Can payment mechanisms promote integrated care?

Economist and GGI Faculty member Jacque Mallender argues that targeted use of provider payment mechanisms can help to deliver improved population health and integrated care.

Guest blog by Jacque Mallender

Can payment mechanisms be used to promote integrated care? The short answer to this question is yes. Payment mechanisms that promote integrated care are necessary for the success of integrated care systems (ICSs) across England.

The longer answer is that success will depend on whether these payment mechanisms are aligned with the wider financing system, and whether there is sufficient local flexibility for clever strategic purchasing so resources can be targeted to where they are really needed.

I am not alone in thinking payment mechanisms are an important enabler of change. The adoption of the Framework on Integrated, People-Centred Health Services (IPCHS) by the 69th World Health Assembly in 2016 demonstrates the growing global consensus that integrated care and people-centred care can deliver significant benefits across the world. The Framework clearly establishes well-aligned finance and payment systems as one of the key strategies in the development of an enabling environment for IPCHS.

Last November, GGI asked me to share my thoughts on the potential role of provider payment mechanisms in the successful development of the ICSs in England. COVID-19 had shone a harsh light on some of our payment-by-results payment mechanisms, which were already acknowledged as being not fit-for-purpose for the challenges we now face: improving population health, tackling health inequalities, and improving the efficient coordination of services. Indeed, the previous financial regime was rapidly retired from service within weeks of the start of the first COVID-19 wave, with provider funding since then being protected through rolling block budgets.

More flexible payment mechanisms

I suggested back in November that moving forward, we have an opportunity to give more flexibility to the ICS to select provider payment mechanisms to best meet local needs and priorities.

Starting with a shared vision of what needs to improve and how, at the level place, the ICS partners can then use different payment mechanisms to drive these improvements. Used well, payment mechanisms can help to address disparities in need, invest in new services, incentivise capacity building, incentivise expanded or reorientation of service delivery, reward quality, and/or reward outcomes.

By selecting a mix of capitation, block contract, fee-for-service, activity-based and performance or outcome-based payments, it is possible to balance the need to provide the necessary financial stability for providers, with the need also to fund innovation to enable changes which result in improvements to population health and integrated care. In the near term there will also be a need to fund strategies to tackle the long treatment backlog caused by COVID-19.

Locally blended approach

I argued that as they mature, local flexibility will be needed for ICSs to pick and mix and design a local approach to payment mechanisms to solve local problems and fit local requirements: a locally developed blended approach aligned to achieving system goals.

In line with the NHSE plans, this local flexibility should be done within a national payment mechanisms framework that enables some standardisation of definitions and default mechanisms, if only to drive inter-ICS funding flows.

This is all very well and good and really my thinking on payment mechanisms and their use hasn't changed in the last six months. However, talking to health system leaders, it is clear that even with this local flexibility, the impact of well-aligned payment mechanisms is likely to be marginal in the context of the more fundamental challenges facing health finance in England.

Now is the time to consider whether:

- **the way we allocate resources to other government departments and through local government does much in terms of addressing disparities in the wider social determinants of health.** As we know, differences in social and environmental factors such as employment, housing or transport are thought to account for 40-50% of variation in health outcomes – a greater influence than provider payment mechanisms. All this in a declining budgetary environment. Local authorities have faced dramatic cuts to their budgets over the last decade (60p in every £1) and whilst they have been supported during the pandemic, the future continues to look uncertain.
- **we are spending anywhere near enough on prevention**. We seem to compare well with OECD and EU countries but is anyone really doing enough? Recent estimates from the Centre for Health Economics at York found a return of 15:1 – yes for every £1 spent you get £15 in terms of value! They went on to conclude that expenditure on public health interventions is between three and four times more productive than health treatment expenditure. Yet prevention only accounts for 5% of health spending .
- **we will ever sort out social care funding.** The Health Foundation estimates a £14.4bn funding gap if we are to meet demand and improve quality and access to services.
- **the health budget itself is sufficien**t. We spend about 10% of our GDP on healthcare which compares well with the OECD average of 8%. But again, are we doing enough? This is investment and has the potential to actually power economic growth. Estimates suggest a GDP growth impact of 1.77:1 from investment in health systems for developed countries. Yet still we think of it from the perspective of cost rather than value.

Shift from treatment to prevention?

I often hear people say, when presented with the evidence, 'given the return on investment from prevention, couldn't we solve the problem by simply shifting money from treatment to prevention?' Yes of course we can, but there is a time dimension to this. Investment in prevention deals with a problem we will face tomorrow, while spending on treatment deals with a problem we are facing today. If the money for treatment is insufficient there will never be sufficient headroom to shift resources to prevention.

We already have seen how the COVID-19 response has impacted on less urgent treatments. If we had invested more in prevention a decade ago, we would almost certainly need relatively less spending on treatment now. But we didn't.

We can't – and shouldn't – expect these challenges to be passed down to the ICSs just by passing down the budgets, setting tough population health goals, and devolving the problem. While there are a number of commendable, locally driven innovative projects involving pooling funding to enable investment in housing, or transport projects or investment in transitional social support services, I would argue that the scale of the required investment in prevention is way too big to expect it to be financed by an ICS transferring resources away from health treatment in real time.

At-scale prevention programmes can achieve a relative shift in demand and thereby reduce the pressure on health services. But the impact is likely to be to dampen longer term growth in demand for treatment, not reverse it. Moreover, at least for the next two-to-three years it will be impossible to deliver the required shift when providers will need funding to catch up with the treatment backlog from COVID-19.

What can ICSs do?

So, what then will be within the gift of the ICS given this rather challenging context? I think ICSs can achieve a considerable amount in terms of aligning financing and payment mechanisms to ensure they are making the best use of the budgets they have and the structural constraints they face. ICS leaders will achieve an enormous amount if they can:

- get to grips with what is currently being spent by geography, programme, sector and how much things actually cost to change, and over what timescale
- engage with citizens, communities and patients to analyse health challenges, health needs, and local priorities
- develop a shared system-wide plan to address these priorities which can guide 'strategic purchasing' across the system in agreement with affected providers
- make sure the plan is backed up by realistic and achievable quality and financial targets set for providers and groups of providers
- ensure that providers use their role as big local employers and, as anchor institutions, to themselves generate economic benefit locally including prevention and the wider determinants of health.

Only then should consideration be given to the use of different payment mechanisms to make sure the money is in the right place, incentives are created where needed, and achieved performance is rewarded in line with the priorities set out in the plan.

I do think targeted use of provider payment mechanisms provides a necessary tool for delivering improved population health and integrated care. We should at least be able to use them to try to improve efficiency and effectiveness and hence show, with honesty, what can be achieved within existing budgets.

But their impact can only be marginal if we don't address the larger health financing challenges as well. And finally, let's not forget, by no means are they sufficient to enable successful development of population health and integrated care.

As the IPCHS Framework tells us, an enabling environment also requires leadership, investment in workforce transformation and digital health and health regulations which reduce rather than increase barriers to change.