NHS Payment Scheme: a secret weapon for health corporations

KONP ICS Working Group

"How service providers are paid matters as much as how much they are paid," as the World Bank puts it. Yet few patients, NHS staff or health campaigners have heard of the new Payment Scheme introduced by the Health and Care Act 2022. As the Bill went through Parliament, only Margaret Greenwood MP and Lord Hendy spoke out against the Scheme. But it will have a profound impact on the finance available in each Integrated Care System (ICS), and therefore on staffing and patient care. For example, NHS England envisages a fixed budget for Emergency Care in hospital, with no provision for what happens when that money has been spent.

The Scheme will come into effect next April (2023), on the back of NHS providers being ordered to reduce spending by over 4% on average, while RPI inflation is 14.2% and the NHS faces real term funding cuts through to 2025, at least, even after the Chancellor's Autumn Budget. But the Scheme is not simply another budget cut. It aims to control total expenditure through a single pot of money for each Integrated Care Board (ICB); promote population health management across the ICS area; shift care out of the acute sector into the community; stimulate elective treatments; promote the private sector; and fragment the national pricing system in favour of local deals.

The Scheme, to be published by NHS England, will allow a postcode lottery with different prices for the same treatment or service in different places, a patient lottery with different prices for different types of patients, and a provider lottery with different prices for different providers supplying the same treatment or service. The private sector will be consulted on the details. Meanwhile, under the NHS England Health Systems Support Framework (HSSF), several hundred companies are accredited to support ICSs on a wide variety of topics. One heading is "Organisational redesign, governance, payment and contract reform" and 57 companies are accredited for it. This suggests an ICB may appoint one or more to advise them on the Payment Scheme. It may also mean such companies are already involved in the Scheme's development. Some of the accredited firms promoted the idea for years and have welcomed the Scheme, as discussed below.

In friendly discussions, several KONP campaigners have argued variously that the Scheme does not represent a fundamental change, as the NHS has had to fight for resources and funding at least since 2010, and / or that planning inevitably involves judgements on how to ration available resources, whether the funding is generous or not, and all funding methods have problems, or that there is no necessary connection between the Scheme and population health management and it is a mistake to conflate the arguments, or that focusing on these details is somewhat of a diversion from the fight for adequate funding. However, our collective view is as follows.

How will it work?

Each ICB will draw up a forward plan for NHS services in their area. The allocation from NHS England to the ICB is intended to cover the cost of their plan, and the plan must be adjusted to fit within the cost. NHS England will force ICBs to stay within budget. But how will a forward plan be costed? **Will planners use public health methods to estimate and update the need for healthcare**

in the coming period and apply prices set nationally, using the bargaining power of the national NHS? Not really. The Scheme opens the door to a new method.

The Health and Care Act does not give details, it simply instructs NHS England to draw up and publish the Scheme. However, the Act does specify many ways that prices can vary, and requires consultation with the private sector and others, as explained below. The Scheme will last for a period specified in the Scheme, and the Act does not limit that period. It says the Scheme can make:

different provision for different services;
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 that NHS England must have regard to:
differences in the costs incurred in providing those services to persons of different descriptions;
differences between providers with respect to the range of those services that they provide.

The scheme may allow or require a price to be agreed between the commissioner and the provider of a service.

Before publishing the payment scheme, NHS England must consult in a 28 day period with
(a) each integrated care board;
(b) each relevant provider;
(c) such other persons as NHS England considers appropriate.

The term "relevant provider" means—
(a) a licence holder, or
(b) another person, of a prescribed description, that provides—
(i) health care services for the purposes of the NHS, or
(ii) services in pursuance of arrangements made by NHS England or an integrated care board by virtue of section 7A or 7B of the National Health Service Act 2006 (Secretary of State's public health functions).

