How can the NHS payment system do more for patients?

I. I write with regard to Monitor and NHS England’s discussion paper on designing a payment system for NHS services for the long term.

II. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

III. We gratefully acknowledge the contributions of the RCGP Centre for Commissioning, RCGP Clinical Champions and RCGP Council members in formulating this response.

Summary

- The RCGP welcomes the opportunity to comment on this discussion paper and looks forward to engaging further with Monitor/NHS England as it develops a long-term strategy for the payment system.
• We welcome the ambition to redesign the payment system in the interests of patients. We strongly agree that the Payment by Results (PbR) approach does not promote the best value service design for patients (p.9). Indeed, our 2011 policy report on the integration of care\(^1\) identified an urgent need to review the PbR system in England, in order to find ways of strengthening incentives to provide high-quality, integrated care. This report, which was developed through broad consultation with the RCGP’s members, found that the PbR system is one of the most important barriers to integration and runs counter to the provision of integrated care in the following ways:

  o Payment is structured around single episodes of care, discouraging the development of integrated services around long term conditions and care pathways;

  o Reimbursement is based on activity (and to a certain extent quality), rather than health outcomes;

  o By making the income of secondary care providers dependent on the volume of patients they treat, it pits their interests against those of commissioners and undermines efforts to provide more services in the community;

  o There is also anecdotal evidence of specialists being told not to undertake work that is not remunerated under Payment by Results, such as undertaking telephone consultations with GPs and helping to establish community based clinics.

• We support the overarching objective for the payment system to reimburse outcomes, rather than activity. However, we would draw attention to the challenges of both definition and measurement in implementing such an approach, including the identification of usable metrics and the availability of data (please see Q1(a) below). Careful thought is also needed to avoid incentives that encourage providers to ‘cherry pick’ patients whose outcomes are likely to be better (and who will therefore be more profitable).

• As part of an integrated, ‘whole person’ approach, we strongly believe that financial mechanisms must be found to encourage acute providers to provide specialist support to

GPs and to work alongside them to move more services out of hospital and into primary care and the community. We would also like to see further emphasis on the need to create new incentives to embed care planning and coordination (p. 10). To this end, we suggest that research is needed to develop improved measures of the patient experience and the quality of consultations, as well as the outcomes of care planning.

- We propose that bundled or ‘year of care’ payments for costed patient pathways may provide appropriate funding models for some (but not all) patients with long term conditions. However, further research is urgently needed to identify ways in which payments can be developed that promote integrated care for people with multi-morbidity, such as the development of capitated budgets that cover the holistic care needs of an individual (rather than disease or condition based budgets) (please see paragraphs 9 - 10 below).

- We recognise the inevitability of trade-offs between different competing priorities (p. 12) and would caution against a ‘one size fits all’ approach. To this end, we would strongly support a system that allows flexibility and a range of payment approaches, with as much ownership and autonomy at a local level as possible.

- In the interests of encouraging an integrated approach to care, we urge Monitor/NHS England to consider the ways in which different payment systems - such as the Quality and Outcomes Framework (QOF) payment system for general practice, payments for community services and social care - relate to one another.

- We note that all too often clinical and payment/contract discussions take place entirely separately. We do not see how the NHS can be clinically led unless there is much greater alignment between clinical service redesign and the payment systems that will underpin these services and clinical pathways.

- Finally, our comments on this discussion paper should be viewed in the context of our response to Monitor on their draft guidance on the Procurement, Patient Choice and Competition Regulations. It is generally recognised that transformational change is needed to ensure the future sustainability of our health and social care system. We are concerned that a presumption that services will be put out to tender unless exceptional circumstances apply will make it even more difficult to drive transformational change towards integrated care in the community, even if it is supported by different payment structures. To this end, we suggest that Monitor explores how payment systems, competition regimes and contractual mechanisms can be aligned to support a sustainable, high value health and social care system.
Detailed response

Q1. How do we make sure that the payment system delivers for patients? Are these the right objectives? What is missing?

a. To reimburse outcomes for patients rather than treatments or inputs:

1. We support the overarching objective for the payment system to reimburse outcomes, rather than treatments or inputs. Two major challenges to implementing this approach lie in defining what constitutes a good outcome, and how to measure this. For example, there is a need to consider to what extent outcomes will be determined locally or nationally, especially where outcomes may be influenced by socio-economic factors.

2. All outcomes measures must be both evidence-based and designed with patients at their centre, so that metrics record outcomes that are most important to patients. We are concerned that in many cases the data needed to support an outcomes based approach is simply not yet available. Research and investment is urgently needed to develop systematic tools to gather data, including costing data and quality of patient reported outcomes [PROMs], that is both routinely collectable and forms part of an efficient feedback loop to clinicians.

3. We suggest that the Quality and Outcomes Framework (QOF) payment system for general practice may provide a useful reference model when designing an outcomes based approach for the wider health system. Although the QOF is far from perfect – it is often criticised for including too many measures that incentivise processes rather than outcomes – it nevertheless contains a number of useful, evidence-based outcomes indicators, such as the percentage of diabetic patients with well controlled blood sugar.

