

July 14

CONTRACTING FOR OUTCOMES

A Value-Based Approach

This technical paper offers an understanding of the different contracting, reimbursement and incentive mechanisms available to deliver Value and Outcomes-Based Healthcare in a UK context.



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Contracting for Outcomes

A Value-Based Approach

If the word ‘outcomes’ is used meaningfully, it is unlikely that any single provider of care is able to deliver any given outcome in isolation from other providers. Commissioning for outcomes is only possible if appropriate contracting mechanisms that encourage and reinforce shared accountability are in place for delivery of those outcomes across provider organisations and full care cycles. Additionally, outcomes and costs must be measured over similar periods during the care cycle, to ensure an accurate interpretation of the results achieved against the full costs of providing care.

This paper provides background information and analysis about the different contracting and reimbursement mechanisms available to deliver Value-based Healthcare in a UK context, looking at the operational challenges and legal considerations. It was produced in support of the North Central London (NCL) CCGs’ Value-based Commissioning (VBC) Programme.

Table of Contents

I.	INTRODUCTION	2
II.	CONTEXT	3
III.	ANALYSIS	5
3.1.	CURRENT COMMISSIONING LANDSCAPE.....	5
a)	Current Landscape: Contracting	7
b)	Current Landscape: Reimbursement.....	9
c)	Current Landscape: Challenges and Implications for VBC	14
3.2.	VBC OPTIONS.....	15
a)	VBC Contracting Routes	17
i)	CONTRACTING MODELS DESCRIPTION	18
ii)	CONTRACTING MODELS: STRENGTHS AND WEAKNESSES	21
b)	VBC Reimbursement Options	29
i)	BUNDLED PAYMENT OPTIONS.....	31
ii)	INCENTIVE MECHANISMS	38
IV.	FURTHER CONSIDERATIONS.....	42
V.	APPENDICES	43

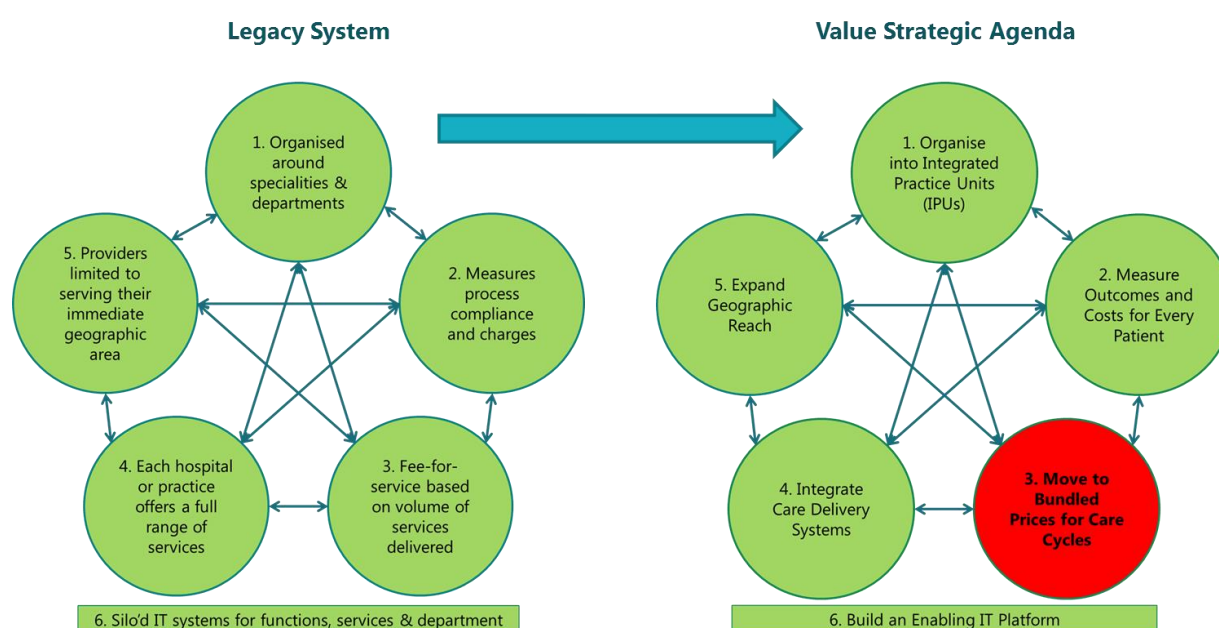
Commissioned by:

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I. INTRODUCTION

This paper is underpinned by the principles of the Value-based Healthcare Agenda^{1,2}. The overarching goal of the agenda is to achieve the best outcomes for patients at the lowest cost, and it is composed of 6 inter-dependent but mutually reinforcing components, as set out in Diagram 1 below. In common with most healthcare systems, the NHS is currently fragmented with little true integration of care across complete care cycles³. This can result in duplication of services and increased costs, as well as lack of overall accountability for the outcomes achieved by the users of healthcare services. The Value Agenda moves the focus towards achieving patient outcomes, and away from volume and activity, which is how most healthcare services are currently commissioned.

Diagram 1: The Value-based Healthcare Agenda



Source: VBHCD Intensive Seminar, Harvard Business School (2014)

This paper focuses on component number 3 of the Value Agenda - *Move to Bundled Payments for Care Cycles* – being the first step towards exploring available contracting options and reimbursement mechanisms in a Value Based Commissioning (VBC) context. Although financial analysis is beyond the scope of this paper, the “cost” element of component number 2 is also linked to component 3: ultimately an understanding of the true costs to deliver outcomes across the full care cycle is required to successfully implement any Value-based approach.

The changing pattern of need requires greater integration – that is, much better alignment – in the commissioning of health and social care services. Yet, in recent years the tendency has been for that to become more fragmented. Some 211 clinical commissioning groups currently commission acute hospital and community health services. Social care on the other hand is the responsibility of 152 completely separate local authorities, while NHS England is responsible for commissioning all primary care and specialist provision.

Source: King's Fund. “A new settlement for health and social care”, 2014

¹ Porter M. and. Lee T. “The strategy that will fix health care”. Harvard Business Review, 91.12 (2013): 24-24.

² Porter M. “What is Value in Healthcare”. N Engl J Med 2010; 363:2477-2481 December 23, 2010 DOI: 10.1056/NEJMp1011024

³ Oldham J. “Reform Reform: An essay by John Oldham”, BMJ 2013;347:f6716

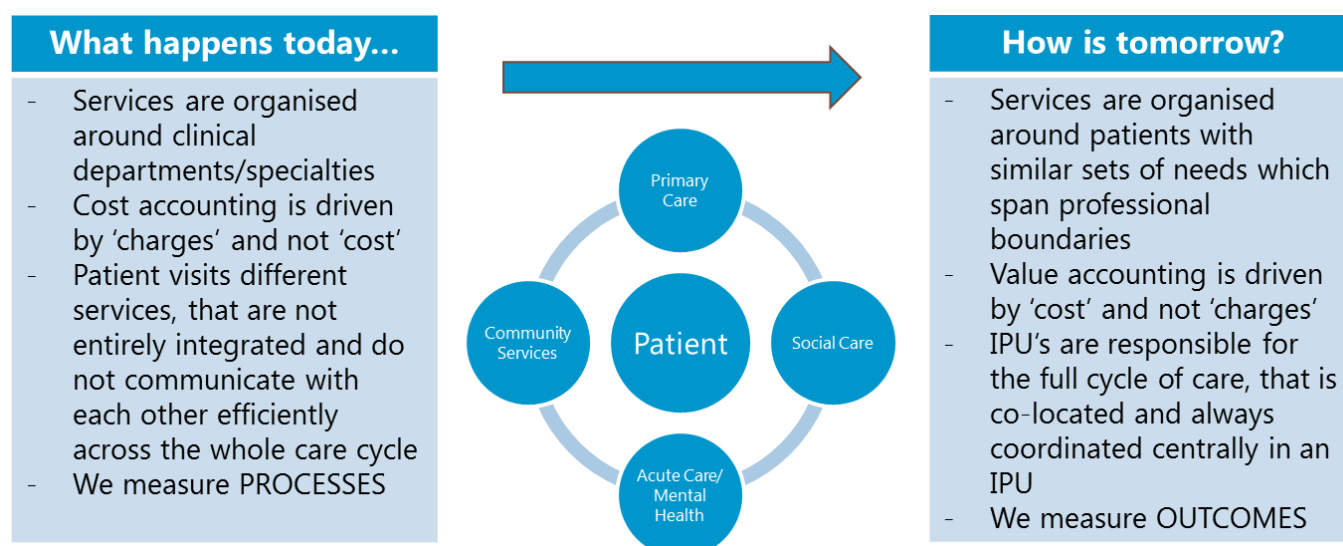
II. CONTEXT

Redesigning care around the delivery of outcomes that matter to patients requires a multi-disciplinary approach to prevention, diagnosis, treatment, and follow-up, creating an environment of continuous learning, improvement, and innovation in which robust assessments of quality are constant and on-going⁴. This is delivered through component number 1 of the Value Agenda: *Organise into Integrated Practice Units (IPUs)*. Membership of an IPU cuts across a number of existing care settings and requires a range of providers from primary, secondary and social care, local government and the third sectors. The IPU team and precise combination of providers in an IPU may vary significantly between different patient 'segments'.⁵

This means that in order for VBC to be successfully implemented, there is a need to explore beyond existing activity and volume based contractual routes and to consider new, innovative contractual solutions that focus on incentivising integration of care between multiple providers. The focus of VBC is on improving outcomes across the full care cycle, such as improving the mobility and lives of people with osteoarthritis, rather than focusing on discrete elements of a care pathway, such as the number of hip replacements carried out. Therefore, the chosen contractual route needs to incentivise providers to work together to achieve a common objective.

If the word 'outcomes' is used meaningfully, it is unlikely that any single provider of care is able to deliver any given outcome in isolation from other providers. This means that in a VBC context, there is **joint accountability for outcomes and costs**, and therefore existing contracting models require modification. Merely strengthening existing arrangements is very unlikely to achieve integrated care because there are few levers or incentives to foster joint accountability. Commissioning for outcomes is only possible if appropriate contracting mechanisms that encourage and reinforce shared accountability are in place for delivery of those outcomes across provider organisations and the full care pathway.⁶

This paper sets out the various multi-provider contractual and reimbursement options to support VBC, starting with an understanding of the existing contractual landscape.



⁴ Pollock R., "Value-based Health Care: The MD Anderson Experience" *Annals of Surgery*. 2008; 248(4):510-516

⁵ OBH. "Integrated Practice Unit (IPU): An Introduction", April 2014.

⁶ Dunbar-Rees, R. and McGough, R. "Team effort: Commissioning through alliance contracts". *Health Service Journal*, November 2013.

Joint accountability for outcomes and costs: In the current system no one individual or group is accountable for, or has visibility of the whole cycle of care. This results in a lack of ownership of the overall, and continuing, health of the patient. Since no clinician or teams of clinicians are answerable to, or have sight of, the continual health of their patients, focus tends to be on reactive treatment, rather than proactive intervention and preventative action. In an IPU model of care delivery, its membership is defined by the different providers that are needed to deliver the specified outcomes across the full care cycle for a group of people with similar needs (segment). Their key objective is 'how can we best deliver this outcome together?', rather than the current system, where each provider often acts on an individual basis, accountable only for their direct contribution with sometimes differing and potentially clashing organisational objectives for delivering care for their part of the patient's care pathway.

