**Notes on Payment Schemes and Frameworks for Integrated Care Systems (ICSs).**

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*Economics is a political argument. It is not-and can never be-a science; there are no objective truths in economics that can be established independently of political, and frequently moral, judgements. Therefore when faced with an economic argument you must ask the age old question ‘cui bono’*? Ha-Joon Chang 2014[[1]](#footnote-1)

**Introduction**

In England cuts to state-funded healthcare provision have been presented to staff and the public as a ‘transformation’ into ‘integrated’ care; how care has to be delivered for services to continue sustainably into the future. We have been given the FYFV[[2]](#footnote-2) and LTP[[3]](#footnote-3) and will very soon have 42 or so ICSs based on American Accountable Care Organisations (ACOs)[[4]](#footnote-4). At the same time a critical part of the process is for private companies to become ‘partners’ engaged to advise and assist, to provide services and create new markets and investment opportunities[[5]](#footnote-5).

A key element in the functioning of the ICSs in their attempt to provide ‘financial sustainability’ is the payment system, and it is this that the present paper will mainly consider.

**Integrated care as Accountable care[[6]](#footnote-6)**

While services in the NHS have endeavoured over the decades to improve how they detect, diagnose and manage disease in a cost effective way, with care and consideration for patients and their families, the latest strategy deemed necessary to provide ‘sustainable’ care has resulted in the breaking up of the NHS in England into 42 (or so) Integrated Care Systems (ICSs or ‘systems’). These are based on ACOs with each system responsible for commissioning services for their own designated ‘populations’ and their own budgets. Such a structural change with its fragmentation reduces the benefit of risk pooling,[[7]](#footnote-7) a feature that works best in as big and diverse a population as possible. By disconnecting contributions such as taxes or insurance premiums from a person’s health status or health risks, pooling serves to spread the financial risk associated with the need to use and pay for health services so that it is not fully borne by any individual. Its central objective is to maximise redistributive capacity. Thus National arrangements maximise pooling benefits, and they also enhance the purchasing power of the pool and the potential to purchase health services more strategically for poorer or otherwise disadvantaged people[[8]](#footnote-8).

Each system when ‘mature’ will be allocated its own, mainly fixed, annual payment[[9]](#footnote-9) via NHSE. This cannot be overspent and it is the Integrated Care Board (ICB), the ICS’s statutory body, that must manage and distribute it within the ICS through contracts, which can then be managed by Place Based Partnerships or Provider Collaboratives[[10]](#footnote-10). All ‘Partners’ within a system must act to stay within their own allotted budget and cooperate with each other to keep the system within its fixed annual payment- hence the term ‘accountable’.

**Requirements for the NHS Payment Scheme as documented in the amended Health and Care Bill as sent to the House of Lords, winter 2021**

**NHS Payment Scheme (114A)**

Clause 68 of the Bill states that Schedule 10 of the Bill legally replaces the national tariff[[11]](#footnote-11) with the NHS payment scheme, and makes provisions relating to that scheme with respect to patient choice and provider selection, procurement, expenditure, and resource use[[12]](#footnote-12).

*The document*

NHS England must publish a document, to be known as ‘the NHS payment scheme’, containing rules for determining the price that is to be payable by a commissioner for the provision of health care services for the purposes of the NHS; and services in pursuance of arrangements made by NHS England or an ICB in the exercise of any public health functions of the Secretary of State, (within the meaning of the National Health Service Act 35 2006).

The commissioner and the provider of services must comply with rules which may:

* specify prices;
* specify amounts, formulae or other matters on the basis of which prices are to be determined;
* provide for prices to be determined for, or by reference to, components of services or groups of services;
* make different provision for different services or provision for some services but not others;
* make different provision for the same service by reference to different circumstances or areas, different descriptions of provider, or other factors relevant to the provision of the service or the arrangements for its provision; and
* confer a discretion on the commissioner of a service or on NHS England.

Rules may allow or require a price to be agreed between the commissioner and the provider of a service and make provision about how the price is to be agreed. For the purpose of securing that the prices payable for the provision result in a fair level of pay for providers of those services, NHS England must have regard to differences in the costs incurred in providing those services to persons of different descriptions, and differences between providers with respect to the range of those services that they provide.