4. There is a significant risk that an outcomes based approach will have the adverse effect of incentivising providers to ‘cherry pick’ patients whose outcomes are likely to be better (and who will therefore be more profitable) – for example, patients who are more engaged in improving their own health, or who suffer from fewer multi-morbidities. Thought must be given to minimising the unintended consequences of new outcomes based payment systems.
5. Retrospective outcomes based payments, whilst desirable, may restrict the ability of small voluntary sector organisations to enter the market, unless ways can be found to support them. Similarly, sustainable outcomes may take some time to be delivered; this could lead to providers requesting a higher base payment.

b. To promote the long term, sustainable well-being of the whole person:

6. We strongly support the aim to promote the long term, sustainable well-being of the whole person.

7. As outlined above, we believe that financial mechanisms must be identified to move more services out of hospital and into primary care and the community. The NHS will increasingly need to provide care that is integrated both vertically (primary/secondary care) and horizontally (social services/community/primary care) in order to meet the challenges of an ageing population and a rise in multi-morbidity - and the payment system should reflect this new structure.

8. In the interests of encouraging an integrated approach to care, we urge Monitor/NHS England to consider the ways in which different payment systems - such as the QOF payment system for general practice, payments for community services and social care - relate to one another.

9. Bundled or ‘year of care’ payments for costed patient pathways may offer appropriate funding models for some (but not all) patients with long term conditions. This approach would need to be underpinned by significant service level redesign of care pathways, with pilot programmes and research needed to define packages of care, gather the costing data necessary to define pathway budgets and identify clear performance markers to drive improvements.

10. It is vital to recognise that, while the redesign of care pathways can deliver real benefits, there is a danger that, if limited to a disease specific focus, this approach would create new silos and fail to deliver integrated care for those with multi-morbidities. Further research is urgently needed to identify ways in which payments can be developed that promote integrated care for people with multi-morbidity, such as the development of capitated budgets that cover the care needs of an individual (rather than disease or condition based budgets).

c. To allow for different payment approaches for different care needs with room for local flexibility bounded by rules:
11. We strongly support this aim. As mentioned above, we would welcome a system that allows flexibility and a range of payment approaches, with as much ownership and autonomy at a local level as possible.

d. To signal to providers and commissioners available choices that will sustainably promote better outcomes for patients:

12. We support this aim. We would note that it is important that any payment system takes into account the financial sustainability of the entire service, and not simply a single component of this.

Q2. We propose that patient needs and patterns of supply can be described in three main dimensions. What do you think of this way of categorising patterns of supply according to patient need? Could you add to this proposal or suggest alternatives?

Proactive versus reactive:

13. This makes sense. We believe that there is a pressing need to create new incentives to embed care planning and coordination across care settings, providers and time. As discussed above, different payment models may be needed for patients with long-term conditions and/or co-morbidities, and it is important that where possible a ‘whole person’ approach is taken to promote integrated care (please see paragraph 10 above)

14. The current payment system tends to reward reactive care (which may in some cases be regarded as a sign of system failure), but does not appropriately reward prevention leading to a reduction in activity.

15. While it is important to reward prevention, care must be taken to ensure that the payment system does not also reward the clinically inappropriate denial of services.

16. Much of the responsibility for proactive preventative care now lies with the local authority, with acute reactive care still resting with the CCG and specialist commissioning. It will therefore be important to have wider system level incentives in place; these should be based on the population as well as the individual.

Routine versus complex and rare:

17. We are concerned that this definition is too simplistic. As care becomes more sophisticated and the population ages, an increasing proportion of NHS activity will become both routine and complex.
Planned versus unscheduled:

18. This principle makes sense. Where possible, the payment system should reward an approach that reduces expensive unscheduled activity through increases in planned care. Please see also our comments on care planning and proactive versus reactive care (paragraph 13).

Q3. We suggest that there is a spectrum of different ways to regulate payment. What are your views on the different degrees of intervention in the spectrum and when they might be appropriate?

19. As mentioned previously, we believe that it is vital that payment approaches allow flexibility and a range of payment approaches, with as much ownership and autonomy at a local level as possible. We would encourage a spectrum of arrangements, with experimentation in pilot areas prior to implementation.

Q4. For 2014/15 we aim to ensure that payments are predictable, but at the same time we want to allow for experimentation as well as immediate improvements where necessary. What do you think of this approach?

20. We broadly support this approach.

21. We recognise the need to review the 30% marginal rate for emergency admissions to ensure that it is better tailored to the local health system. At the same time, it is important not to remove the incentive for acute providers to work with community and primary care services to develop alternate pathways of care that reduce the need for hospital bed occupancy.

We look forward to ongoing dialogue with Monitor and NHS England as thinking on this subject develops and we would welcome further opportunities to engage with this process.

Please do not hesitate to contact me if you have any questions about our response.

Yours faithfully,

Professor Amanda Howe MA Med MD FRCGP

Honorary Secretary of Council