Source: OBH, Integrated Practice Unit (IPU): An Introduction – IPU Knowledge Pack for North Central London (NCL) VBC Programme. For more information, see Appendix 1.

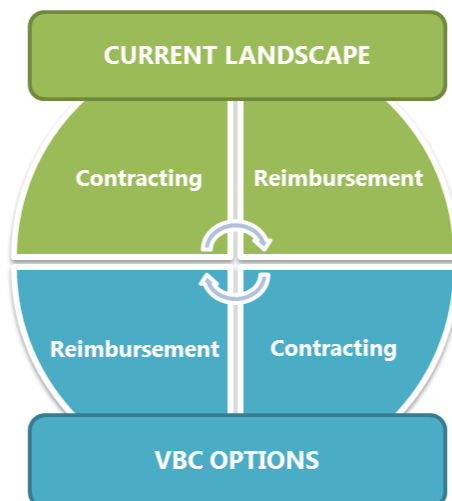
The next analysis section covers in detail:

➤ **Current Commissioning Landscape**

- Contracting Landscape
- Reimbursement Landscape

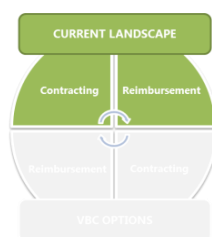
➤ **VBC Options**

- VBC contracting routes
- VBC reimbursement options



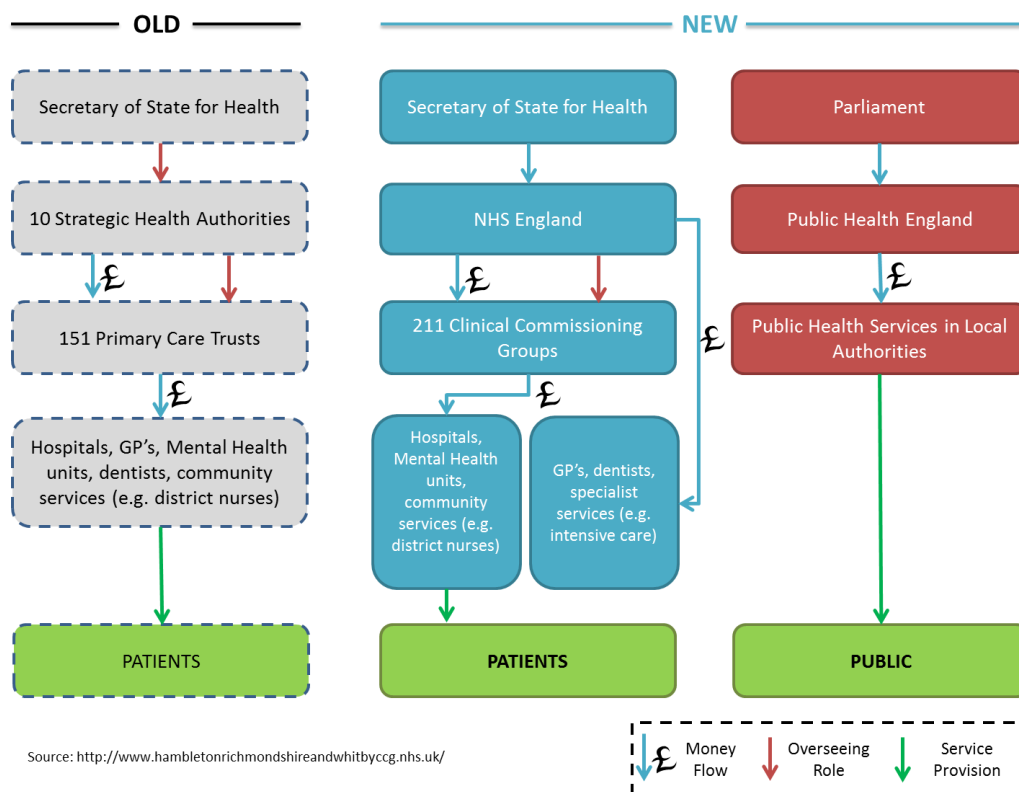
III. ANALYSIS

3.1. Current Commissioning Landscape



To understand VBC contracting in a UK context requires first a comprehensive understanding of the existing contractual landscape in the NHS. The new commissioning landscape following the NHS reforms which came into effect in England in April 2013 is shown in a simplified diagram below:

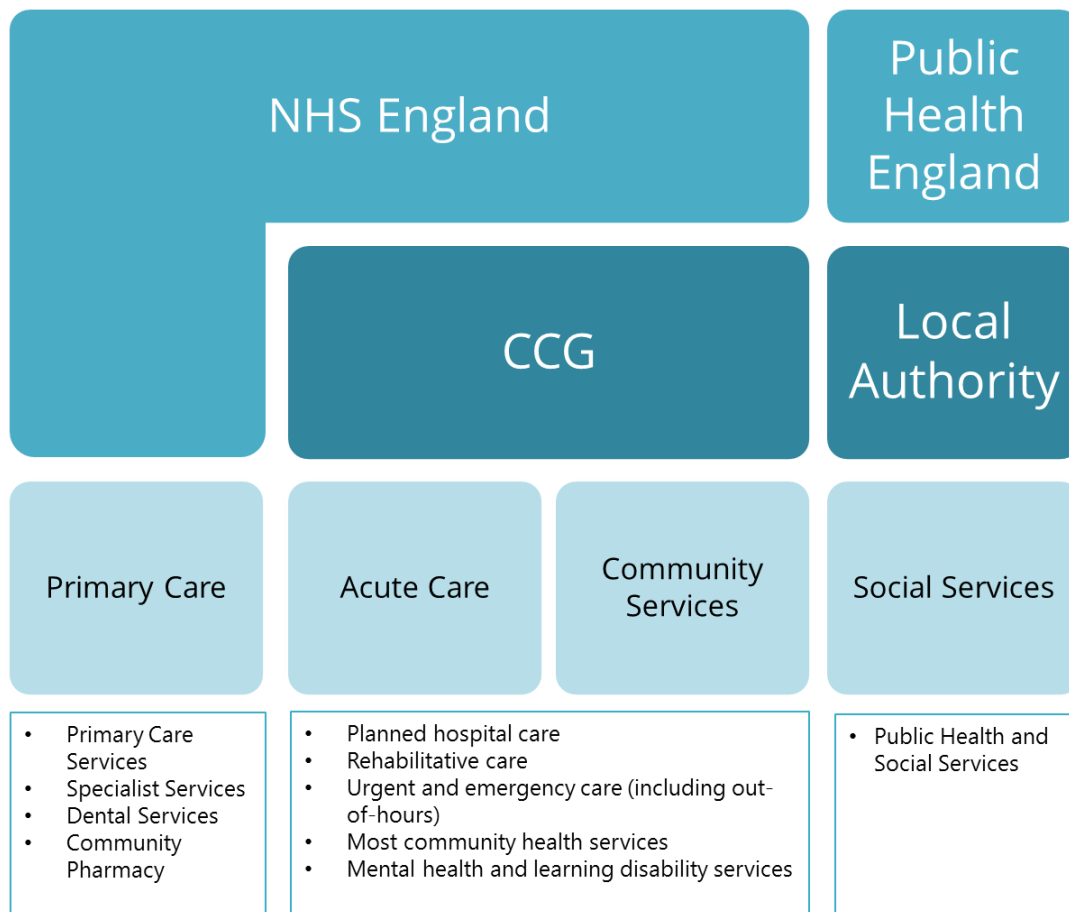
Diagram 2: Comparison - Commissioning Landscape in the NHS⁷



⁷ Source: http://www.hambletonrichmondshireandwhitbyccg.nhs.uk/data/uploads/publications/health_diagram_april2013.jpg

The following diagram clusters the main statutory categories of health services into 4 groups - primary care, acute care, community services and social services – according to their corresponding source of funding:

Diagram 3: NHS Statutory Providers and Source of Funding



Several different entities now commission services that were previously under PCTs' responsibility. The fact that different types of providers hold different types of contracts, which can trigger reimbursement in fundamentally different ways, presents challenges when seeking to adapt contracts for use in VBC.

The challenge now is to take account of this (system) fragmentation in designing a payment system for NHS care which supports joint working and the creation of a true health care system for patients.

Source: The NHS payment system: evolving policy and emerging evidence, Nuffield Trust, 2013.

a) Current Landscape: Contracting



Under law and/or guidance, Commissioners must use specific contracts when contracting for clinical services and the appropriate contract depends on the services commissioned. The appropriate contract that generally must be used for each type of service is set out in the table below:

Table 1: Clinical Services and Respective Types of Contracts

Clinical Services Commissioned	Type of Contract
1. Acute	NHS Standard Contract
2. Community	NHS Standard Contract
3. Mental Health	NHS Standard Contract
4. Primary	PMS Contracts
	APMS Contracts
	GMS Contracts
	NHS Standard Contract (Community-Based Services)
5. Pharmacy	LPS Contract
6. Dentistry	PDS Contract
	GDS Contract

If the contract is required to comply with legislation, then it must do so or the Commissioner would be contracting unlawfully. Primary care services may only be provided under the following three contracting regimes:

- GMS – General Medical Services;
- PMS – Personal Medical Services; or
- APMS – Alternative Provider Medical Services.

Community-Based Services may be provided by primary care providers, in which case NHS Standard Contracts are used by CCGs.

GMS

The GMS contract is a UK-wide contract between general practices and primary care organisations for delivering primary care services. The contract contains all of the mandatory terms for GMS contracts that are currently required by the Health and Social Care (Community Health and Standards) Act 2003 and the National Health Service (General Medical Services Contracts) Regulations 2004 (SI 2004/291) (as amended) (GMS Regulations). The contract also contains further terms that are strongly recommended for inclusion (although they are not required by the 2006 Act or GMS Regulations).

PMS

Personal medical services arrangements are an alternative to GMS, in which the contract is agreed locally between the contractor and the Commissioner (NHS England).

The requirements for the contractual terms of PMS contracts are currently set out in the National Health Service (Personal Medical Services Agreements) Regulations 2004 (SI 2004/627) (as amended) (PMS Regulations) and, in many ways, reflect the content of the GMS Regulations.

APMS

Under the terms of APMS (alternative provider medical services) contracts Commissioners may engage with a wide range of providers to deliver primary care services tailored to local needs. APMS contracts must comply with the Alternative Provider Medical Services Directions 2013 (APMS Directions) and a new standard version of this form of contract has recently been issued by NHS England for use by Commissioners.

In terms of payment the current structures for primary care are set out at b) below.

NHS Standard Contract (NHSSC) for use in commissioning NHS Funded Healthcare Services

The NHS Standard Contract must be used by CCGs and by NHS England (NHSE) where they wish to contract for NHS-funded healthcare services (including acute, ambulance, patient transport, care home, community-based, high-secure, mental health and learning disability services). The only exceptions to this in the guidance are:

- (a) primary care services commissioned by NHS England;
- (b) any primary care improvement schemes commissioned by CCGs on behalf of NHS England (which would be effected through the primary care contracts held by NHS England); and
- (c) any out-of-hours primary medical services commissioned by CCGs on behalf of NHS England, for which an APMS contract must be used.

