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

Presentation to 18th Annual BHF conference

FTI CONSULTING™

B·H·F SOUTHERN AFRICA
Board of Healthcare Funders of Southern Africa

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Agenda

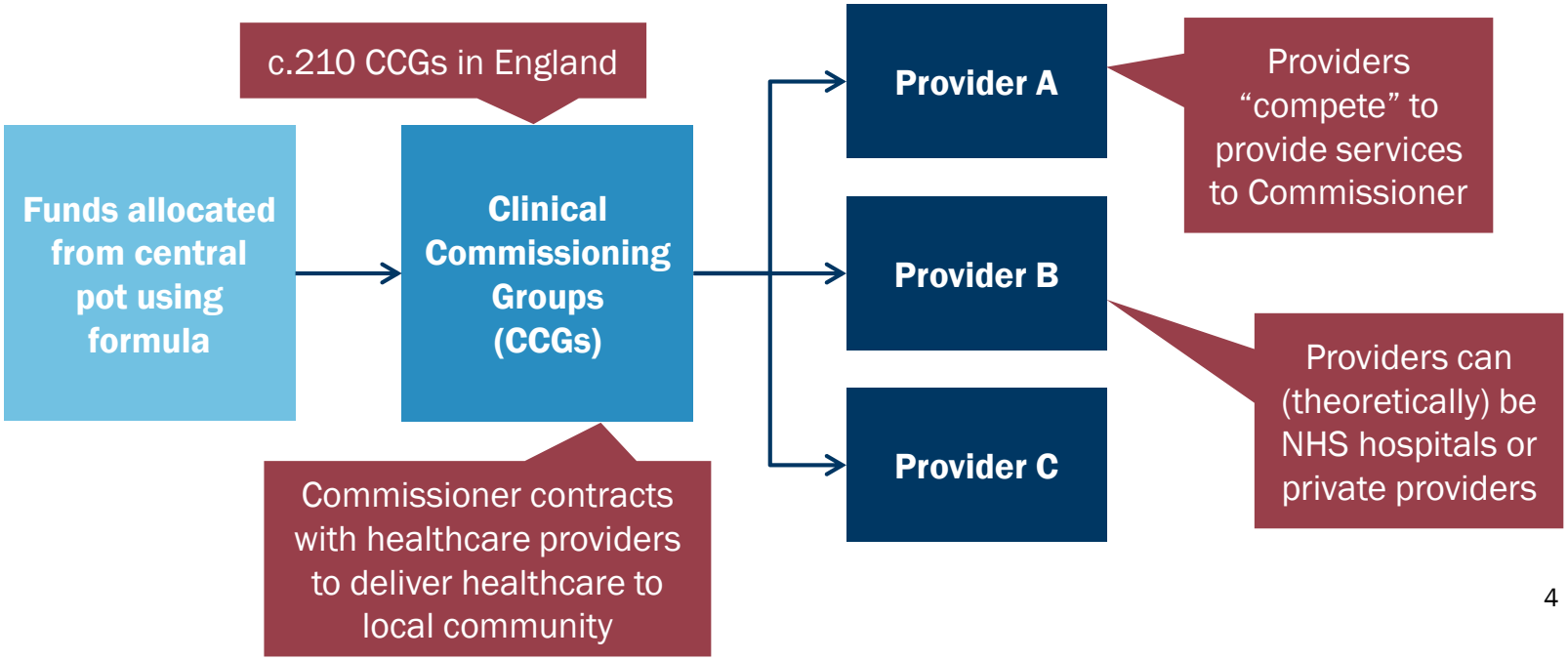
- Introduction
- Overview of reimbursement models and evolution of reimbursement in the NHS in England
- The case for change – diabetes care example
- The way forward – alternative reimbursement models