The NHS payment scheme may contain rules relating to the making of payments to the provider of a service for the provision of that service.

Before publishing the NHS payment scheme, NHS England must

carry out an assessment of the likely impact of the proposed scheme, or

publish a statement setting out its reasons for concluding that such assessment is not needed.

NHS England must also consult: each ICB; each relevant provider; and such other persons as NHS England considers appropriate. In this section of the Bill ‘relevant provider’ means a license holder, or another person, of a prescribed description, that provides health care services for the purposes of the NHS, or services in pursuance of arrangements made by NHS England or an ICB by virtue of section 7A or 7B of the National Health Service Act 2006 (Secretary of State’s public health functions).

*Patient choice and provider selection*

Clause 69 states that regulations must ensure that NHS England and ICBs commission in such a way as to enable patients to make choices with respect to ‘specified aspects of specified treatments or other specified services’, and ensure that NHS England and ICBs protect and promote the rights of people to make such choices (section 6E). NHS England may enforce these regulations (6F) by investigating compliance and directing to prevent or remedy failure. Schedule 1ZA makes further provision about these undertakings in that NHS England must actually publish a ‘procedure’ to ensure patient choice, having consulted with all appropriate parties; but it must not publish any part of any undertaking that contains commercial information or ‘private affairs’ that may harm business or personal interests. NHS England will issue certificates of compliance to ICBs only when satisfied about their undertakings. Any appeal by an ICB against NHS England’s refusal to issue a certificate ‘lies to the First Tier Tribunal’.

*Procurement*

Regulations (12ZB) may make provision to ensure that transparency or fairness, compliance, and management of conflicts of interest are achieved by relevant authorities that procure health care services, and other goods or services that may be procured with them, in England. With the approval of the Secretary of State, NHS England may publish guidance about compliance with procurement requirements imposed by regulations.

*Expenditure and Total resource use*[[13]](#footnote-13)

NHS England must act to ensure that total capital and revenue resource uses and expenditure incurred[[14]](#footnote-14) by itself and ICBs in a financial year (taken together) do not exceed the aggregate of any sums received and the limits specified in the year (223C and 223D) by the Secretary of State. Descriptions of what is to be included in these calculations may be specified by the Secretary of State. Any subsequent direction to vary a limit in relation to a financial year may occur **only if** a) NHS England agrees to the change, b) a parliamentary general election takes place, or c) the Secretary of State considers that there are exceptional circumstances which make the variation necessary.

As an ‘additional control’ on resource use it is stated that the Secretary of State may direct NHS England to ensure that relevant capital and revenue resource amounts specified are not exceeded in a financial year (223E). Likewise NHS England may direct ICBs about their management or use of financial or other resources and this includes imposing the limits on expenditure or resource use which have been specified (223GB).

*Joint financial objectives*

NHS England may set joint financial objectives for ICBs and their partners (223L)[[15]](#footnote-15) who must seek to achieve them (223M). Where an NHS trust or NHS foundation trust is the partner of more than one ICB, its use of resources is to be apportioned to one or more of the ICBs as directed by NHS England.

Again as an ‘additional control’, this time it is NHS England that may direct an ICB and its partners to ensure that relevant capital and revenue resource amounts specified are not exceeded in a financial year (223N).

*Relevant resources*

The Secretary of State may, in relation to any financial year, specify descriptions of, and the uses of, any resources which must be treated as capital resources or revenue resources to be taken into account for the purposes of financial control (223O).

From the Bill, the performance of the new Payment System will be further structured and monitored as shown in the **Appendix**.