Under the NHSSC (and affirmed within the related technical guidance)⁸, Commissioners now have greater flexibility to:

- (a) determine the duration of the contract they wish to offer, within the framework of national guidelines and regulations on procurement, choice and competition, with the option of longer contract terms than previously to assist in transformational approaches;
- (b) in agreement with providers, move away from rigid national prices, using the Local Variation flexibility set out in the National Tariff guidance, potentially developing different payment models based more on quality and outcomes and less on activity; and
- (c) utilise innovative contracting models such as the prime provider approach (described in a subsequent section).

⁸ NHS England. "NHS Standard Contract 2014/15 – Final Technical Guidance", February 2014.

b) Current Landscape: Reimbursement



The main existing contracting reimbursement schemes in the UK healthcare system can be summarised into five categories, with the last one, fee-for-service, having very marginal representation in the UK compared to the totality of healthcare services commissioned.

Block Payments	• Provision of specified services for a specific time period (e.g. Community Care)
Global Capitation	• Provision of care for a specific patient population (e.g. Primary Care Global Sum)
Case-Based	• Provision of fixed sum for episodes of care (e.g. Payment by Results, Acute Tariff Based Care)
Pay-for-Performance	• Payment that rewards or penalises providers for aspects of their performance (CQUINs, Best Practice Tariff, QOF).
Fee-for-Service	• Provision of specific services (e.g. some Local Enhanced Services, but significantly more common outside the UK)

The following table summarises the key characteristics of the current reimbursement models utilised in the UK:

Table 2: Reimbursement Models – Keys Characteristics

	Block	Capitation	Case-Based	Fee-for-Service	Pay-for-Performance
Definition	Provision of services for a specific time period	Provision of care for a specific patient population	Provision of fixed sum for episodes of care	Provision of specific services	Payment that rewards or penalises providers for aspects of their performance
Payment Basis	Historical Prices	Population characteristics and demographics	Episode of care	Delivery of specific service	Achievement of performance thresholds
Type	Prospective	Prospective	Retrospective	Retrospective	Retrospective
Advantages	Low transaction costs	Relatively low transaction costs, although higher than block contracts.	Increased competition can boost care quality where tariffs are fixed ⁹	Increased competition can boost care quality where tariffs are fixed	Potential to enhance quality and efficiency of care delivered
	Budget is predictable, allowing for financial control	Budget is predictable, allowing for financial control	Providers incentivised to reduce cost per episode since "currency" is fixed	No provider incentive to withhold care. They are paid for every service	Financial reward and penalties incentivises providers to comply with guidelines.
	Flexibility for providers to change services offered without it having an impact on their finances	Budget is adjusted according to population characteristics and demographics	Quality improvement might be incentivised to attract patients	Quality improvement might be incentivised to attract patients	System that enables comparison between providers, increasing competition
		Takes into consideration social and health inequalities in target population	More transparency around cost allocation and activity	Full transparency around cost allocation and activity	Full transparency around cost allocation and activity

⁹ Cooper Z. et al. "Does Hospital Competition save lives? Evidence from the English NHS Patient Choice Reforms". The Economic Journal, Volume 121, Issue 554, pages 228-260, August 2011

	Block	Capitation	Case-Based	Fee-for-Service	Pay-for-Performance
Disadvantages	Lack of transparency and accountability	Risk posed by increased activity and cost of care	Providers are incentivised to increase activity in what may not be the most effective care setting	Providers are incentivised to increase activity in what may not be the most effective care setting	Frequently rewards compliance with processes of care rather than outcomes
	Spending limit constrains volume of services provided	Risk posed by sudden changes in demographics	Incorrect coding can result in over or underpayment	Provider incentivised to offer more services, even if unnecessary	Risk of becoming a "tick-box" exercise, rather than improving care for patients
	Risk posed by increased activity and cost of care	Incentive for provider to not deliver care that is complex/costly	Incentive to reduce cost per episode of care might compromise quality where prices	High transaction costs; requires complex administration of services	Attention shift: risk that unrewarded work may be sacrificed ¹⁰
	Pressure on "good" providers that attract more activity		Higher transaction costs due to need of a more sophisticated billing system	No incentive for provider to focus on prevention, taking a population level-approach	Higher transaction costs due to need for a more sophisticated billing system
Impact on Outcomes for Patients	No specific focus on delivery of outcomes; providers may choose to 'under deliver' services if there are costs/activity pressures, impacting quality of care	No specific focus on delivery of outcomes; providers may choose to 'under deliver' services if there are costs/activity pressures, impacting quality of care	Incentive to reduce costs in order to improve profits may have a negative impact on patient outcomes	Incentive to increase activity without explicit considerations of outcomes for patients	As measurement is frequently related to care processes, model doesn't closely impact outcomes

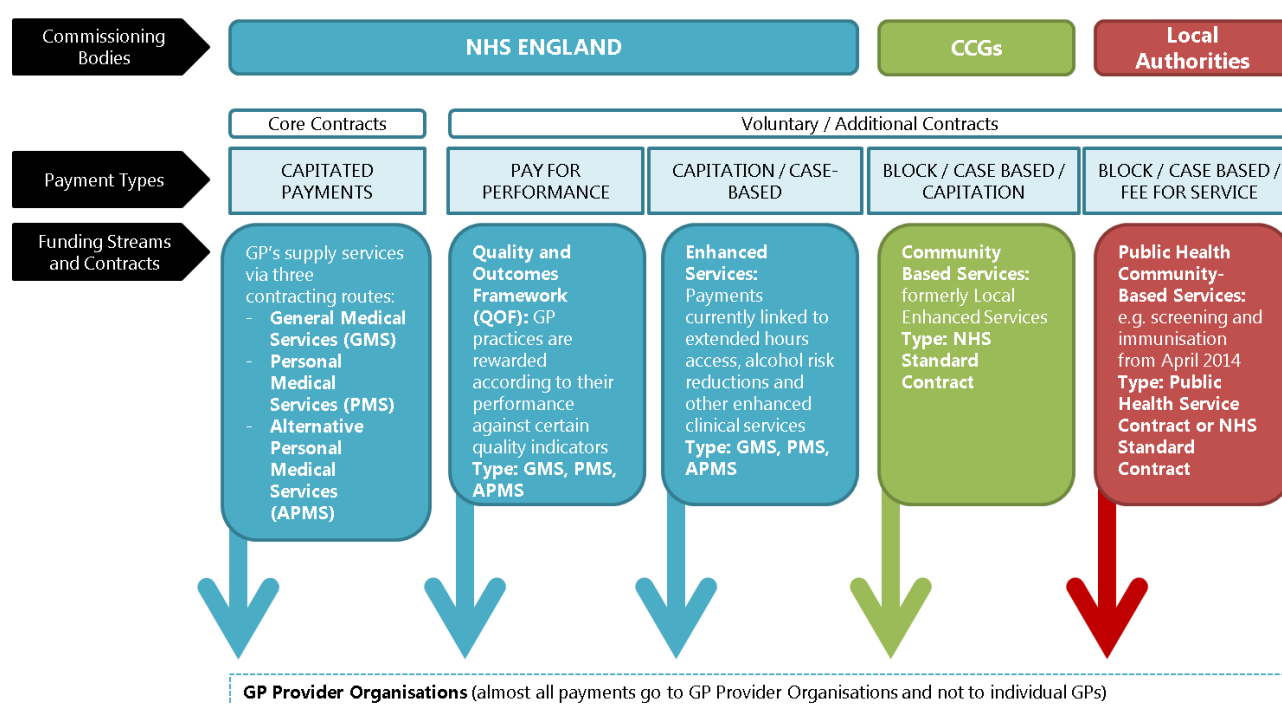
¹⁰ Holmstrom B and Milgrom P. "Multitask principal-agent analyses: incentive contracts, asset ownership and job design". Journal of Law, Economics and Organization 7 (special issue), 24–52, 1991.

In the UK acute sector there is a predominance of case-based payments in the form of Payment by Results (PbR) and/or Local Tariff arrangements¹¹. In primary care, capitation contracts predominate. However, different provider organisations can currently hold a mix of different types of contracts.

i. Primary Care (General Practice):

Within primary care, the current commissioning landscape sees a mix of weighed capitation payments, fee-for-service for certain local enhanced services i.e. immunisation, pay-for-performance schemes in the form of the Quality and Outcomes Framework (QOF) and block payments for community based services. The diagram below summarises the flow of funding and contracting in general practice:

Diagram 4: Funding and Contracting in Primary Care (General Practice)¹²



ii. Secondary care: Acute, Community and Mental Health

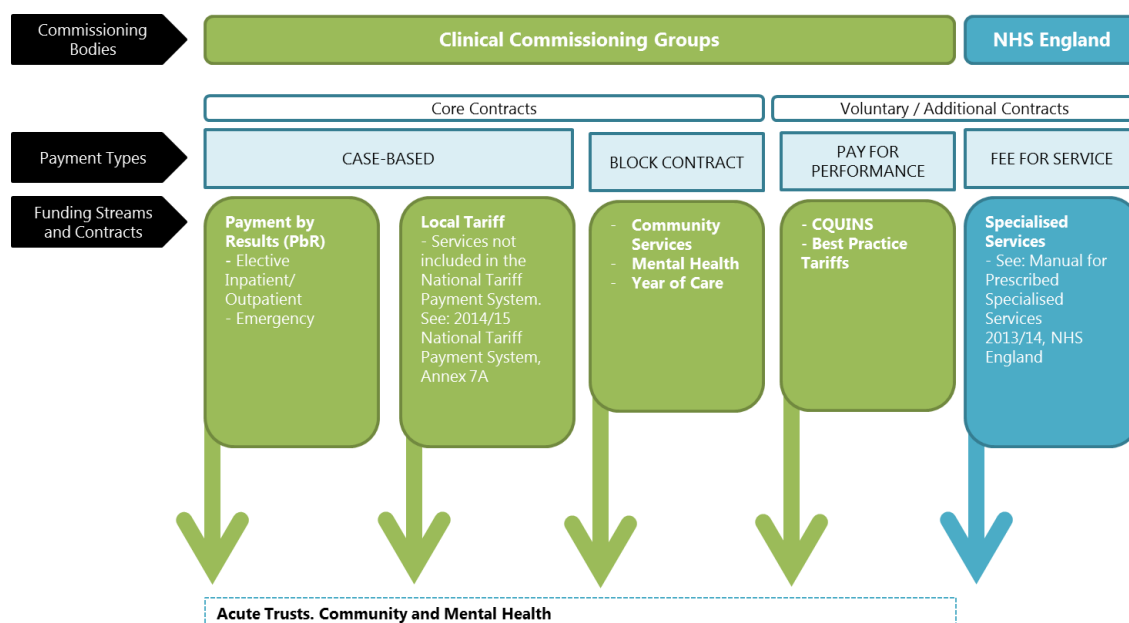
Case-based payments in the form of PbR and/or Local Tariff arrangements are the predominant payment system in the acute setting, coexisting with block budgets, some fee-for-service, for example, for 'unbundled' diagnostics and a number of pay-for-performance mechanisms. While for acute hospitals over two-thirds of the activity is commissioned through case-based contracts, the predominant payment system for the remaining secondary services is block budgets – around 90% of community services and two-thirds of mental health are commissioned that way, with local tariffs applying to the remainder.¹³

¹¹ Monitor and NHS England. "An Evaluation of the Reimbursement System for NHS-funded Care". February, 2012

¹² Adapted from: Addicott, R. and Ham, C. "Commissioning and funding general practice". The King's Fund, 2014

¹³ Marshall L., Charlesworth A. and Hurst J. "The NHS payment system: evolving policy and emerging evidence". Nuffield Trust, 2014.