Thus G4S, Spire or any other private company holding a licence as an independent provider or an NHS-controlled provider, or providing "services for the purposes of the NHS" or for the Secretary of State's public health functions (e.g. G4S Sexual Assault Referral Centres), must be consulted before the Scheme is published. The Act does not limit the scope, so the consultation could apparently cover any issues in the Scheme. In response, NHS England may decide to amend the Scheme and can consult again, if it thinks it should.

Of the 57 firms accredited by NHS England under the HSSF for Organisational redesign, governance, payment and contract reform, 14 are US-owned: AT Learning (Centene), DXC Technology, FTI Consulting, Gartner, GE Healthcare Finnamore, IBM, IQVIA, McKinsey, Oliver Wyman, Operose (Centene), Optum (UnitedHealth), PA Consulting Group, Teneo Business Consulting, and The Boston Consulting Group.

For example IQVIA, with a $13.87bn annual revenue, an HQ in North Carolina, and major COVID contracts, has 13 accreditations including "Organisational redesign, governance, payment and

contract reform". Months before the Bill was even published, they waxed lyrical about the new payment model:

> IQVIA (Jan 2021)
> **A new dawn for the commissioning of health and social care in England**
> A new payment model has been created, which can be considered as a hybrid that combines a capitated population budget, an improvement payment scheme and a gain/loss share arrangement. NHS England and NHS Improvement (NHS England/I) have made it clear that they want ICSs to have financial accountability, with a 'single-pot' which provide the funding for health and social care services which are commissioned at a System level.
>
> Capitated payments are lump-sum and **not linked to how much care is provided** [*emphasis added*]. Providers have the flexibility to spend money on services they think will secure the best outcomes for their respective patient population. Commissioners will set the outcome measure and tender to select the best provider to deliver services.
>
> The improved payment scheme will provide incentives to improve quality and mitigate against the risk that providers will deliver as little care as possible to minimise costs, given that they are not reimbursed based on the quantity of care delivered.
>
> Savings (i.e., gains) and overspends (i.e., losses) will be shared across commissioners and providers, which should help align financial incentives across the System.

NHS England

NHS England is now fleshing out the Scheme through a series of engagement exercises, which began in July. Slides explain the "Aligned payment and incentive (API)" method to be used for elective activity. The baseline component for a particular service will be a "fixed element" set by assessing the costs of delivering an agreed level of activity, assuming the provider uses best practice and achieves the full Quality and Innovation target. The scheme rules would not specify how the fixed payment should be calculated. It will be agreed between the provider and commissioner and will depend on available data and local system preference, with consideration of previous years' income and adjustments for service transformation, inflation, efficiency, etc. In other words, no-one will know in advance what the funding will be for the "fixed element", and the same service may cost different amounts in different areas using different providers or different ICB preferences, or perhaps the Market Forces Factors already in use. The Scheme will lead to local competitive markets in which ICBs will make deals with providers.

Furthermore, "a whole system planning approach is expected to be used when setting the fixed element", which appears to mean that the fixed element for a particular service will depend on what else the ICB wants to do. It won't be enough to estimate 250 lung cancer cases over the next year, whose treatment would cost on average £20,000 (say). That £5m estimate would then be adjusted by whether the ICB also wanted to promote virtual wards, a new computer system for electronic patient records or commission financial advice from a management consultancy...

Beyond the baseline, the API will include a variable element. If activity goes above plan, the provider will receive 75% of tariff prices for the increased activity, whilst if activity falls below plan, payment will be deducted at the 75% rate. This is an incentive to stick to the plan, but allows for the possibility that more, or less, treatments may actually be needed. The engagement exercise does not explain whether the extra costs would come out of the overall ICB budget, or whether they would trigger additional funds from NHS England, which seems very unlikely except in a national emergency.

It's unclear whether this complex mechanism will work, and even NHS England is wondering whether Payment by Results would be a safer method to promote elective care. As the Health Service Journal reported on 4 November, "One well-placed source told HSJ there was 'strong momentum' towards reviving PbR for elective care, which could mean trusts being paid purely for each unit of activity delivered, without a block contract element. There is a belief this could help drive up activity levels, which have remained below the levels recorded before the pandemic."