**Provider Selection Regime consultation[[16]](#footnote-16)and response[[17]](#footnote-17)**

In relation to the procurement element of the new NHS payment scheme, there has been a Consultation and response to the new procurement regime proposed by NHS England which they are continuing to develop. There is a summary of the current situation on the KONP website[[18]](#footnote-18)

In summary, NHS England is currently seeking: i) 4-6 weeks from announcement of intention to contract to completion; ii) no right for independent scrutiny but competitors can approach the commissioners within a time frame if they believe that the procurement criteria have not been met; iii) for judicial review to be the only way to challenge the lawfulness of any decision; iv) to keep NHS procurement separate from other public services; v) to enhance Any Qualified Provider (AQP) procurement through simplifying arrangements to improve choice (they say) by making it easier for providers to be placed on ‘provider lists’. If providers simply demonstrate that they meet the stated required service conditions they must then be offered the NHS Standard Contract by the decision-making body and can then register their services on the Electronic Referral System (ERS) lists from which patients make their choice; **vi)** **that to ‘reduce administrative bureaucracy’, decision-making bodies must not run any additional local procurement/comparative/ competitive process when managing these ‘legal right to choice’ lists; vii) that decision-making bodies cannot set their own criteria for services where patients have a right to choice; viii) that decision-making bodies have no discretion to remove a provider from the ERS lists, or end/withdraw their NHS Standard contract unless the provider ceases to meet the required service conditions or is demonstrably failing to deliver the safety/quality/service standards; ix) that for these ‘legal right to choice’ provider lists, the decision-making body cannot restrict the number of providers on the list, so long as they meet the stated qualification criteria.**

The AQP regime does not prevent decision-making bodies from seeking to contract directly with voluntary and independent sector providers for other reasons – for example, to secure additional capacity for the NHS (as has happened recently to help support the response to the COVID-19 pandemic). It would require mutual agreement for these arrangements to be instead of the AQP arrangement for that provider, while still protecting patient choice.

Decision-making bodies also have an important role to play in shaping local healthcare provision, ensuring that services are sustainable and able to innovate. Where changes to services are being considered, the regime’s key criteria (see below) ensure that decision-makers must take into account the potential effect of any changes on the sustainability of other services and providers, and do not stifle innovation in the short or long term.

Key Criteria:

1.Quality (safety, effectiveness and experience) and innovation

2.Value

3. Integration and collaboration

4. Access, inequalities and choice

5. Service sustainability and social value

**Payment Frameworks- from recently published NHS England documents**

The impact of Covid-19, and the financial arrangements of ‘block payments’ introduced in response to the crisis[[19]](#footnote-19), have created a different starting point for the payment system development to that envisaged in 2019/20 when a ‘blended payment framework’[[20]](#footnote-20) was first introduced. This blended payment framework comprises a fixed element, based on forward-looking forecasts of activity and best available cost data, and at least one of

* + a variable element,
	+ a risk-sharing element and/or
	+ a ‘quality’[[21]](#footnote-21) or outcomes based element

All of these are used to incentivise new ways of working, either by tying financial gain to less expensive, alternative models of care or bonus payments to ‘quality’ or outcomes and financial savings.

The starting point for proposals being developed for 2022/23 is called the ‘Aligned payment and incentive’ (API)[[22]](#footnote-22) a blended payment introduced for the 2021/22 national tariff and designed to support a smooth transition out of the Covid-19 payment arrangements, while making progress towards the new payment system. The 2022/23 API model[[23]](#footnote-23) involves providers and commissioners agreeing locally a fixed element to deliver an agreed level of activity, with a variable element using Best Practice Tariffs[[24]](#footnote-24) and CQUINs[[25]](#footnote-25) to address ‘quality’ of care while also helping with any deviations from the planned activity levels used to set the fixed element. API arrangements cover almost all secondary healthcare services, including acute, community, ambulance and mental health. For 2022/23, NHS England are considering two threshold options for contracts to be within API: £10 million which maximises the scope of API and means there is no policy change from 2021/22, and £30 million which broadly retains the same level of contract value as 2021/22 but also keeps a significant level of funding locally determined and simplifies things for specialist trusts and independent sector providers23.