Diagram 5: Funding and Contracting in Secondary Care



iii. Social Care Services

Local social care services are funded in a much more localised way when compared to the NHS. The part of Social Care funds that come from central government - and is allocated to Local Authorities - is defined based on a "Relative Needs Formula", designed to reflect the relative needs of individual authorities in providing services. However it is important to note that unlike the majority of NHS care, social care services are not entirely free at the point of use, remaining "both heavily needs and means tested"¹⁴.

In the light of this allocation, councils then set their budget and agree the level of council tax – which represents 39 per cent of total expenditure – but in some councils as much as 80 per cent of spending is funded this way. Total national spending on social care is therefore the aggregated product of separate decisions made by 152 councils. This locally determined pattern of spending then shapes Department of Health planning in terms of Spending Review bids and the eventual settlement. These dislocated funding processes make it difficult to align NHS and social care resources with national policy objectives in a coherent and co-ordinated way.

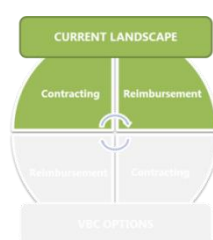
Source: King's Fund. "Social care funding and the NHS: An impending crisis?", March (2011)

Local Authorities mainly commission social care services from providers through the use of block contracts, which brings a level of complexity when trying to establish which particular population segment funds are being spent on i.e. older people living with frailty, people with diabetes, people with mental health problems, etc. The introduction of personal budgets (where individuals rather than the Local Authorities decide the services to buy) has the potential to put pressure on the use of block contracts. As more people arrange and buy their own services through direct payment, Local Authorities would have to use more "flexible procurement models", such as framework contracts and outcome-based contracts¹⁵.

¹⁴ King's Fund. "A new settlement for health and social care", 2014

¹⁵ Audit Commission. "Financial management of personal budgets". Local Government, October 2010.

c) Current Landscape: Challenges and Implications for VBC



There are a number of challenges to overcome in any move towards contracting on the basis of outcomes and Value:

Poor visibility of existing costs: The variability in payment and contracting systems across provider groups in the UK has a significant impact on the visibility of costs for defined segments of the population within the different care settings. Budgets designed around block contracts and global capitation provide little clarity around where costs of care are incurred.

Existing contractual restrictions: In a system where activity or case-based payment is predominant for acute and emergency care while capitated and block budgets prevails for community and primary care services, there appears to be little incentive to shift care from the high cost to more efficient care settings, or to incentivise prevention. These contractual constraints appear to work against some of the key benefits of a Value-based system.

Discrepancies in quality of coding: Even though there is more clarity around budgets under case-based contracts, incorrect coding poses significant obstacles to identifying real costs associated with specific populations segments. A 2012 report for Monitor found that about 9% of services are coded incorrectly.¹⁶ They also found that providers reported very different unit costs in providing the same services to patients, and that local reimbursement negotiations (through block contracts and local tariffs) are not based on reliable cost information.

Difficulty matching outcomes with costs: Difficulties in identifying the costs associated with delivering care to a specific patient segment across multiple providers can lead to potential mismatches between the outcomes being measured against the costs which relate to them.

Inaccuracies in estimating whole care cycle costs: In any whole care cycle costing model, it is likely that initial costs may be an under or overestimate. The extent to which any initial inaccuracy will impact providers depends on choices around how much of the budget will be linked to achievement of outcomes, and over what period (see section 3.2 b).

Spending on diabetes services in the United Kingdom has increased from £0.9 billion in 2006-07 to £1.3 billion in 2009-10. These figures are likely to be a substantial underestimate because of a lack of good-quality cost data for primary care and community services, which provide the majority of care, and because of the way in which costs are assigned to hospital activity. We estimate that the total cost of diabetes to the NHS in 2009-10 was at least £3.9 billion.

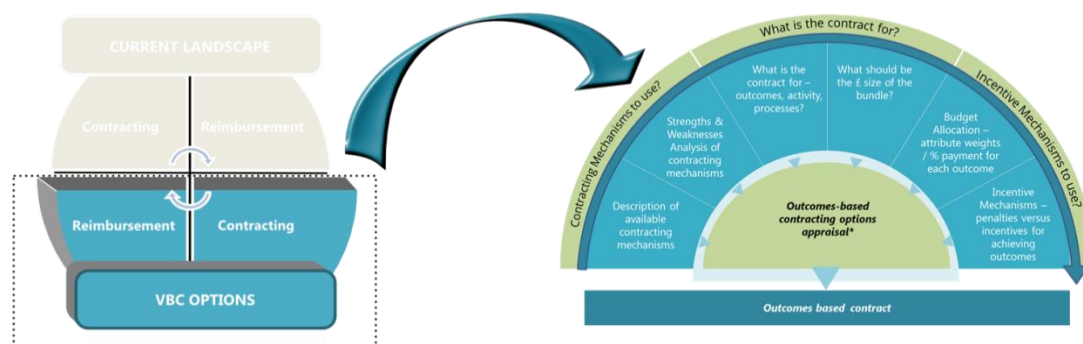
Source: The management of adult diabetes services in the NHS, National Audit Office, Department of Health (2012).

Avoiding 'double counting' of services: Depending on the contracting choice taken, there is also a need to review the services to unpick any "double counting" of services which are effectively covered under two (or more) contracts with different providers. These will then need to be refined and clarified in the specification and costings.

There is no doubt that there are a number of significant challenges to ambitions to integrate services under a single ('bundled') payment across care cycles. The existing commissioning landscape presents difficulties when applying the concept of 'bundled' payments/contracts across complete care cycles. However there are in fact a range of options to support implementation of VBC described in the next section of this paper to address many of these. Making the right choices in the light of local context allows many of the challenges outlined above to be overcome.

¹⁶ Monitor and NHS England. "An Evaluation of the Reimbursement System for NHS-funded Care". February, 2012

3.2. VBC Options

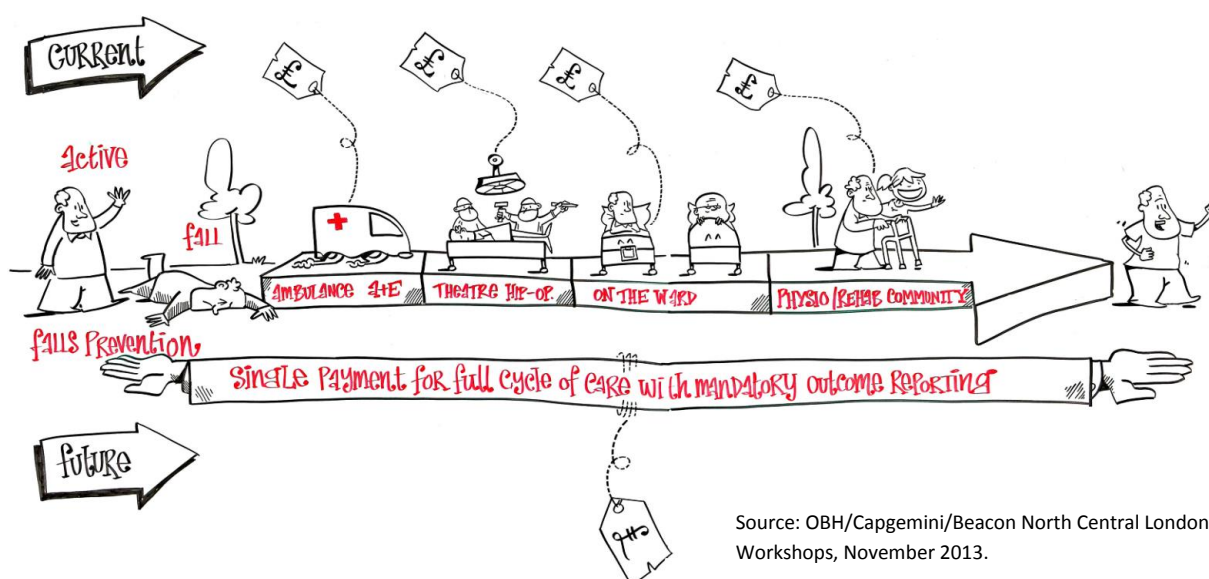


The reimbursement mechanisms required to foster joint accountability for outcomes and costs means a fundamental shift from existing models. Any reimbursement mechanism that supports the implementation of VBC should have the following characteristics- known as a 'bundled payment'¹⁷:

- It encompasses a single payment for a full cycle of care, with mandatory outcome reporting
- It incentivises providers to improve outcomes and lower costs across the full care cycle
- It is underpinned by shared incentives between providers on achievement of agreed outcomes

➔ This results in incentivising prevention and shifting care to the most efficient settings.

Diagram 6: Bundled Payment vs Existing Payment System



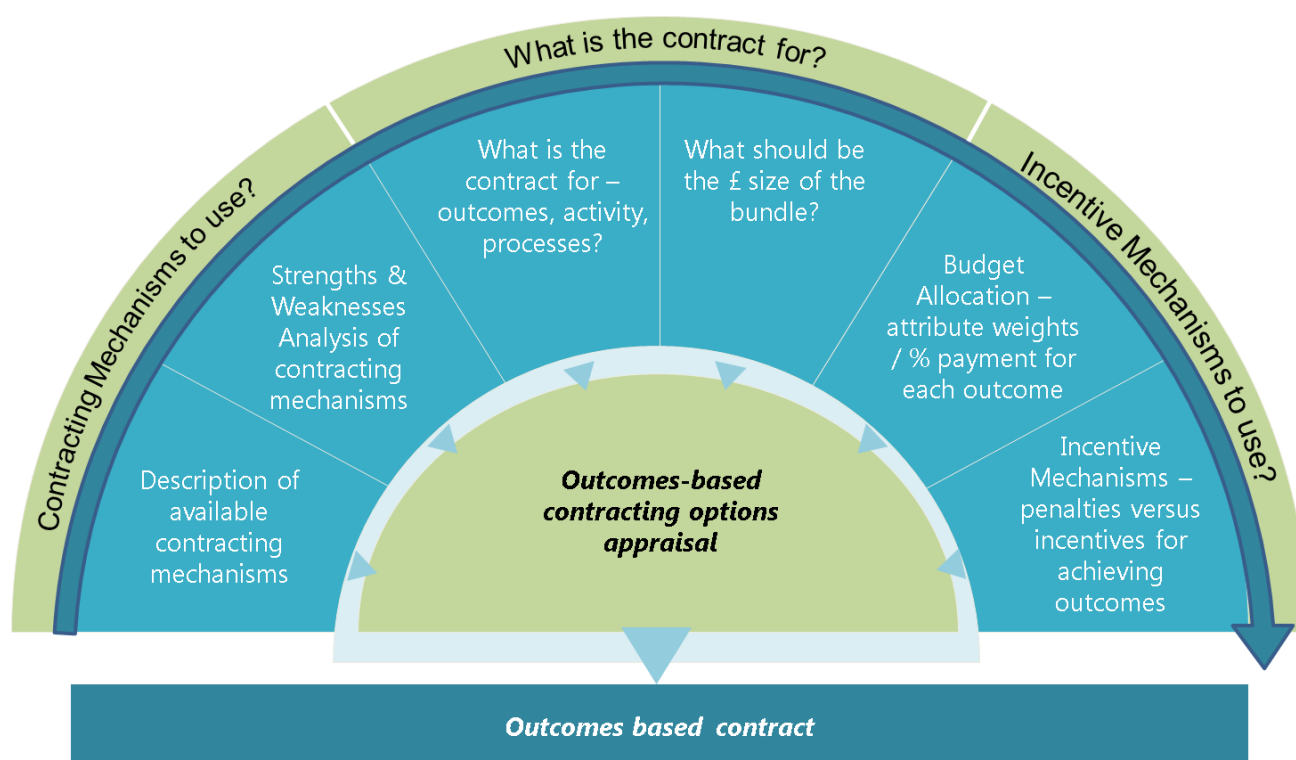
Source: OBH/Capgemini/Beacon North Central London Outcomes Workshops, November 2013.

