Reimbursement models: Lessons from the UK and the case for change

Presentation to 18th Annual BHF conference
Agenda

- Introduction
- Overview of reimbursement models and evolution of reimbursement in the NHS in England
- The case for change – diabetes care example
- The way forward – alternative reimbursement models
Quick introduction to Victoria Barr

- Economist and Senior Director at FTI Consulting
- Deputy Director of Pricing at Monitor, healthcare sector regulator in England (now NHS Improvement) – 2011-2013
  - Implemented new regulatory regime following Health and Social Care Act 2012
  - Developed 2014-15 National Tariff (payment rules for NHS services, including 1500 nationally mandated prices for hospital episodes)
- Worked with funder organisations to develop alternative reimbursement models to support the delivery of ‘value’-based healthcare – 2013-2016
  - These contracts were designed to create the right incentives for healthcare providers – to improve outcomes for patients as cost efficiently as possible
- Moved to South Africa in 2016 to establish FTI’s Economic Consulting practice in Southern Africa

Reimbursement models:
- Lessons from the UK and the case for change

Introduction
- Overview of reimbursement models and evolution of NHS reimbursement
- Case for change: diabetes care example
- Way forward: alternative reimbursement models
Very quick introduction to the UK’s National Health Service – Part 1

- The NHS provides healthcare which is free at the point of use for everyone in the UK, and funded by taxpayers.
- As patients do not pay to use the system, there must be some means of organising the flow of taxpayers’ money to healthcare services used by patients (e.g. hospitals).
- The NHS in England is structured into “commissioners” (funders) and “providers” (sellers) of healthcare.
- Commissioners act as agents for patients (and taxpayers) to purchase care on their behalf from providers (e.g. GPs, hospitals, pharmacies etc.).

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**Clinical Commissioning Groups (CCGs)**

- Funds allocated from central pot using formula
- C.210 CCGs in England
- Commissioner contracts with healthcare providers to deliver healthcare to local community
- Providers compete to provide services to Commissioner
- Providers can (theoretically) be NHS hospitals or private providers

**Way forward:** alternative reimbursement models

**Introduction**

- Overview of reimbursement models and evolution of NHS reimbursement
- Case for change: diabetes care example
- Way forward: alternative reimbursement models
Very quick introduction to the UK’s National Health Service – Part 2

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Introduction
Overview of reimbursement models and evolution of NHS reimbursement
Case for change: diabetes care example
Way forward: alternative reimbursement models

HM Treasury
- £107bn
- R1.82 trillion

Department of Health
- £90bn

NHS England
- £10bn
- £58bn
- £14bn
- £8bn

Specialist Commissioning (part of NHS England)
- £10bn

Clinical Commissioning Groups
- £38bn

Primary Care (GPs, dentists, opticians, pharmacy)
- £9bn

Prescriptions
- £9bn

Acute care (hospitals)
- £12bn

Mental Health

Community Health

Ambulances
There are many different reimbursement models, and no one approach is perfect – all have advantages & disadvantages

<table>
<thead>
<tr>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td><strong>Global budget</strong></td>
<td>Administrative simplicity</td>
<td>No incentive to increase activity</td>
</tr>
<tr>
<td>Lump sum payment for specific service or groups of services; does not vary by activity or no. of patients</td>
<td>Offers commissioner control over expenditure</td>
<td>No financial incentive to improve quality</td>
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<tr>
<td><strong>Fee for episode</strong></td>
<td>With national tariffs, fee for service payments incentivise cost efficiencies, as providers benefit from difference between tariff and actual cost incurred</td>
<td>No incentive to improve quality (unless combined with choice)</td>
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<tr>
<td>Activity-based payment per patient based on groups of treatments which use similar amounts of resources</td>
<td>Incentivises activity</td>
<td>Does not incentivise most cost effective choice of care &amp; setting</td>
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<tr>
<td><strong>Fee for service</strong></td>
<td>Incentivises fullest possible care for patients</td>
<td>Creates potential incentive for unnecessary activity</td>
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<tr>
<td>Activity-based payment per service performed (e.g. for every x-ray, diagnostic test, surgery, bed day)</td>
<td></td>
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<tr>
<td><strong>Global fee</strong></td>
<td>Could incentivise more cost effective care provision</td>
<td>Initial definition of pathways is resource intensive</td>
</tr>
<tr>
<td>Single payment to cover an entire episode/pathway of care.</td>
<td>Could incentivise quality, depending on payment structure</td>
<td>Relatively untested</td>
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<td><strong>Capitation/Year of Care</strong></td>
<td>Potentially better at incentivising lower cost, integrated care across settings, e.g. for patients with long-term conditions.</td>
<td>Set up is resource intensive</td>
</tr>
<tr>
<td>Payment for multiple elements of a patient's treatment over a period</td>
<td></td>
<td>Relatively untested</td>
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A (very) brief history of NHS reimbursement

