ICS – driving value by the effective use of payment mechanisms

GGI webinar

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Briefing paper to prompt discussion

The new integrated care systems (ICSs) being established across England have ambitious goals to improve health and wellbeing outcomes and to oversee the delivery of properly joined-up health and care services.

Realising the value promise of integrated care systems is probably the biggest transformation challenge the NHS in England has faced since the publication of Working for Patients in 1991. This initiated a radical governance redesign; it saw the creation of the 'internal market', which has characterised the operating model of the NHS in England for the last 30 years. The creation of payers (to become known as commissioning) and independent providers of care for hospital and community health services was designed to incentivise efficiency improvements, decentralise, increase provider responsiveness, and improve accountability, management information and 'customer service'.[1]

We have seen many reorganisations of the internal market since 1991 as the design has been adjusted to respond to opportunities and challenges. Change fatigue means there is now little appetite for further reorganisation. However, there is a need for radical change in the way the system collaborates if we are to deliver solutions to the deep and long-standing system challenges that were arguably exacerbated by the internal market.

1. Alain C Enthoven, "Internal Market: Reform of the British National Health Service" Health Affairs (1991)

On top of responding to the unprecedented COVID-19 pandemic, there is much work to be done to improve health, reduce health inequalities, mend fragmented service pathways, and improve system efficiency and effectiveness.

Despite recent funding settlements, there is and will remain little financial headroom, even at a system level, to fund the changes needed to deliver on these goals. A key step on this journey will therefore be to think again about how funding should flow through the system and ultimately how we ensure money is available at the front line to pay for the right resources in the right place at the right time.

Moving away from tariff-based payments

In recent months, turbocharged by COVID-19 pressures, we have seen a dramatic move away from the tariff-based payment mechanisms that have characterised the hospital and community healthcare internal market for the last 17 years.

Tariff-based payments were initially introduced to drive volume growth, specifically as a means of dealing with the prevailing problems of big waiting lists and long waiting times for planned surgery. However, it became clear that 'payment by results' might result in an over-reliance on hospital care, did little to reward quality and outcomes, and hindered investment in more efficient and effective prevention programmes and community based care. This resulted in a wider and deeper and increasingly sophisticated system of payment models and corrections to incentivize performance in ever-more complex directions.

Since March 2020 that has all gone, as has the associated immense administrative burden. The pandemic has seen an accelerated move to financial performance being monitored at system level, with commissioning budgets aggregated for the ICS. For hospital and community health care providers, there has been an immediate move to block contracts based on rolling costs.

NHS England is shortly due to announce the results of a consultation on payment models for the coming cycle and it is expected to endorse aligned incentive contracts for next year, which combine a fixed, variable and risk share element supported by an appropriately blended payment system.

The transition to a new payment system for ICS has happened faster than anyone anticipated at the start of the year – and there will be no going back.

ICSs should not just be interested in funding flows for hospital and community health services; their goals are also linked to the role and quality of primary care, public health and related expenditure, and social care funding. Indeed, there has been inadequate investment in prevention, inequity of access for vulnerable populations, and fragmented care pathways. These are potentially being exacerbated by a lack of alignment between funding flows for hospital and community health services and those partner agencies and providers who play a pivotal role in achieving population health goals and integrated health and care delivery.

There remains much discussion about a longer-term move towards a population health approach supported by value-based payment models, but the search for the payment model nirvana continues.

So how are payment mechanisms likely to develop over the coming decade and can we start thinking now about whether and how we can better use them to drive value locally?

In this webinar we will take a world view of provider payment mechanisms and explore how they are being seen as enabling tools for universal health coverage. We will look to see what lessons can be used in the design of a new payment model(s) for ICSs.

Key questions to address include:

i. What drives the choice of one payment mechanism over another?

ii. How do we ensure the right allocation of funds to support place-based care?

iii. Can we better align funding flows across the wider network of agencies and providers?

iv. We have been trying to get payment mechanisms right for 29 years – what is going to be different this time?

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