New approaches to paying and contracting for health care

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Cargo cults
The culprits
The new public management

• Distancing politicians from delivery of public services

• A clear separation between state purchasers and provider organisations

• A focus on defining high level outcomes desired from services

• Competitive tendering for the best providers

• Greater freedom for providers to decide how to deliver contract requirements

• Financial incentives to reward good performance or punish poor performance
The only problem is that it never worked ....

• The Conservative government did not come close to creating and unleashing market forces”

• “The desired long run benefit to patients was too remote and diffused to be an effective force for change.”

• ‘Creating a quasi-market that improves performance in a social service prone to market failure is a very complex matter, more complex than the government of the time thought, more complex than I had realised.’
- £700 million contract to deliver bundle of services for adults and older people
- 14% of contract dependent on performance against high level KPIs. Requirement to deliver 10% efficiencies.
- Uncertainty about baseline costs, current performance and current and future population needs
- Partnership of two FTs ‘low balled’ to win the contract
- Sought unsuccessfully to renegotiate budget on contract award.
- Terminated after five months. Transaction and termination costs in tens of millions.
Uniting Care Contract (2)

• ‘Gross irresponsibility’
• ‘An astonishing array of errors’
• Stronger governance
• More rigorous scrutiny
• More experienced staff
• Better commercial advice
• More careful upfront service design
• Better cost information
• Appropriate contract terms
But why did the contract really fail?

- Profound uncertainty about future needs of the population, what services they would need in future, how to measure success

- Inability to make market mechanisms such as tendering work as they are supposed to in private markets

- Inability to actually apply the incentives designed to improve performance when providers run into difficulty

- Inability to really transfer risk and reward from commissioners to providers in monopolistic public systems

- Astonishing transaction costs, distraction costs and damage to relationships in local systems
Cognitive dissonance

New world realities

• Merger of NHS England and NHS Improvement
• Increasing state control of Foundation Trusts
• Direct support for struggling providers
• Abandoning the failure regime
• Reviewing the role of competition and merger rules

Old world thinking

• Integrated care contracts modelled on US ACO contracts
• Development of new financial incentive schemes
• Complex risk share agreements based on commercial contracts
• New forms of complex payment schemes
Canterbury, New Zealand (1)

- Investment in shared vision
- ‘One system, one budget’
- A commitment to partnership working and benefits sharing
- Direct investment in leadership and improvement capability in providers
- Direct support for cross-cutting improvement projects
- Investment in new services
- Investment in infrastructure to measure performance
Canterbury, New Zealand (2)

- Improved joint working between GPs and hospitals
- Shift of resources into primary and community care
- Improved prevention and earlier intervention in community
- Reduction in volumes of patients for hospital services
- Shorter hospital stays when admission is needed
Bolton’s ‘aligned incentives’ contract

• From 2014 to 2015, CCG and hospital trust sent each other more than 300 formal letters on contract disputes.

• In 2016, agreed a new set of principles for collaborative working across the health system.

• Moved from arm’s length contracting to a commitment to working together to ensure system sustainability.

• Replaced financial incentives with global budgets and simple arrangements for sharing savings from improvement.
A manifesto

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<td>Market mechanisms</td>
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What should commissioners do in the new system?

- A convenor and consensus builder in a complex system
- Helping to develop a powerful shared vision and principles for the system
- Leading discussions on priorities, where to focus resources, new models of care, how to cope with contingencies and overspends
- Looking across the system for opportunities for improvement. Developing the data and analytics capability to do so
- Making direct investments in the leadership, culture and improvement capability of the system
- Building meaningful links and accountability to local communities
Questions for discussion and feedback to plenary

• What is your thinking on the changing roles of commissioners and providers in your system?

• Do you see a continued role for financial incentives and market mechanisms to motivate performance?

• What other changes do you envisage to how commissioners and providers work together?