- Evolution of reimbursement has been driven by specific challenges facing the NHS at different times

### Issues
- Long waiting lists for elective treatment
- Emphasis on volume of activity, not quality
- Lack of investment in pro-active care for long-term conditions
- Measuring quality/outcomes is challenging

### New reimbursement models are relatively untested

### Way forward: alternative reimbursement models

### Case for change: diabetes care example

### Introduction

### Overview of reimbursement models and evolution of NHS reimbursement

### Payment model

### Global budget

### Fee for episode

### 2004

We illustrate the shortcomings of fee for episode in the context of long-term conditions with a diabetes example on the following slides.
Current approach to contracting in healthcare in England (and South Africa) creates unhelpful financial incentives...

Diabetes pathway example

- **Patient outcomes**
  - Better for patients
  - Worse for patients
  - Diagnosis
  - Glucose management
  - Diabetes education
  - Podiatry
  - Amputation
  - Stroke care

- **Cost of healthcare**
  - Cheaper
  - More expensive

- **Care setting**
  - Primary care
  - Community care
  - Hospital care
  - GP contract
  - Global budget
  - Fee for episode

- **Incentive**
  - Reduce activity
  - Reduce activity
  - Increase activity

- **Implication**
  - Primary and community care incentivised to **push activity to acute care**...
  - **...acute care** incentivised to **take it**

- **Potential result**
  - Higher costs
  - Worse outcomes for patients

**NB:** Pathway is indicative and incomplete
...but we can change contract approach to directly address these problems and incentivise earlier investment in care

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- **Care setting**
  - Primary care
  - Community care
  - Hospital care

- **Contract type**
  - Global budget

- **Incentive**
  - Reduce more costly activity

- **Outcomes component**
  - Also need to reward outcomes to ensure providers’ incentives are always aligned with patients’ interests...

**Implication**
- Provider incentivised to work out **most efficient use of resources** along pathway;
- e.g. **invest in care earlier** (which is generally cheaper) to prevent more costly care later

**Potential result**
- Lowers costs
- Improves patient outcomes

NB: Pathway is indicative and incomplete
There are three high-level approaches for implementing more value-based reimbursement models

- **Option 1:** Global fees/bundled pathways – more broadly defined version of fee for episode, with some quality or outcomes metrics/payment

- **Option 2:** Value-based contracts for certain conditions, alongside conventional contracting

- **Option 3:** Full population segmentation with value-based, capitated contracts for each population cohort
Alternative reimbursement models – it can be done!

- We have designed value-based diabetes contracts for a number of funder organisations in the UK, including Liverpool Clinical Commissioning Group and Camden Clinical Commissioning Group.

- We have also developed a capitated, ‘year-of-care’ contract for elderly care for West Essex Clinical Commissioning Group.

- Our approach involves working through all the issues in a collaborative way, with clinical and financial representatives from both the funder and provider organisations.

- More on this subject at the discussion tomorrow on value-based purchasing...

Please come and speak to me afterwards if you would like to find out more, or e-mail me at victoria.barr@fticonsulting.com
Critical Thinking at the Critical Time™