¹⁷ Porter M. "What is Value in Healthcare". N Engl J Med 2010; 363:2477-2481 December 23, 2010 DOI: 10.1056/NEJMp1011024

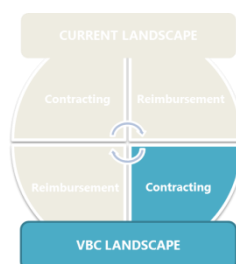
There are three main questions that need to be answered if the decision to contract on the basis of outcomes has been made:

1. **What contract mechanism should be used?**
2. **What is the contract for – i.e. activity, processes and outcomes or just outcomes in scope?**
3. **What incentive mechanisms should be used?**

Each of these decisions should be made in light of the outcomes being sought. Whichever contracting and incentive mechanisms are chosen, they should reinforce and support the delivery, rather than drive the purpose of the service. If the contract type is decided in isolation or in advance of selecting outcomes, there is a risk that the contract type may not be the most appropriate for delivery of those outcomes.



a) VBC Contracting Routes



There are a number of contracting models available that can enable commissioning on the basis of outcomes across complete care cycles and multiple providers. Each have their strengths and weaknesses, operational challenges and legal implications considered below.

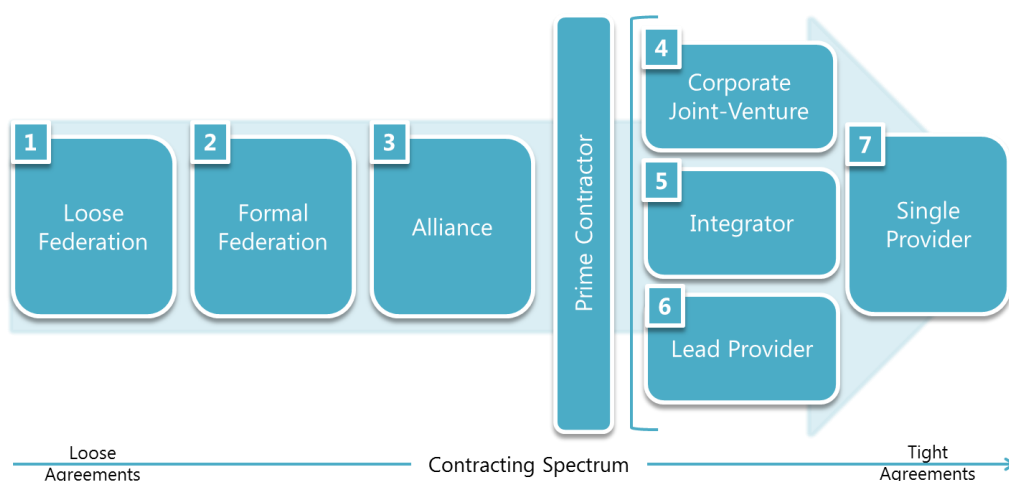
"Any value-based system requires contractual and financial structures to support and sustain delivery of the steps above. A common pitfall is to view a contract or a payment system as the first step to delivering better outcomes across the pathway, before going through the steps above... Whichever contractual form is chosen to deliver improved outcomes at lower cost, any contract should support rather than drive the purpose of a service. No single contract form is a 'magic bullet', suitable for all outcomes-based contracts."

Dunbar-Rees R, et al. "From volume to value?" Heart 2014;0:1–6. doi:10.1136/heartjnl-2013-305269 Harvard Business Review, 91.12 (2013): 24-24.

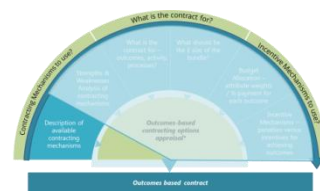
Any decision about the best model for providers to deliver the services under will be very closely linked to the type of commissioning/contracting solution which is proposed by the Commissioner to deliver greater integration and shared accountability for outcomes. The model/contracting solution may take various forms, for example, Commissioners may look to contract for all the services under one contract (such as a Prime Contractor type of model) or a more multi-contract approach utilising a form of interface agreement between existing providers to introduce more integrated provision between them.

The diagram below sets out the main contracting models along a scale of how formalised and 'tight' the contractual structure for integration is.

Diagram 7: Main Outcomes-Based Contracting Routes



i) CONTRACTING MODELS DESCRIPTION

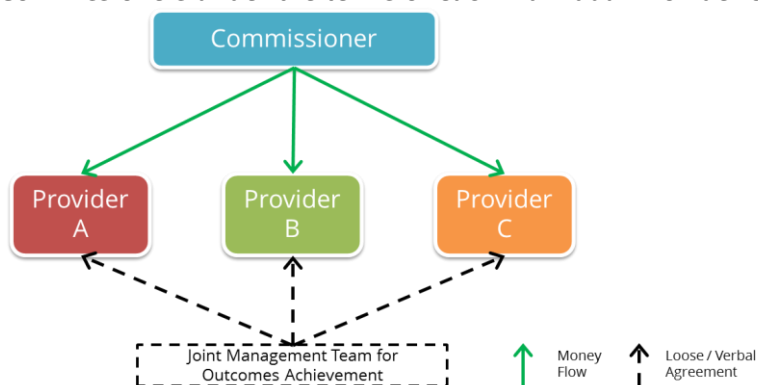


DESCRIPTION OF MAIN CONTRACTING MODELS

1. LOOSE FEDERATION

Features

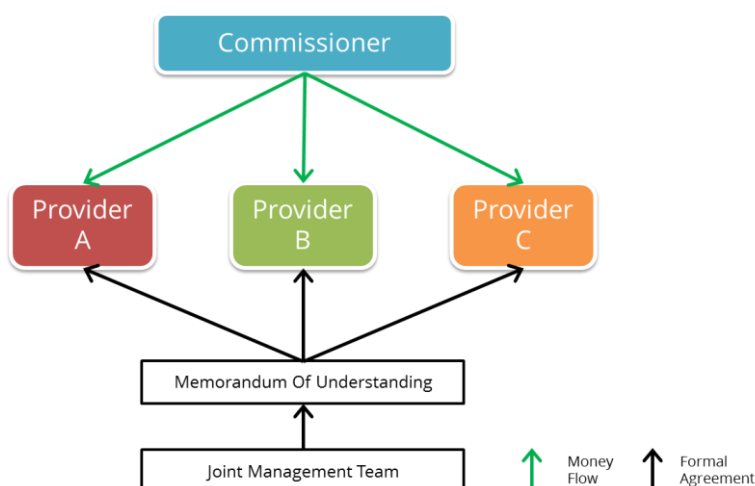
- Commissioner holds several contracts directly with each provider.
- Each provider retains full responsibility for the services they deliver.
- Option to form a joint management team, with a governing body comprised of representatives from each provider, in order to manage this collaboration effectively, though there is no formal contractual obligation upon the Providers to do so.
- Payments made by the Commissioners under the terms of each individual Provider contract.



2. FORMAL FEDERATION

Features

- Commissioner holds several contracts directly with each provider.
- Each provider retains full responsibility for the services they deliver.
- Providers organise delivery of their services via a memorandum of understanding or a service level agreement, reflecting a common understanding around services, priorities, responsibilities, etc.
- Option to form a joint management team, with a governing body comprised of representatives from each provider, in order to manage this collaboration effectively.
- For some forms of contract a contractual obligation to support integrated service provision could be utilised as a specific term under the contract with the Commissioner (only enforceable by the Commissioner).



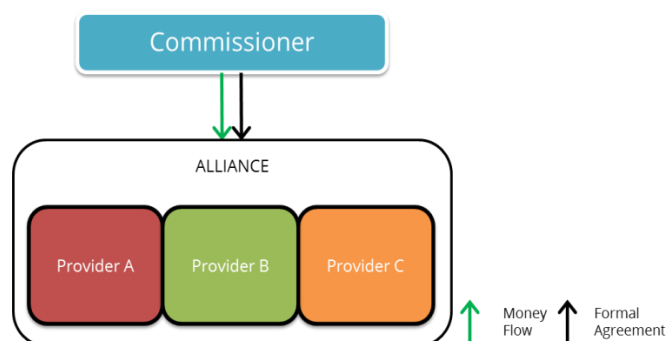
3. ALLIANCE CONTRACTING

Features

Although there is currently no single agreed form for an alliance arrangement in the NHS setting, common features of alliance arrangements in other sectors and geographies include the following features:

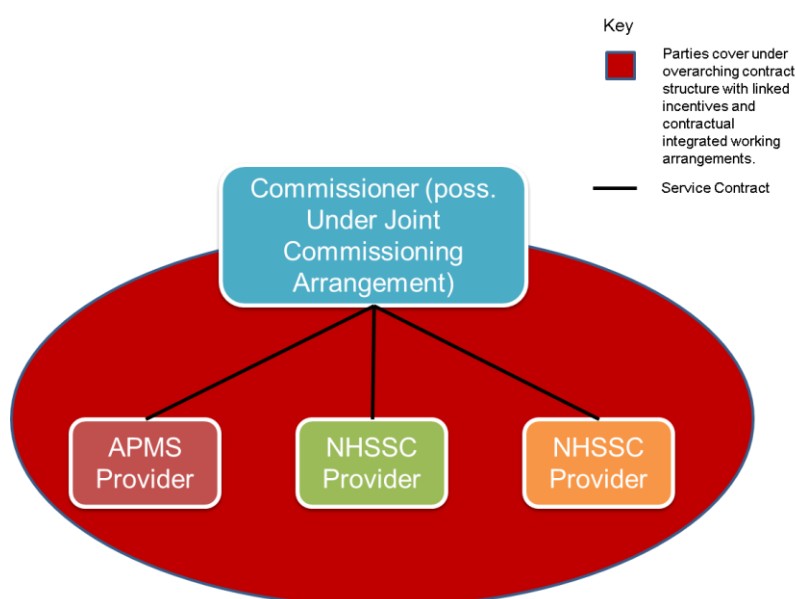
- A number of parties would enter into an overarching agreement to work cooperatively and to share the risk and reward, with clear contractual levers in place to drive integrated working and measured against set performance indicators - often pre-agreed outcomes indicators.
- The Commissioner and providers work as a single "integrated" team in order to deliver a specific project under a contractual framework which looks to tie their commercial interests in with the project's objectives.
- Clear contractual levers in place under the overarching agreement to drive integrated working.
- Providers are jointly responsible for delivering agreed outcomes under the overarching agreement or through alignment of separate contractual mechanisms.
- Each provider would need to agree how they implement the changes set out in our service description. For example, one provider might take responsibility for the single patient records system and another the multidisciplinary leadership team.