**Risk and reward sharing**

Risk and reward sharing is a key feature of the policy agenda for ACOs in the US and also ICSs[[26]](#footnote-26) in England. It is viewed as ‘a simple and attractive concept, offering a commissioner the opportunity to co-opt and incentivise a provider to moderate growth in healthcare demand by sharing in the savings or cost over-runs’. Commissioners might ultimately prefer to pass all the financial risk associated with cost growth to the provider by fixing the budget that providers receive. However, most providers would be reluctant to accept a contract with a fixed budget-at least not one that commissioners could afford. Therefore schemes in which savings and losses are shared between the commissioner and provider can offer a compromise. Elements of risk and reward sharing has already been used as a transition towards the current ‘API’ blended payment contracts- CQUINs have been used in the NHS since 2009[[27]](#footnote-27), and also, more crudely, the bonus payments paid only when ‘annual control totals’ have been met by NHS Foundation Trusts.[[28]](#footnote-28),[[29]](#footnote-29) Both have been used to shape service development towards the conceived ‘transformation’ part of ‘Sustainable Transformation Plans’ i.e. to lay the ground for Accountable Care.

With these profound changes in our healthcare system it is necessary understand that, from a financial point of view, the notion of a ‘counterfactual’ is central to any assessment as to whether or not the structural changes and new payment systems- including risk-reward sharing- have brought real ‘sustainability’ to a system as opposed to reducing costs by simply doing less, or reducing quality. In this context a ‘counterfactual’ is the price of healthcare activity that may be expected under normal circumstances- it is the ‘benchmark’ against which priced activity levels are assessed at year end. If priced activity falls below this level, then the provider may be entitled to a reward payment. If it exceeds this level, then a penalty may be applied. There are many approaches to calculating and agreeing ‘counterfactuals’, but none is simple, and these calculations determine the allocation of enormous sums of money, and can some times represent quite different things entirely. For instance in the US ACO Medicare Shared Savings Programme (MSSP) after 4 years, there were as many ‘winners’ as ‘losers’ among the ‘systems’ and those that saved money had higher ‘benchmarks’ to start with while they spent more dollars per patient, and after ‘bonuses’ the state still lost $216 million plus the running costs of the programme (this was all presented in the media as a $1 billion dollar saving with physicians changing care)[[30]](#footnote-30).

**The future of payment systems**

In the future there may be moves towards greater autonomy for systems with fewer detailed rules about payments and, instead, more supportive guidance describing the default approach and acceptable variations, with case studies of successful implementation. There will be less of a role for published prices, but more for ‘products’ (algorithms) developed to support the setting of the fixed element[[31]](#footnote-31). The systems will also legally be able to generate income and leverage investments to further ‘quality’ care. What this means is that the responsibility for the our healthcare could be considered more the business performance of the people (managers and senior clinicians) running the ICS to which we are allotted, so distancing it from any political decisions other than the need for ‘sustainability’. The measure of success will rest with how well the individual system can achieve the ‘best value’ for their population’s needs. Perhaps as well, this performance will be seen as dependent on each and every individual’s degree of effort to improve their own healthy and ‘caring’ behaviours, creating a dystopian hierarchy of healthcare ‘worthiness’ for citizens

**APPENDIX (from page 6)**

*Annual ‘Five year plan’*

NHS England must publish guidance for ICBs on the discharge of their functions (14Z49), including how they will meet their financial duties (sections 223GB to 223N), and this must include a plan for the next five years (14Z50) prepared each financial year by an ICB and its partners (NHS trusts and NHS foundation trusts). They must give a copy of the plan to the integrated care partnership (ICP) for the board’s area, each relevant Health and Wellbeing Board (HWB), and c) NHS England.

The plan may be revised (14Z51) and if significantly so, then it must be redistributed as if it were the original plan. More minor changes can be sent in a document as if an addendum.

Initial plans and significant revisions require: a) consultation (14Z52) with ‘the group of people for whom the ICB has core responsibility’, and any other persons they consider appropriate; b) the involvement of each relevant HWB by sending drafts of the plan to check whether they take proper account of each current local health and well-being strategy. The HWB may send their opinion on the plan to NHS England, after informing the ICB that they will do so.

*Capital Plan*

In addition before the start of each financial year, an ICB and its partners must prepare and publish a plan setting out their planned capital resource use: its expenditure, consumption or reduction in value (14Z54). They must give a copy of the plan to the ICP for the board’s area, each relevant HWB and NHS England. These joint capital resource use plans may be revised (14Z55), again with significant revisions being treated as an original plan and others documented as addenda.