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

Very quick introduction to the UK's National Health Service – Part 1

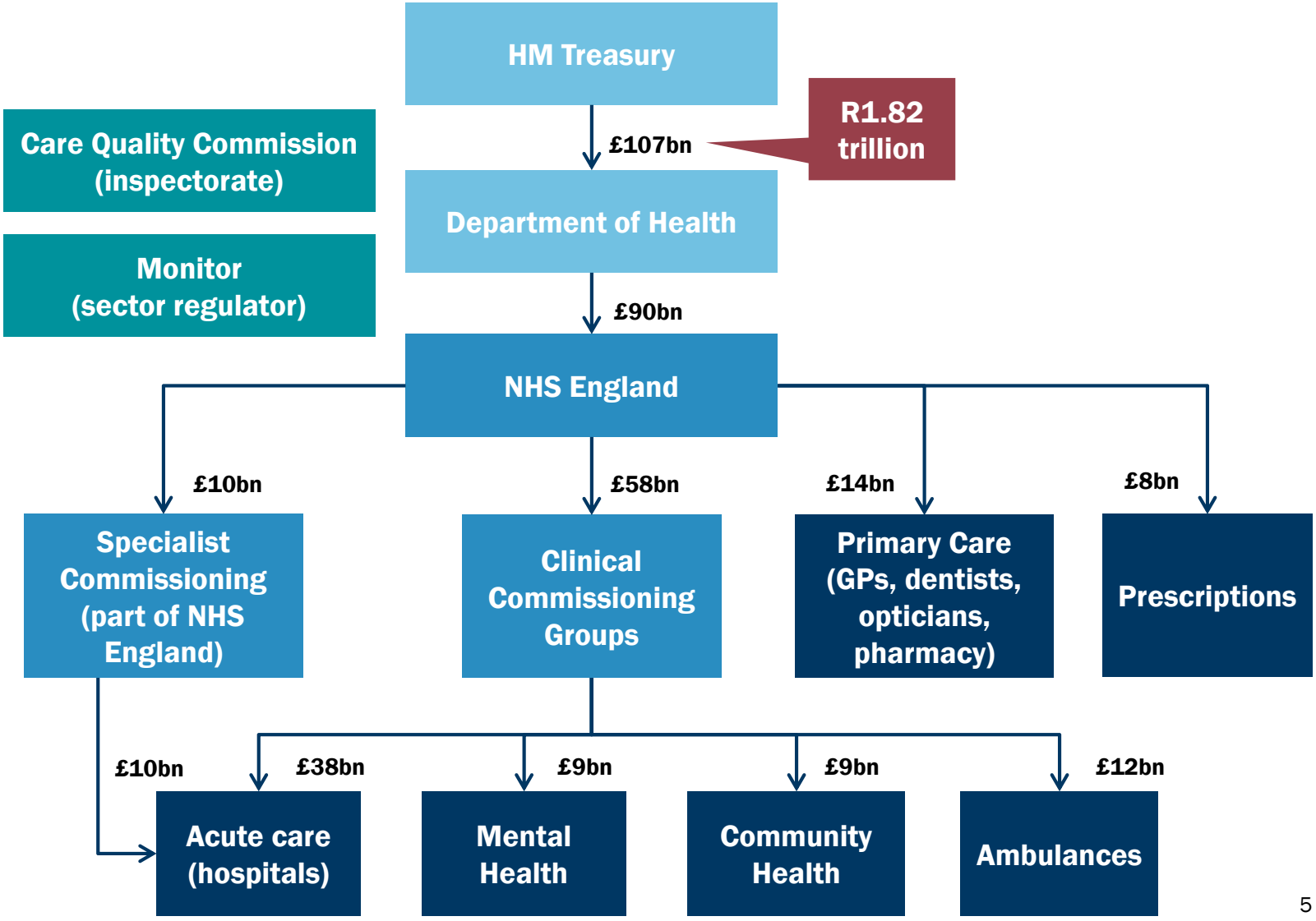
- The NHS provides healthcare which is free at the point of use for everyone in the UK, and funded by taxpayers
- As patients do not pay to use the system, there must be some means of organising the flow of taxpayers' money to healthcare services used by patients (e.g. hospitals)
- The NHS in England 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.)