Typical alliance structure in other sectors:



However, the NHS Standard Contract does not currently permit an approach where one contract is entered into by multiple providers. There is potential to introduce alliance contracting based principles across providers with an overarching agreement entered into by all parties in addition to the providers' core service contracts.

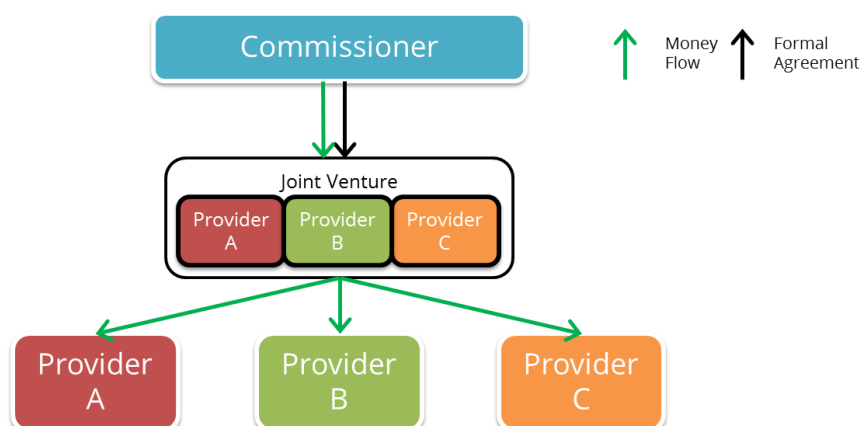
If an alliance contract was to be implemented in the current English NHS context, one approach to dealing with the multiple provider issue identified could use a structure as below:



4. PRIME CONTRACTOR – CORPORATE JOINT VENTURE

Features

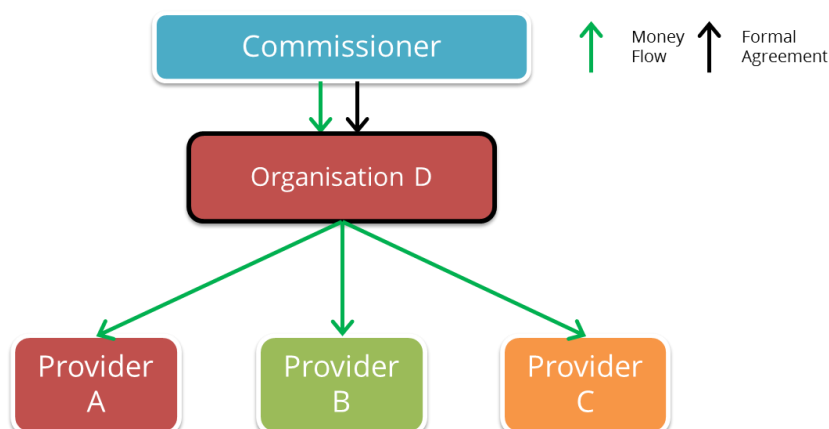
- A joint venture is set up to contract for services where all providers involved in the care pathway/bundle have a representation and agree on terms of collaboration for delivery of services.
- Commissioner holds one contract directly with the “Joint Venture”.
- Formation of an integrated care pathway between primary and acute and community care services for a specific segment of the population.
- Generally, provider joint ventures or partnering/consortia arrangements involve two or more parties who agree to work together, committing defined resources to achieve common objectives.
- If a separate legal entity is established, the joint venture will be known as a corporate joint venture. If a separate legal entity is not established, the joint venture arrangement will be a form of contractual joint venture - which would be akin to a formal federation.



5. PRIME CONTRACTOR – INTEGRATOR

Features

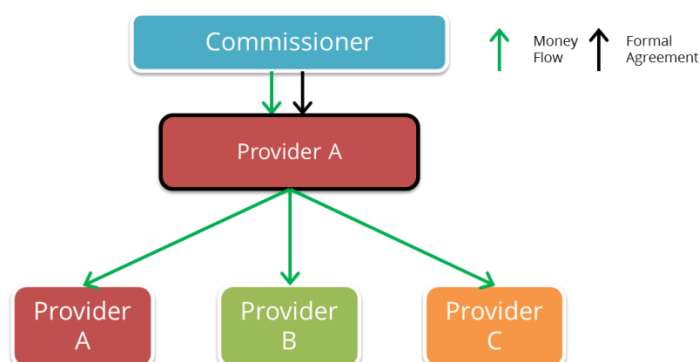
- Commissioner has one contract, specifying desired outcomes.
- Integrator subcontracts with all providers necessary to provide pathway.
- Integrator is performance managed by Commissioner, and, in turn, performance manages all the providers.
- Financial risk sits with integrator to be flowed down to the Providers as appropriate under sub-contracts.
- Integrator DOES NOT provide care but will look to recover its management/risk based costs for delivering the model.



6. PRIME CONTRACTOR - LEAD PROVIDER

Features

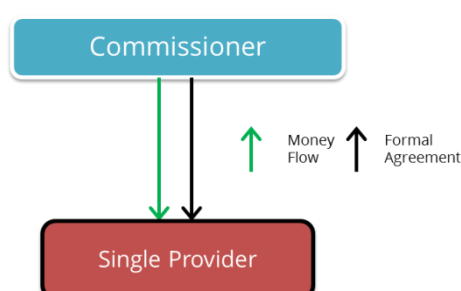
- Commissioner has a single contract with the Lead Provider.
- Lead provider organises other providers along the pathway and is responsible for subcontracting delivery of their services but cannot decommission “material” subcontracted providers without approval by Commissioners.
- Lead Provider provides, manages and maintains patient records system to be used by staff working at all providers
- Lead Provider manages and performance manages all services and monitor outcomes in all services
- Lead Provider ALSO provides care



7. SINGLE PROVIDER

Features

- One single contract with one provider
- Provider delivers the vast majority or all services directly and will subcontract for those services it is unable to deliver directly
- May require full integration/merger of different existing providers into a new organisational form (i.e. an Accountable Care Organisation type model).



ii) CONTRACTING MODELS: STRENGTHS AND WEAKNESSES

The following table summarizes, for each contracting model, its strengths, weaknesses, risks and legal implications.



TABLE 3: STRENGTH, WEAKNESSES, RISKS AND LEGAL IMPLICATIONS OF EACH CONTRACTING MODEL

	STRENGTHS	WEAKNESSES
1. LOOSE FEDERATION	<ul style="list-style-type: none"> • This is the most straightforward option to implement, requiring minimal change to existing commissioning arrangements. • Setting up a Joint Management Team (JMT) would provide an opportunity to share learning about what works, identify common ways of working across providers and make sure patient feedback shapes service development. • The JMT could maintain an oversight of how effectively joint care planning and multi-disciplinary team arrangements were working. It could identify opportunities for skills sharing and shared data and information to the Commissioner. • The structure is easily amended given its informal basis. • May not require Commissioners to revise existing arrangements and can sit above the various service contracts. 	<ul style="list-style-type: none"> • No shared contractual obligations to improve outcomes. This means that achieving common agreement to changes to each provider's resources if this is necessary is likely to be challenging. • There are no incentives or contractual levers to achieve consensus where there is disagreement between JMT members. Whilst this forum could recommend changes, it would have no powers to enforce them on any particular provider. • Implementing single care plans across disciplines requires operational cross-disciplinary management to ensure these are in place and are of high quality. Without an operational cross-provider management team in place, it would be challenging to implement coordinated care plans to deliver whole care cycle outcomes. • Experience to date suggests implementing a single patient records system without contractual change is very difficult, which would then make measuring outcomes and their associated costs also very difficult. Whilst a governing body could provide a common forum for discussion of the issue, it is unlikely that it would result in the adoption of a single system, as there are still no incentives or contractual levers to encourage providers to adopt it. • The providers would only be very loosely coordinated and there would be a risk that the arrangements would not be adhered to or that there would not be a facility to deal with any default between providers and the Commissioner outside of the existing core service arrangements. • Providers may not wish to invest in or take risk with other providers in areas such as data/ Information Technology / Information Governance if there is no contractual tie between them and the other related parties.

TABLE 3: STRENGTH, WEAKNESSES, RISKS AND LEGAL IMPLICATIONS OF EACH CONTRACTING MODEL

	STRENGTHS	WEAKNESSES
2. FORMAL FEDERATION	<ul style="list-style-type: none"> • This model has more structure by introducing a Memorandum of Understanding (MOU) - though these are not normally legally binding - between the providers. It can provide a clearer basis of working and integrated delivery between the providers, even if they maintain separate service delivery under their own contracts. • Potentially Commissioners may look to develop the MoU into a more formal and contractually binding arrangement which can embody the principles of the integration and the work expected from each party. • Relatively straightforward to set up. • May not require Commissioners to revise existing arrangements and can sit above the various service contracts. 	<ul style="list-style-type: none"> • Unless a binding arrangement is agreed and executed there are still no contractual incentives or levers to mandate joint working to deliver specified outcomes and depends on individual providers' enthusiasm until this can be put into place. • There are similar weaknesses to the Loose Federation model. • Any MoU or contract between the providers (with or without the Commissioner as a party) will need active strategic and operational management to execute real improvement and foster innovation in service delivery. • Decision making processes under these arrangements can be quite complex as there is no formal joint senior-level decision-making body, and there is more likely to need to be a consensus based model which can be cumbersome unless all the involved parties are aligned.

TABLE 3: STRENGTH, WEAKNESSES, RISKS AND LEGAL IMPLICATIONS OF EACH CONTRACTING MODEL

	STRENGTHS	WEAKNESSES
3. ALLIANCE CONTRACTING ¹⁸	<ul style="list-style-type: none"> An Alliance Contract is an arrangement where a number of parties enter into an additional agreement to their service contract to work co-operatively and to share risk and reward together, measured against set performance indicators. Unlike the lead provider model (described subsequently), where accountability for multi-disciplinary care planning and leadership arrangements rests clearly with one organisation, responsibility is shared. Potentially a more collaborative and collegiate approach which seeks to create co-operative behaviours between providers and the Commissioner, around a pre-agreed set of objectives. Joint leadership is incentivised through an outcomes-based payments structure. This reduces the risk inherent in the lead provider model that the lead provider may be able to make changes not in line with Commissioners' objectives, because the Commissioner remains the contract lead for all providers under the alliance elements. Much like the loose federation model, a leadership forum would hold responsibility for ensuring all services are of consistently high quality and making changes where necessary. Unlike the loose federation model, providers are contractually incentivised to work jointly. Reliance on strong working relationships between providers. It is essential that it is clear which provider is responsible for delivery at each stage of the pathway, and the level of risk/reward that each of them is prepared to take. 	<ul style="list-style-type: none"> There is no single agreed form of alliance arrangement in an NHS setting at present. This would therefore be a complex approach where the time and cost required for legally compliant documentation and management should not be underestimated. Technically, multiple providers are not able to enter into the same NHS Standard Contract for services and therefore the core alliance model is not compatible at this stage. Commissioners would need to look to introduce overarching alliance principles and mechanisms through a contract which is in addition to the providers existing service contracts. Providers would need to agree roles between them, and sustain these when faced with challenges and there would need to be agreed ways to manage disputes between providers when these arise. Competition and procurement concerns would need to be addressed by the Commissioners in forming the model (i.e. how the alliance can initially be contracted for and then allowing new providers to enter and older providers to exit when their service contracts expire)¹⁹. A further potential complexity is when a contract variation is required, which would normally require the written approval of all parties to the contract. Operation of 'vetos' and/or protection of minority interests could be a particularly tricky area, essential to have considered in advance. Generally decision making processes are more complex, as agreement is needed between all parties. Alliance contracting works better with a manageable number of partners; the greater the number, that greater the complexity and management issues. Only certain types of organisation are currently permitted to hold some types of NHS contracts.