In any case, the variable element will not apply to "acute non-elective activity". That phrase covers Emergency Care in hospital, at least. NHS England explain, "We don't believe a variable payment linked to any acute non-elective activity would be appropriate, given the aims to reduce this demand where possible." (NHS England want emergency care in hospital to be reduced through preventative care, self-care, primary care, and Urgent Treatment Centres.)

The Scheme proposal means that the allocation for emergency care in hospital will have no mechanism to increase payment to a Trust if A&E exceeds the planned levels. Where would that leave Liverpool University Hospitals when the main corridor at Aintree had to be turned into an emergency ward in mid October after ambulance crews refused instructions to take patients back from the Emergency Department and hold them in their vehicles, unable to attend fresh callouts?

Origins

The new payment model has arrived on the back of block payments introduced during the pandemic. It is not a new idea. As NHS England explain, "The NHS Long Term Plan recognised that payment methods should act as enablers of transformation towards the delivery of integrated care and the creation of ICSs, as well as promoting prevention. To support this, the Plan set out that the payment system should move away from activity-based payments and ensure that most funding is population-based." Or, as IQVIA put it, "Capitated payments are lump-sum and not linked to how much care is provided. Providers have the flexibility to spend money on services they think will secure the best outcomes for their respective patient population. Commissioners will set the outcome measure and tender to select the best provider to deliver services."

In the US, this approach was designed to tackle doctors and hospitals making money by performing un-necessary operations, for which they were paid via "fee-for-service". Back in 2015 PA Consulting, another US-owned firm accredited on the HSSF for payment reform, wrote an article entitled "Developing population health programs that add value". A revealing sentence stated "*For example, if post-acute care providers are paid on a fee-for-service basis, then motivating them to reduce number of services rendered might be difficult.*" In other words, in order to ensure that patients discharged from hospital get less services, stop paying for them. It all makes sense for a health insurance company, but not for patients whose care is denied.

In the UK, the ideas emerged after the 2008 banking crisis, when the Brown government commissioned McKinsey & Company to advise on how to save £20bn / year from NHS costs. Their recommendations included savings of £2.7 - 4.1bn from a shift in the management of care away from hospitals towards more cost effective out-of-hospital alternatives. In discussing procuring external support for the various transformations, McKinsey referred explicitly to "health insurers with payment and contracting expertise".

Then in 2013, the World Economic Forum issued a report on Sustainable Health Systems, in collaboration with McKinsey & Company. Its recommendations included:

> New payment models are necessary if policy-makers are to prompt a transformation in their health systems. They should:
>
> – Reform payment mechanisms to change to whom payments are made and how much is paid for what care... pay for e-mail, tele-health and telephone consultations as the norm
>
> – Introduce capitation-payment models to shift risk from payors to providers, giving providers a strong incentive to innovate, while strongly regulating quality and access to care to properly protect patients.

But why did NHS England want to "move away from activity-based payments"? NHS patients do not get treatment they do not need. They may wait for treatment they do need, or discover that the treatment they need is no longer provided on the NHS. Despite this, NHS England embraced the payment model being advocated by healthcare corporations, management consultancies and the World Economic Forum, in which funding is awarded to manage care for a whole population.

In future, instead of the NHS seeking to respond to patients' need for healthcare by providing it, each ICB will set out a area-wide plan with an overall budget policed by NHS England, with targets *they* believe will benefit the population *as a whole*, and award contracts *on that basis*.

Where do the targets come from and what does it mean to benefit the population as a whole?