Very quick introduction to the UK's National Health Service – Part 2

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



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

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

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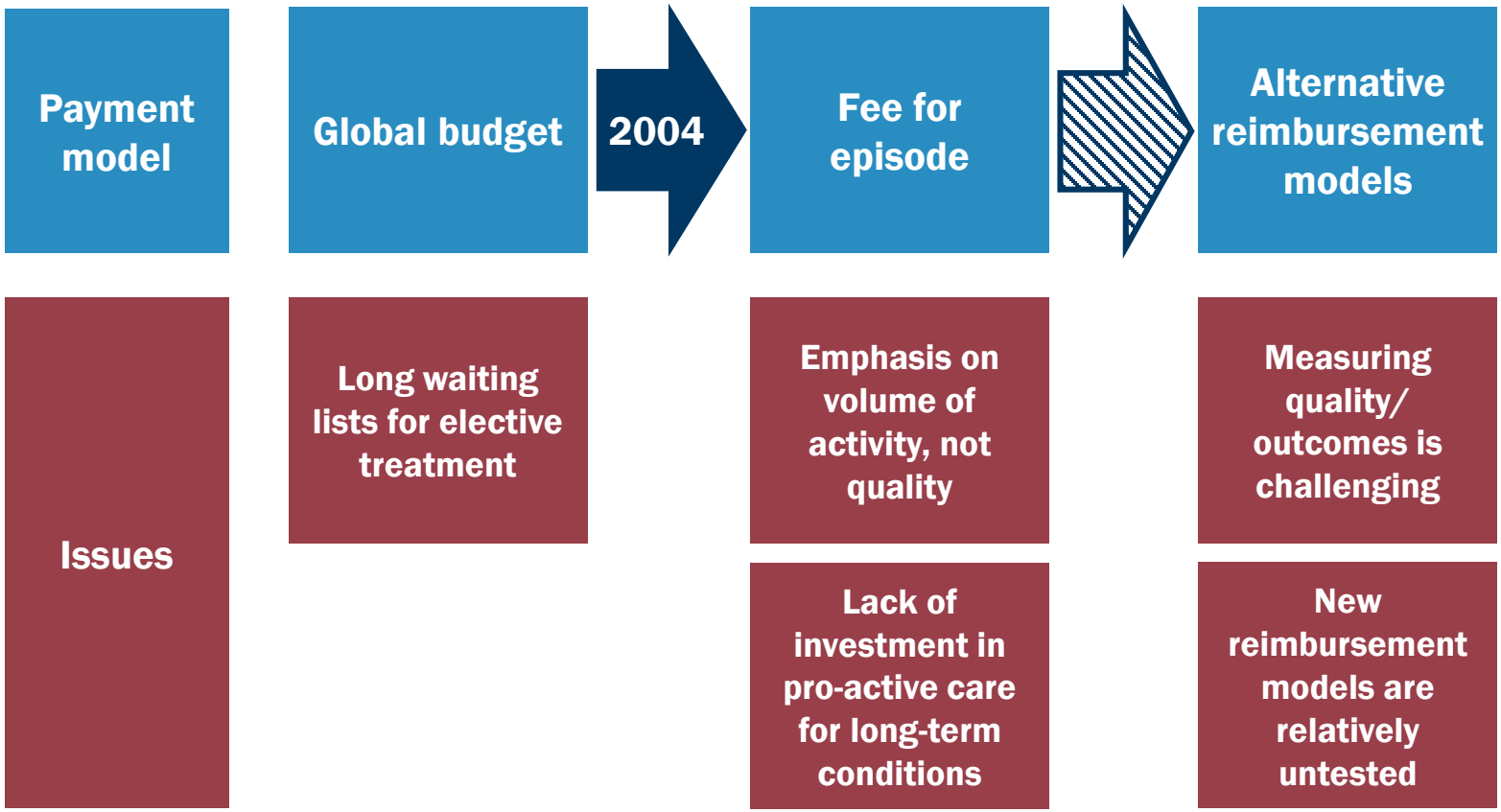
A (very) brief history of NHS reimbursement