¹⁸ Dunbar-Rees, R. and McGough, R. "Team effort: Commissioning through alliance contracts". Health Service Journal, November 2013.

¹⁹ Capsticks. "Checklist for North Central London Project compliance with the NHS Procurement" (2014).

TABLE 3: STRENGTH, WEAKNESSES, RISKS AND LEGAL IMPLICATIONS OF EACH CONTRACTING MODEL

	STRENGTHS	WEAKNESSES
	<p>PRIME CONTRACTING can give the Commissioner the chance to move quickly to an integrated procurement model for particular pathways. It would tend to use the following features which would set it apart from the normal procurement and contracting routes used by Commissioners:</p> <p>(1) overall single-point responsibility for the management and delivery of a service sits with the prime contractor; and</p> <p>(2) the prime contractor is in a position to co-ordinate and integrate the activities of its supply chain to meet the service delivery specification efficiently, economically, innovatively and on time.</p> <p>In contrast to an Alliance, in Prime Contractor models, Commissioners only have one contract and relationship to manage, with a single legal structure to organise delivery. Model demands integration from providers through the subcontracting model.</p>	
4. PRIME CONTRACTOR – CORPORATE JOINT VENTURE	<ul style="list-style-type: none"> • A reduction in the need for management resources for the Commissioner (essentially pushing this onto the Joint Venture). • Potential for greater consistency in provision through proper supply chain management across a broader spectrum of services, enhancement of integrated care through a mechanism which relies upon increased collaboration between providers. • There is effective senior representation across all the providers in a decision-making body so there is joint, equitable and active strategic management (though this may vary depending on the corporate structure used). • Shared budget can incentivise all parties to contribute. Joint venture management structure encourages a collaborative approach and a requirement for 'buy in' to quality/productivity by all parties. 	<ul style="list-style-type: none"> • Can be complex to define the financial risks and how they would be apportioned across the supply chain: it is resource intensive to ensure joint management board works (though this would be the same for many of the potential models). • In an equal joint venture then the parties will need to have an effective decision making mechanism to enable them to take decisions against each other where in the interests of the overall performance. • Any competition and procurement considerations would need to be addressed.²⁰ • If a single contract approach is being adopted then the Commissioner would need to ensure that a single contract could cover all the relevant services (likely to be either NHS Standard Contract or APMS or a variant of these to include primary care with community services). • A Joint Venture entity will be unlikely to have a track record of delivery so guarantees may be sought from the provider organisations themselves. There would be additional complexity in the exit of a provider which holds a stake in the prime joint venture vehicle, as well as a services sub-contract.

²⁰ Capsticks. "Checklist for North Central London Project compliance with the NHS Procurement" (2014).

TABLE 3: STRENGTH, WEAKNESSES, RISKS AND LEGAL IMPLICATIONS OF EACH CONTRACTING MODEL

	STRENGTHS	WEAKNESSES
5. PRIME CONTRACTOR – INTEGRATOR	<ul style="list-style-type: none"> • A reduction in the need for management resources for the Commissioner (essentially pushing this onto the Integrator). Potential for greater consistency in provision through more developed supply chain management across a broader spectrum of services, potentially allowing easier involvement of innovative third sector organisations. There could be enhancement of integrated care through introducing a contractual mechanism via the Integrator which relies upon increased collaboration between providers. • The Integrator organisation's sole objective is to manage the contract. They have no vested interest in how the sub-contract payments are proportionally distributed. Therefore they can be very focused and targeted on providing more focused contract management as there is no distraction by service delivery pressures. • The other providers are solely focused on care delivery via sub-contracts. 	<ul style="list-style-type: none"> • Providers are not individually incentivised to contribute to the whole. The management model may be based on a "stick" (penalty) model rather than a "carrot" (incentive) model, meaning providers could become disengaged and deliver the bare minimum. • All of the supply chain will need to be engaged and to agree the terms of any flow down of the contract – there is a risk of the Integrator enforcing down a position to protect its bid position and margin. This could destabilise the supply chain. • The integrator, as the only non-service deliverer, could become detached from how things work on the ground. This could cause tension between care delivery and contract management. • The CCG would be likely to need to procure the integrator function. Defining the structure of the procurement to allow for risk transfer and sub-contracting with the Providers is likely to be complex and time consuming. • If a single contract approach is being adopted then the Commissioner would need to ensure that a single contract could cover all the relevant services (likely to be either NHS Standard Contract or APMS or a variant of these to include primary care with community services) and that the Integrator could hold the contract.

TABLE 3: STRENGTH, WEAKNESSES, RISKS AND LEGAL IMPLICATIONS OF EACH CONTRACTING MODEL

	STRENGTHS	WEAKNESSES
6. PRIME CONTRACTOR – LEAD PROVIDER ²¹	<ul style="list-style-type: none"> Providers can directly work together, supported by the contracts between them, to ensure the pathway is as efficient and effective as possible. Incentives can be more effectively constructed to ensure all providers benefit from effective operation of the scheme. However, it must be carefully constructed to ensure visibility of the pathway and issues within it and to enable intervention by the Commissioner in dealing with subcontractors if necessary. The lead provider would oversee all services. Commissioners would be able to hold one organisation to account for delivering agreed outcomes and performance across the entire care cycle. The lead provider would normally directly employ a multi-disciplinary/multi-agency management team and provide the IT solution for all Trusts so should be able to deliver this objective. This model does provide a single leadership structure and clear accountability for integrated working. The lead provider would be accountable for reviewing need for all services and planning resources accordingly, though this would need to be undertaken in conjunction with subcontracted providers and not imposed upon them. 	<ul style="list-style-type: none"> The success or failure of this model depends on trust and management relationship between the lead provider and subcontracted providers. The lead provider is accountable for the performance of subcontracted providers and therefore will need their agreement to make any changes needed to integrate care or improve quality. The Commissioner remains accountable for the service, but is reliant on the lead provider to hold subcontracting providers to account. The lead provider is dependent on his sub-contracts to effectively flow the risks down to the supply chain and a failure to do this adequately can destabilise the contract and the providers. Identifying one provider as the prime contractor may disengage other providers who consider they may be more appropriate for that role. There is a risk that the lead provider could also enforce stricter contract terms or lower remuneration on the sub-contractors to cover its management overhead for the structure. Competition and Procurement concerns would need to be addressed in this model.²² If a single contract approach is being adopted then the Commissioner would need to ensure that a single contract could cover all the relevant services (likely to be either NHS Standard Contract or APMS (or a variant of these to include primary care with community services). Careful contractual arrangements would be required to set out clearly what is expected of the lead provider and subcontracted organisations. The key risk of all variants of this model is if the lead provider makes decisions about resources that are not agreed by the subcontractors. It potentially limits Commissioners' ability to maintain leadership across services if required; the main contractual relationship for providers would be with the lead provider. For example, the lead provider may wish to provide a particular service itself and attempt to decommission a subcontracted provider.

²¹ Corrigan P. and Laitner S. "The Accountable Lead Provider". Right Care Casebook ; July 2012.

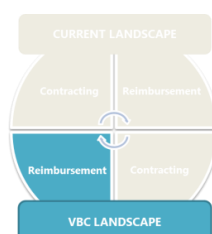
²² Capsticks. "Checklist for North Central London Project compliance with the NHS Procurement".(2014).

TABLE 3: STRENGTH, WEAKNESSES, RISKS AND LEGAL IMPLICATIONS OF EACH CONTRACTING MODEL

	STRENGTHS	WEAKNESSES
7. PRIME CONTRACTOR – SINGLE PROVIDER	<ul style="list-style-type: none"> • A reduction in the need for management resources for the Commissioner (essentially passing this onto the one Provider). • Potential for greater consistency in provision through one contract across a broader spectrum of services, and enhancement of integrated care through consolidation of provision under one organisation. • A single provider could have accountability for outcomes and costs relatively easily. • A single patient records system would be usually introduced by default. Implementing joint care planning arrangements would be reasonably straightforward, with clear lines of accountability. • A single leadership structure and more strategic resource planning and workforce development could be implemented. 	<ul style="list-style-type: none"> • The main, significant risk of a single provider model is the considerable disruption to services created by loss of key staff and/or existing estates if one provider takes over the services from the current provider body. • There would be issues in terms of competition and patient choice to be addressed in such a model for the Commissioners. If the provider failed there would be a greater risk of a need to ensure the protection of a wider spectrum of services. • A number of staff, including some senior clinical managers, work across borough boundaries or in community and acute settings. There is the potential an area may lose these highly skilled staff if they remain within the organisations that are decommissioned (assuming that they do not move under TUPE - Transfer of Undertakings (Protection of Employment) arrangement). • Depending on the patient segment, this could be incredibly difficult to achieve given the number of providers involved and if an entirely new organisation is procured there would need to be considerable work in the short term to build relationships with partners, to ensure there is no fall in the quality of care provided. • Estates responsibilities could sit with different providers and ongoing use of these sites would need to be ensured, or find alternative service delivery locations, which may have financial implications. This could result in an unacceptable reduction in service quality in the short to medium term. • The main risk for Commissioners is that once a contract has been awarded, they may have limited ability to engage with the detail of implementation to ensure the issues set out in the service description are resolved. This is particularly likely to be the case if the single service becomes part of an existing large contract as managed by the CSU.

While the main types of model are described above, it is possible to develop 'hybrid' models combining features of more than one approach- for example a Lead Provider model with Alliance Contracting features. Having decided on the most appropriate outcomes-based contract model for the circumstances, the next decision is to decide which elements of care the model is applied to i.e. everything (activity, processes and outcomes), or exclusively to outcomes. The following section sets out the main considerations.

b) VBC Reimbursement Options



In an ideal scenario, in order for perfectly accurate bundled payment mechanisms to be developed, a different approach to cost mapping is required^{23,24}:

- Cost should be aggregated over the full cycle of care for the patient's medical condition, spanning across all providers involved in the care, and not for departments, services, or line items, which means it spans across different care settings and therefore providers;
- Where the care cycle is not defined by discrete episodes, for example in relation to chronic diseases, a set period of care is usually chosen for measurement of costs- typically a year of care;
- Cost is the actual 'true' expense of patient care, not the charges billed or collected;
- Outcomes and their associated costs should be measured around the patient not the organization;
- Cost depends on the actual use of resources involved in a patient's care process (personnel, facilities, supplies);
 - The time devoted to each patient by these resources
 - The capacity cost of each resource
 - The support costs required for each patient-facing resource.