*Annual report*

An ICB must, in each financial year, prepare a report for NHS England on how it has discharged its functions in the previous financial year (14Z56) with respect to its forward plan and it’s capital resource use plan.

*Performance Assessment*

NHS England must conduct a performance assessment of each ICB for each financial year (14Z57), consulting each relevant HWB as to its views on any steps that the board has taken to implement any joint local health and wellbeing strategy. It must publish a report each financial year containing a summary of the results of each performance assessment it has conducted.

*Obtaining Information and dealing with failure*

The Bill gives NHS England power to: obtain information(14Z58) from an ICB, provided in such a form, and at such time or within such a period, as it may require; to give directions to ICBs (14Z59) if they are failing or have failed to discharge any of their functions, or there is a significant risk that they will fail to do so.

In acting to ameliorate, NHS England may: give directions to the ICB to try to improve the situation over a period of time; direct the ICB, or its chief executive to cease to perform any functions over a period of time; terminate the appointment of the chief executive, and direct the chair of the board whom to appoint as a replacement and on what terms; exercise, on behalf of the ICB, any of the functions required; direct another ICB to perform any of those functions on behalf of the ICB; prohibit or restrict the ICB from making delegation arrangements.

*Consolidated accounts for NHS trusts and NHS foundation trusts*

NHS England must, in respect of each financial year, prepare a set of accounts that consolidates the annual accounts of a) all NHS trusts established under section 25, and

b) all NHS foundation trusts (65Z4)

NHS England must send a copy of the consolidated accounts to a) the Secretary of State, and b) the Comptroller and Auditor General. The latter must a) examine, certify and report on the consolidated accounts, and b) send a copy of the report to the Secretary of State and NHS England who must then lay before Parliament a copy of the consolidated accounts and the report on them

*Funding for service integration (Clause 10)*

In section 223B (funding of NHS England) the Secretary of State may direct NHS England a) that a certain amount of the money paid to it under this section in respect of a financial year is to be used for service integration and b) about how that money may be used.

Likewise NHS England may direct an ICB that an amount of the money paid to the board in respect of that year is to be used for purposes relating to service integration.