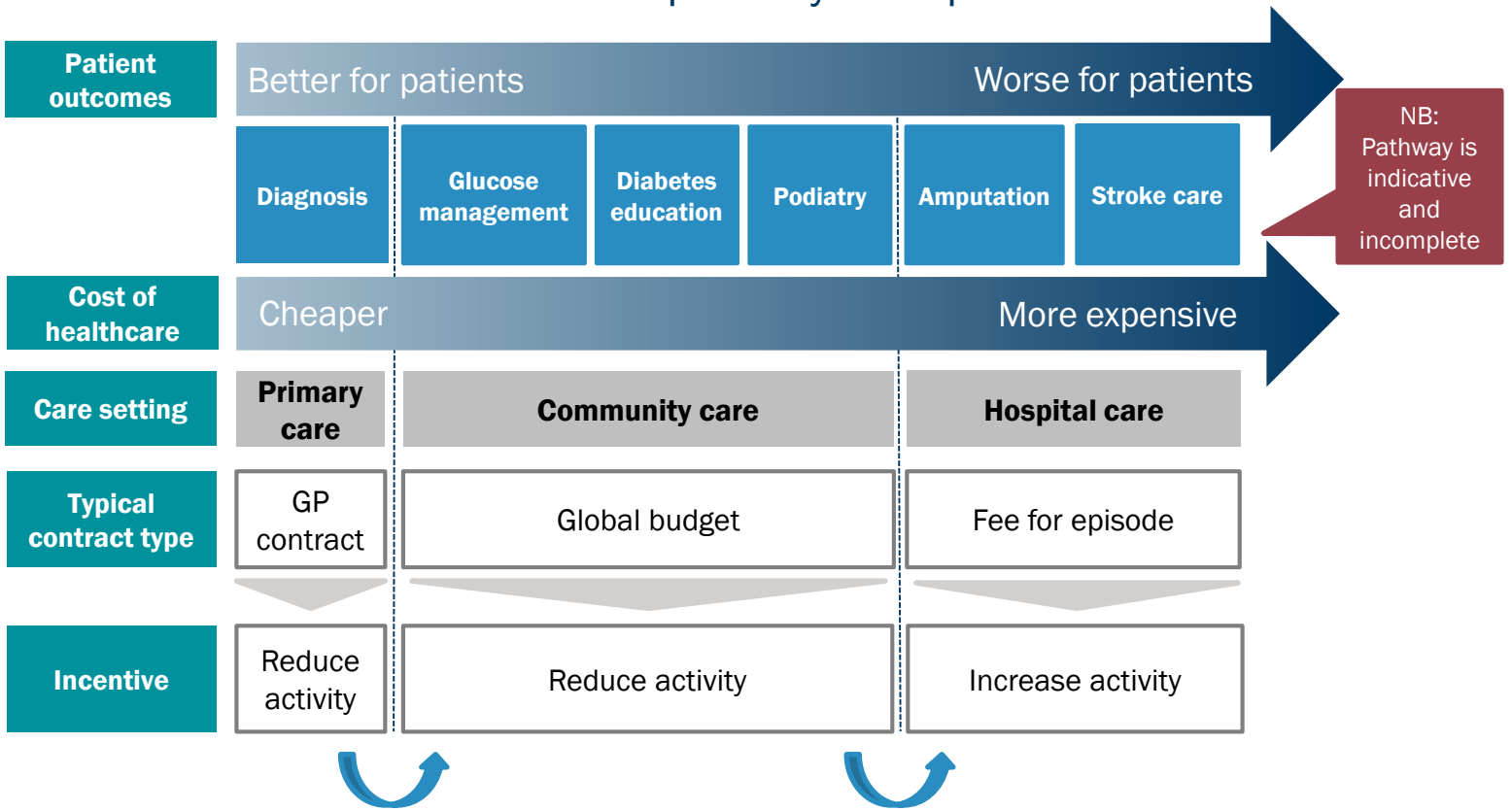
- Evolution of reimbursement has been driven by specific challenges facing the NHS at different times



- 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



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

...but we can change contract approach to directly address these problems and incentivise earlier investment in care

Diabetes pathway example

Patient outcomes: Better for patients → Worse for patients

- Diagnosis
- Glucose management
- Diabetes education
- Podiatry
- Amputation
- Stroke care

