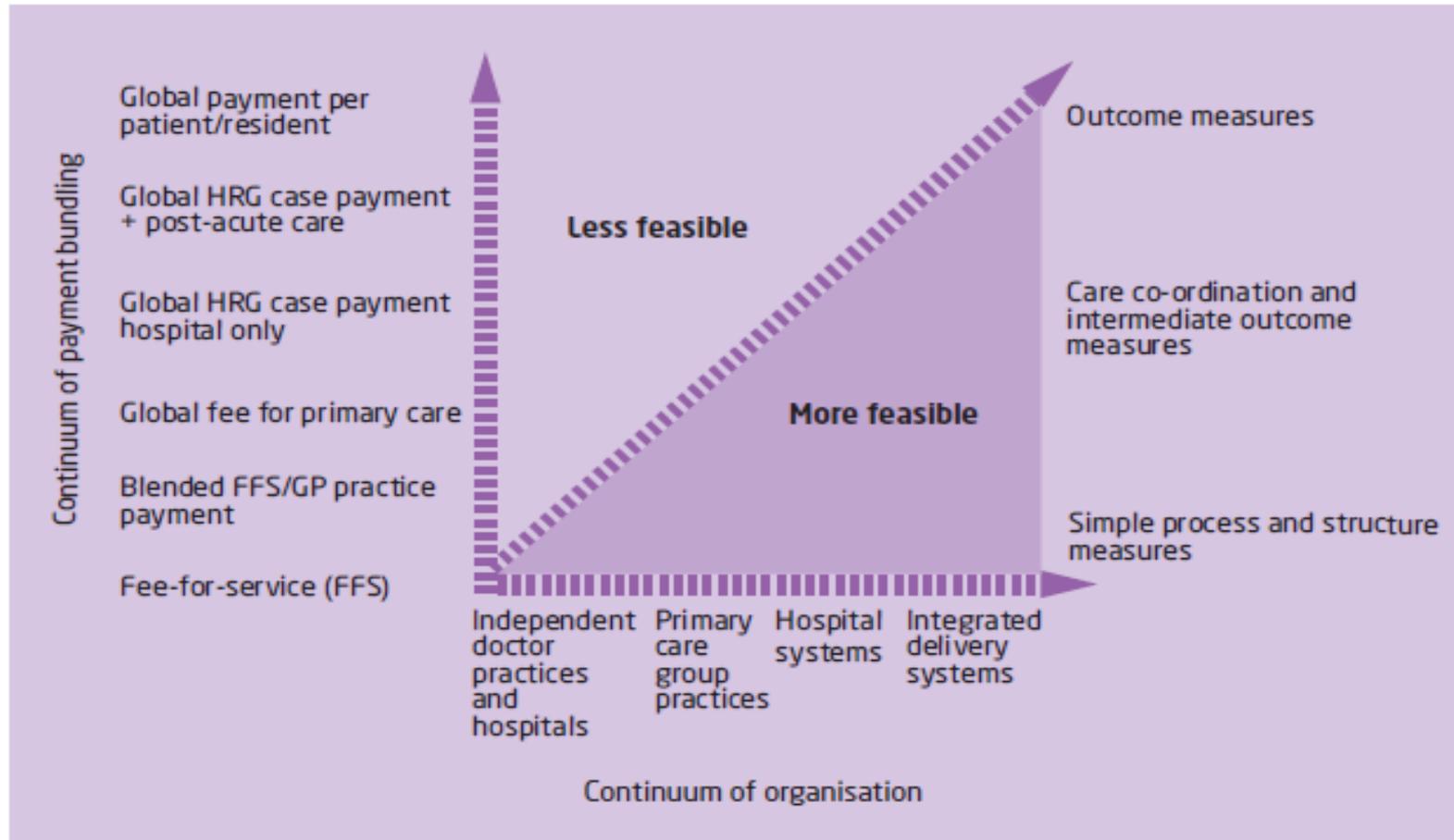
The wrong kind of integrated care

- › Small scale
- › Disease based
- › Organisational (not clinical or service integration)
- › Integrated care that creates unresponsive monopolies

Implications for providers

- › Capitated budgets make heavy demands on providers
- › Providers need to operate on the appropriate scale and to have the right capabilities
- › The more comprehensive the scope of capitated budgets, the more important this becomes
- › Used well, payment reform can drive change and innovation among providers

Figure 4 Organisation and payment methods



Source: Adapted from Commonwealth Fund (2009) (p 35, Exhibit 18)

Finally

- › This is important, innovative and hard work
- › Don't underestimate the time it takes
- › Commissioners have a vital role in developing integrated care
- › Prime providers and capitated budgets can contribute but the devil is in the detail

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