1. Chang H-J. Economics: the user’s guide. Penguin 2014 [↑](#footnote-ref-1)
2. <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [↑](#footnote-ref-2)
3. <https://www.longtermplan.nhs.uk/online-version/> [↑](#footnote-ref-3)
4. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4422096/> [↑](#footnote-ref-4)
5. <https://www3.weforum.org/docs/WEF_Maximizing_Healthy_Life_Years.pdf> [↑](#footnote-ref-5)
6. Fisher, Elliott S.; Staiger, Douglas O.; Bynum, Julie P. W.; Gottlieb, Daniel J. (2007-01-01). Creating Accountable Care Organizations: The Extended Hospital Medical Staff. A new approach to organizing care and ensuring accountability <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2131738/> [↑](#footnote-ref-6)
7. <https://apps.who.int/iris/rest/bitstreams/1268045/retrieve> [↑](#footnote-ref-7)
8. <https://www.allysonpollock.com/wp-content/uploads/2013/04/UNISON_2002_Pollock_WhatsGoodNHS.pdf> [↑](#footnote-ref-8)
9. <https://www.england.nhs.uk/wp-content/uploads/2019/08/13-Whole-Population-Budget-Overview.pdf> [↑](#footnote-ref-9)
10. <https://www.england.nhs.uk/wp-content/uploads/2021/09/Context-for-finances-and-payment-for-2022-23.pdf> [↑](#footnote-ref-10)
11. National Tariff is an annually set list of prices of interventions, and rules for their use, used by providers of NHS care and commissioners in an attempt to deliver the most efficient, cost effective care to patients. [↑](#footnote-ref-11)
12. The measures in the Bill on tariff are designed to meet the NHS request for changes to give the NHS more flexibility in how tariff prices and rules are set, to help support the delivery of more integrated care at local levels. To reflect that, **the new measures on tariff mean that there may not be any national tariffs**, the Bill therefore proposes to revoke the national tariff and replace it with a new NHS payment scheme. The scheme will be published by **NHS England, who will consult with ICBs as the new commissioner of most NHS services, as well as relevant providers (both NHS providers and those from the independent or voluntary sector)**. The NHS payment scheme will set rules around how commissioners establish prices to pay providers for healthcare services for the purposes of the NHS, or public health services commissioned by an ICB or NHS England, on behalf of the Secretary of State (known as section 7A and section 7B services). *Explanatory Notes relate to the Health and Care Bill as brought from the House of Commons on 24 November 2021 (HL Bill 71)* [↑](#footnote-ref-12)
13. <https://www.gov.uk/government/publications/how-to-understand-public-sector-spending/how-to-understand-public-sector-spending> [↑](#footnote-ref-13)
14. other than use that consists of the transfer of resources between relevant NHS bodies. [↑](#footnote-ref-14)
15. Financial objectives under this section may apply to a) ICBs and their partners, b) a particular ICB and its partners, or c) an ICB of a particular description and its partners. [↑](#footnote-ref-15)
16. <https://www.england.nhs.uk/wp-content/uploads/2021/02/B0135-provider-selection-regime-consultation.pdf> [↑](#footnote-ref-16)
17. <https://www.england.nhs.uk/wp-content/uploads/2021/02/B0706-NHS-Provider-Selection-regime-response-to-consultation.pdf> [↑](#footnote-ref-17)
18. <https://keepournhspublic.com/wp-content/uploads/2022/01/statement-on-response-to-Provider-Selection-Regime.docx> [↑](#footnote-ref-18)
19. <https://www.england.nhs.uk/coronavirus/publication/block-payment-guidance-documents/> [↑](#footnote-ref-19)
20. <https://www.england.nhs.uk/wp-content/uploads/2021/02/20-21NT_Guidance_on_blended_payments.pdf#page7> [↑](#footnote-ref-20)
21. By this they mean developing ‘new models of care’ and reductions of ‘unwarranted variations’-see paper on ‘value’ [↑](#footnote-ref-21)
22. <https://www.hfma.org.uk/docs/default-source/publications/Briefings/an-introduction-to-aligned-incentive-contracts.pdf?sfvrsn=8c777be7_2> [↑](#footnote-ref-22)
23. <https://www.england.nhs.uk/wp-content/uploads/2021/09/22-23-finance-and-payment-engagement_blended-payment.pdf> [↑](#footnote-ref-23)
24. According to NHSE, Best Practice Tariffs (BPTs) help the NHS to improve ‘quality’ by reducing ‘unwarranted variation’ and universalising best practice. The aim is to have tariffs that are structured and priced appropriately to incentivise and adequately reimburse providers for adopting the new models of care/ways of working -see paper on ‘value’. [↑](#footnote-ref-24)
25. CQUINs (Commissioning for Quality and Innovation) are extra ‘quality’ improvement goals that can be agreed; there is a financial incentive to achieve those goals. [↑](#footnote-ref-25)
26. <https://www.strategyunitwm.nhs.uk/sites/default/files/2018-06/Risk%20and%20Reward%20Sharing%20for%20NHS%20Integrated%20Care%20Systems%20-%20180605_0.pdf> [↑](#footnote-ref-26)
27. <https://tavistockandportman.nhs.uk/about-us/governance/cquin/> [↑](#footnote-ref-27)
28. Teaching trust boasts £76m surplus after asset sales and STF bonus. Lawrence Dunhill, Health Services Journal, 10th May 2018. [↑](#footnote-ref-28)
29. Trust's ﬁnancial position £60m worse than expected after audit judgement. Lawrence Dunhill, HSJ,15th June 2017. [↑](#footnote-ref-29)
30. <https://blogs.sph.harvard.edu/ashish-jha/2016/08/30/aco-winners-and-losers-a-quick-take/> [↑](#footnote-ref-30)
31. <https://www.england.nhs.uk/wp-content/uploads/2021/09/Context-for-finances-and-payment-for-2022-23.pdf> [↑](#footnote-ref-31)