NB: Pathway is indicative and incomplete

Cost of healthcare: Cheaper → More expensive

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

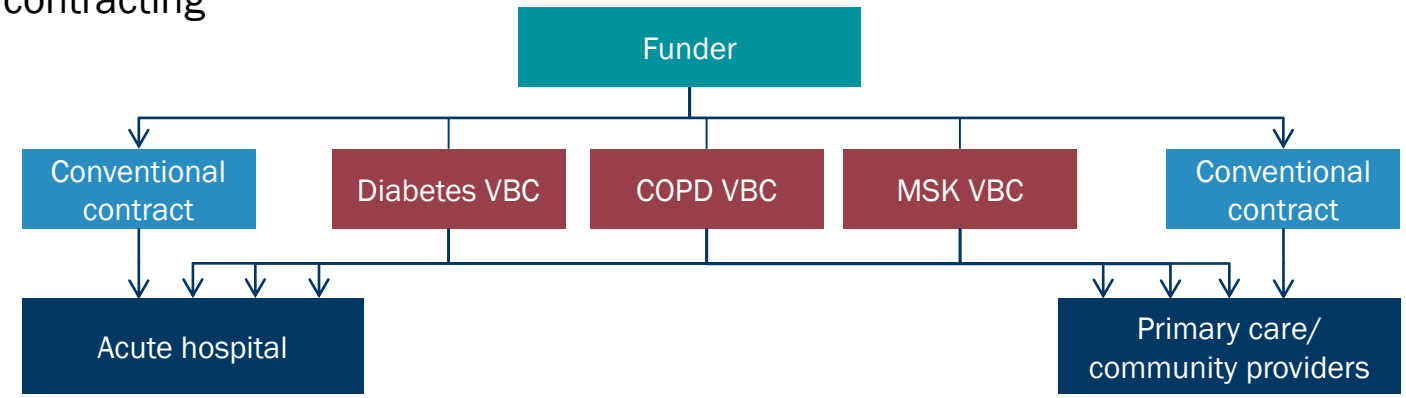
- Provider incentivised to work out **most efficient use of resources** along pathway;
- e.g. **invest in care earlier** (which is generally cheaper) to prevent more costly care later

Potential result

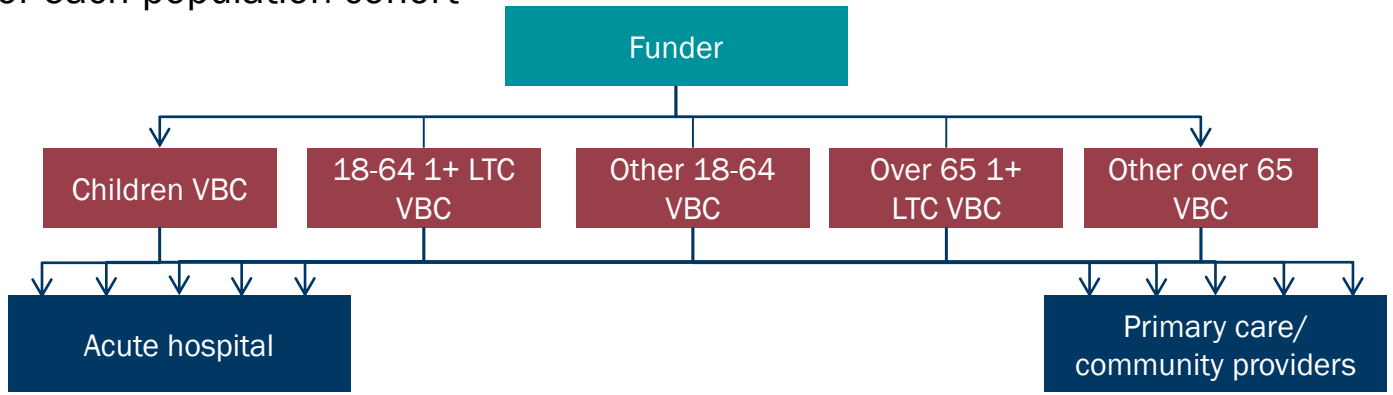
- Lowers costs
- Improves patient outcomes

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

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