ICBs will use population health management to set priorities and targets. The Long Term Plan, the White Paper which led to the Health and Care Bill, and the explanatory notes to the Bill, make frequent reference to "population health management" and "population health" without defining the terms, which are missing from the Act itself. For example, the White Paper said "As we move towards a system of ICSs focused on population health, we want to ensure that the payment system supports that direction of travel." The Explanatory Notes to the Bill said:

> 700 Clause 81 also amends section 261 (dissemination of information) of the 2012 Act so that NHS Digital may only share information for purposes connected with the provision of health care or adult social care or the promotion of health (It is intended that this amendment will put beyond doubt **NHS Digital's power to share data** [*emphasis added*] in connection with health care or adult social care. This could include for example commissioning, planning, policy analysis and development, **population health management** [*emphasis added*], assessment of the quality of services and individuals' experiences of them, workforce planning, research for purposes which benefit or are relevant to the provision of health or adult social care and developing innovative approaches to the delivery of health and adult social care.

But what is population health management? According to the HSSF, "Population Health Management is an approach aimed at improving the health of an entire population and improves population health by data driven planning and delivery of care to achieve maximum impact for the population." US-owned corporations and UK consultancies accredited by the HSSF to support ICSs are more explicit.

PA Consulting (owned by US engineering giant Jacobs):

> "In a recent analysis for a major provider, we found the need to achieve a 10-fold reduction in cost of care to meet the expected price. Such reductions are only possible by revisiting the care model assumptions and leveraging technology solutions, such as highly precise risk stratification, remote monitoring and telehealth."

"Developing population health programs that add value"

Health Catalyst (US "provider of data and analytics technology and services to healthcare organisations"):

> As value-based care delivery models — like accountable care organizations (ACOs) — enter the healthcare mainstream, managing population health and risk stratification is more important than ever. Healthcare organizations working to change their cost structure and improve outcomes must design interventions that target high-risk, high-cost patients who need to be carefully and proactively managed.
>
> Understanding Risk Stratification, Comorbidities, and the Future of Healthcare

IBM (in suggesting that computer algorithms offer the best way to measure and compensate for the risk of patients attributed to each provider):

> "Multiple versions of the HHS [US Dept of Health and Human Services] algorithm exist for the metal tiers of available insurance plans: platinum, gold, silver, bronze, and catastrophic. The algorithm will be used as the risk adjustment engine for computing net-zero payment transfers between health plans, based upon average risk of patients in each plan."
>
> IBM: Risk estimation, stratification,and adjustment

Deloitte

> Population health management (PHM), while just one of many levers to tackle health outcomes, is viewed increasingly as the key to ensuring the affordability and sustainability of care. PHM is a data-driven approach that guides the planning, resource allocation and delivery of care to optimise population health. It brings together big data, patient engagement and health care delivery and requires a combination of:
>
> - Behavioural change, from both health care providers and patients, with a greater focus on prevention and patient activation measures delivered in a tailored manner, using an array of analytics, technology and communication tools
> - Proactive identification and monitoring of high-risk patients, and equitable access to evidence-based medicine, focusing on prevention and treatment and on improving function and wellbeing for individuals
> - Realignment of funding flows and incentives to encourage staff to work differently across care settings, underpinned by an appropriate outcomes framework.

How do ICBs themselves use the term? The Cheshire & Merseyside ICB are appointing a Consultant in Population Health. The Job Description includes "working with partners to ensure the effective use in population health management approaches to assist in equitable restoration and recovery of health and care services to reduce health and social inequalities". The Person Spec includes as Essential Experience: "* Delivery of successful change management programmes across organisational boundaries * Evidence of successful resource and financial management, including

managing conflicting priorities, formulating budgets, and applying rigorous monitoring and control procedures." The Consultant will sit on the ICB Transformation Committee, which meets in private.

Amongst the Cheshire & Merseyside system priorities for 2022-23, the Digital Group is tasked with tackling digital exclusion, driving **integration of care records and population health management** [*emphasis added*], systems to support transformation including; remote monitoring, digital primary care and digital social care, cyber security and service recovery plans to improve treatment times.

The proposed structure for the Sefton "place" board within Cheshire & Merseyside shows PHM (Population Health Management) as a subgroup of the "Finance, investment and resources group" - a strange location if its function is to improve population health indicators like Cancer deaths under 75, or Hospital stays for self-harm, but entire appropriate if its purpose is financial. In St Helens, Population Health is an Enabling Group within the System Resources Group which reports to the Integrated Finance and Resources Committee.

Cheshire & Merseyside have their own population health management tool System P. This uses the Bridges to Health segmentation model developed by Outcomes Based Healthcare, whose founder and company Secretary is Dr Rupert Dunbar-Rees. He was a "Partner in General Practice before joining the Dept of Health as Clinical Lead on the Commercial Team... He holds a finance MBA with distinction from CASS Business School in the City, with an award-winning research dissertation on competition in healthcare in England." Outcomes Based Healthcare is accredited under the HSSF for Population Health Intelligence, Business and Clinical Intelligence, Research Tools, and Decision Support Tools.

Conclusion

This may all sound very far removed from the daily problems patients face in accessing care. But in the end, the care depends on finance as well as a properly trained and highly motivated, caring workforce. Consulting the private sector on how to set costs which vary around the country, from one healthcare provider to another, from one group of patients to another, with budgets set in obscure ways with no necessary link to the actual delivery of care or, in some categories, no mechanism to increase funding when actual demand exceeds the plan, looks extremely dangerous.

The 2006 Dental Contract, still in place, illustrates the problems with rigid fixed funding and ill-considered local variability. As the Doctors for the NHS Sept 2017 newsletter explains:

> Back in 2006, the government imposed a controversial contract based solely on the number of units of dental activity (UDAs) achieved by dentists. The new target-driven contract has had a corrosive impact on the way dentistry is delivered to patients, and on how dentists feel about providing services for the NHS. It brought in a fixed budget for NHS dentistry because dental practices were limited in the amount of NHS care they could provide patients, depending on how many UDAs they were commissioned to deliver in their contract. If a dental practice were contracted to say deliver 1200 UDAs over the year, the expectation would be that these will be spread out evenly over the year. If the practice reaches its quota – and spikes do happen! – sometimes dentists are forced to turn away patients, regardless of need, for fear of breaching their contract. Senseless targets without any regard to patients' needs. Dentists receive financial penalties when they don't hit targets, receive no compensation when they exceed them, and have no scope to take on new NHS patients, even when they have spare capacity. This has led to a conveyor-belt model of provision. NHS dentists are

> forced to chase targets for curative treatment, rather than provide vital preventive care...

A Dept of Health proposal in 2010 highlighted the problems with local variability:

> Individual dentists have been given contracts, and different dentists have been paid widely differing sums for delivering the same treatments. Some dentists are paid half what others receive for the same treatments. The purpose behind this was to take account of the different needs of local populations, but because the contract value was derived from each dentists' treatment records, it further cemented dentists into a pattern of treatment rather than prevention. A significant number of dentists chose to stop working in the NHS rather than sign a contract, that they saw as unfair. Following the introduction of the contract, there was sharp fall in the numbers of people able to access NHS dentistry.

With the Payment Scheme, if each ICB is arranging its own budget which NHS England will enforce, with prices varying between providers, why wouldn't ICBs seek to undermine national agreements on pay, terms and conditions? Lord Hendy confronted some aspects of this danger when the Health and Care Bill was still in Parliament. His amendments were brushed aside as the Bill sailed through.

The assumption that redesigning funding flows and cheaper care in the community can replace the need for properly funded and fully staffed hospitals including Emergency Care remains just that, an assumption. If the need for healthcare turns out to exceed the predictions from a planning model and the budgets derived from that model, patients and healthcare workers are not to blame for the failure of the model!

In one sense, it all comes down to aims. Is the primary concern the financial viability of "the system" which delivers healthcare, or the actual delivery of appropriate care to those with needs which could be met, in part or in full, by medicine and social care? If it's "the system", it may seem appropriate to use tools developed in the health insurance industry to minimise the cost of care, including by reducing the care on offer. NHS England and the Government have made this choice. The rest of us have not.