While the scenario above is not yet a reality in the UK system, there are no fundamental barriers to developing bundled payment mechanisms. In the first instance, whole pathway '*price*' calculation (i.e. on the basis of historical prices paid for care across the whole pathway) is a reasonable alternative to true costs of care. Over time, efforts by providers to understand the cost as opposed to price would provide more support to strategic decision making. However, the risks involved in miscalculating costs/price need to be acknowledged when defining the size of the bundle.

²³ Kaplan, R. and Anderson, S., Time-Driven Activity-Based Costing (November 2003). Available at SSRN: <http://ssrn.com/abstract=485443>

²⁴ Kaplan R. and Porter M. "The Big Idea: How to Solve the Cost Crisis in Health Care". Harvard Business Review, September 2011.

Two principal options for designing a bundled payment model are considered to incentivise collective achievement of outcomes, although there are variants on each.

- **The first consists of integrating the total costs/budget related to services in scope (including activity, processes and outcomes) under one bundled contract.**
- **The second consists of including only the portion of the total costs/budget attributed to the achievement of outcomes under a bundled contract, while existing contracts - for activity and processes - remain largely unaltered. Throughout**

The latter represents less of a risk for providers in a scenario where costs are underestimated, as the financial impact for not achieving the desired outcomes will be less destabilising. At the same time, if the chosen portion is not meaningful and material, providers might not have an incentive to pursue achievement of outcomes.

Financial and costs analysis are beyond the remit of this paper, and in this section the conceptual bundled models that can be applied to any population segment will be explored.

To simplify the following graphical representations, the current commissioning landscape will be referred to as “commissioning for activity and processes”, acknowledging that there are extra mechanisms in place reimbursing providers for individual performance – but not for collective achievement of outcomes.

A number of decisions need to be made when designing any pay-for-performance program. Creating incentives around achievement of outcomes is no different. However, the design of a bundled payment system requires some extra steps. In this section we will look into the 2 main areas that need to be considered when commissioning on the basis of outcomes:

Bundled Payment Options

- What should we contract for?
- Activity, processes and outcomes?
- Just the outcomes portion ?

Incentive Mechanisms

- What is the ideal bundle / incentive size?
- Outcomes weight allocation
- Gains versus Penalties

i) BUNDLED PAYMENT OPTIONS

Bundled Payment versus Pay-for-Performance

While there has been some progress around developing mechanisms to tie part of the providers' payments to "performance" – i.e. Quality Outcomes Framework, CQUINS, Better Care Fund – providers currently are largely incentivised by "**activity and processes**".

Outcomes-based contracts are largely aligned with pay-for-performance models. However there are marked differences between commissioning for outcomes and existing "pay-for-performance" mechanisms.

Firstly, outcomes are not currently being measured systematically and routinely reported across complete care cycles. Where pay-for-performance does exist, it is largely on the basis of compliance with structural/training requirements and/or quality processes. Most metrics currently used on pay-for-performance schemes relate to processes of care and measures of efficiency or activity i.e. early discharge rates from hospital.

Secondly, the mechanisms currently in place differ fundamentally from a bundled payment approach, as they are still designed to incentivise individual providers without taking into consideration the whole pathway approach or the concept of shared accountability, vital for successfully commissioning based on the delivery of outcomes.

Finally, current pay-for-performance schemes rarely take the approach to segmentation which underpins the Value agenda: outcomes can't be successfully defined, measured and interpreted when applied to heterogeneous segments of the population which do not share similar needs.

A number of studies evaluating the effectiveness of pay-for-performance schemes in improving care quality and reducing costs have been undertaken.^{25,26,27,28} The general agreement is that there is very little evidence that these schemes are successful. Designing such programmes is a challenge. Successful implementation requires the right combination of number of performance indicators, size of financial incentive and criteria for evaluation. However, the defining factor of success – or failure - is "what" is being measured.

As current pay-for-performance schemes largely incentivise narrow processes and activity measures, attention is diverted away from the overarching system goals i.e. improving population health. Providers therefore have little motivation to solve problems they feel are outside their control, or find innovative new processes to deliver the same or better outcomes.²⁹

There is no substitute for measuring actual outcomes, whose principal purpose is not comparing providers but enabling innovations in care.

Source: Porter M. What is value in health care? N Engl J Med 2010;363:2477–81.

²⁵ Dixon A. et al. "Impact of Quality and Outcomes Framework on health inequalities", Kings Fund, April 2011.

²⁶ Gemmill M. "Pay-for-Performance in the US: What lessons for Europe?". Eurohealth Vol 13 No 4, 2007;

²⁷ Andrew M. Ryan and Rachel M. Werner. "Doubts About Pay-for-Performance in Health Care". HBR Blog Network, 2013.

²⁸ Effects of pay for performance in health care: A systematic review of systematic reviews, Eijkenaar, Frank et al Health Policy , Volume 110 , Issue 2 , 115 – 130, 2013.

²⁹ Porter M. and. Lee T. "The strategy that will fix health care". Harvard Business Review, 91.12 (2013): 24-24.

Research into pay-for-performance in relation to outcomes rather than processes is in its relative infancy:

As a result, pay-for-performance can divert attention from the big picture and toward a myopic focus on meeting the performance goals that are typically defined in these contracts. Thus, even if we had pay-for-performance programs with smarter designs, it remains unclear whether we could overcome the fundamental problems associated with incentive contracts directed at narrow goals for intrinsically motivated activities.

Source: Andrew M. Ryan and Rachel M. Werner, Doubts About Pay-for-Performance in Health Care, HBR Blog Network,

Getting the metrics right is essential. As Ashish Jha from the Harvard School of Public Health explains "... we have to stop playing around with process measures. Pay-for-performance programs can be way too prescriptive, and focusing on a small number of processes, no matter how "evidence-based" they might be, is not going to get us where we want to be. We need to focus on a small set of high value outcomes. Who chooses? In the ideal world, if patients actually influenced the healthcare system, providers would figure out what mattered to patients".³⁰

This is also valid in the UK context: contracts that incentivise "true" outcomes across complete care cycles and multiple providers remain very rare in the NHS. That being said, process, structure, and outcomes indicators need to be sensibly aligned and balanced in order to avoid internal conflicts and enable the achievement of desirable outcomes.

Designing a Bundled Payment around Delivery of Outcomes

When designing a bundled payment model, some initial questions need to be addressed:

1) Which provider groups will be involved in the bundle?

In section 3 of this paper, we summarised the main provider groups in the UK and the types of contracts they currently hold. The ideal outcomes-based contract should include all providers involved in the care of the patient/population segment being explored. However, in the UK there are legal boundaries that need to be addressed when designing these types of contracts. Under law and/or guidance, Commissioners must use specific contracts when contracting for clinical services of certain types.

The chosen selection of healthcare services must be matched against the relevant legal and guidance requirements of the applicable regulatory framework to determining which type (and number of) contracts. For example:

Common Regulatory Issues For Integration

- Ø Community services should be commissioned under the NHS Standard Contract.
- Ø New primary care services would generally be commissioned under an APMS contract (which is not a mandatory form, but must comply with the APMS Directions currently in force).
- Ø Local pharmaceutical services and/or dentistry cannot be combined in a primary care contract.

³⁰ Ashish K. Jha is a practising Internist physician and a health policy researcher at the Harvard School of Public Health. His material can be accessed via <https://blogs.sph.harvard.edu/ashish-jha/about/>.

CCGs must also now use the NHS Standard Contract for all community-based services provided by GPs, pharmacies and optometrists that were previously commissioned as Local Enhanced Services (as set out in the 2013/14 guidance on primary medical care functions delegated to CCGs).³¹

2) Which activities are in scope?

Defining the scope of the population for which outcomes will be measured and commissioned is essential to identify the “pound” value of the bundle. The development of the bundled models should be consistent with the consensus achieved around the scope for those segments.

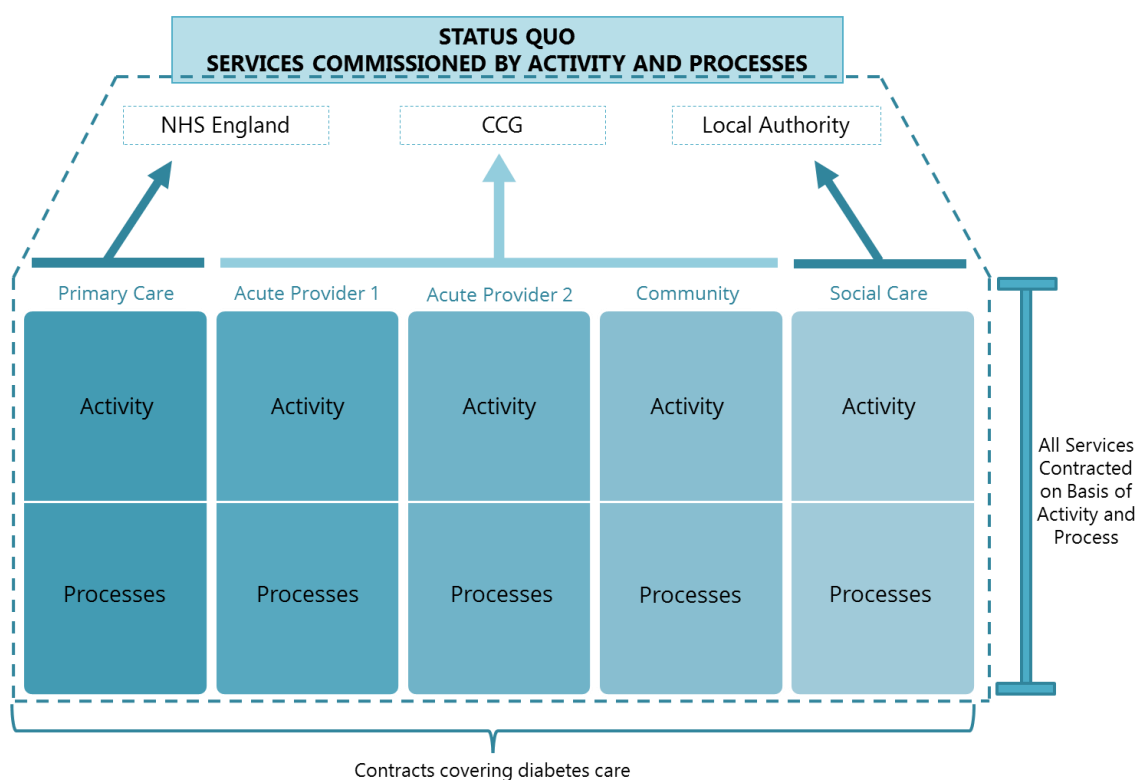
Main Bundle Options – What is the contract for?



Status Quo

The diagram below is a representation of the current commissioning landscape in the England, depicting a scenario where all services for a given segment – i.e. People with Diabetes - within primary care, acute care, community and social services - are contracted “by activity and processes”, with individual provider organisations.

Diagram 8: Commissioning Landscape – Status Quo



³¹ NHS England. “Primary medical care functions delegated to clinical commissioning groups: Guidance”. March, 2014.

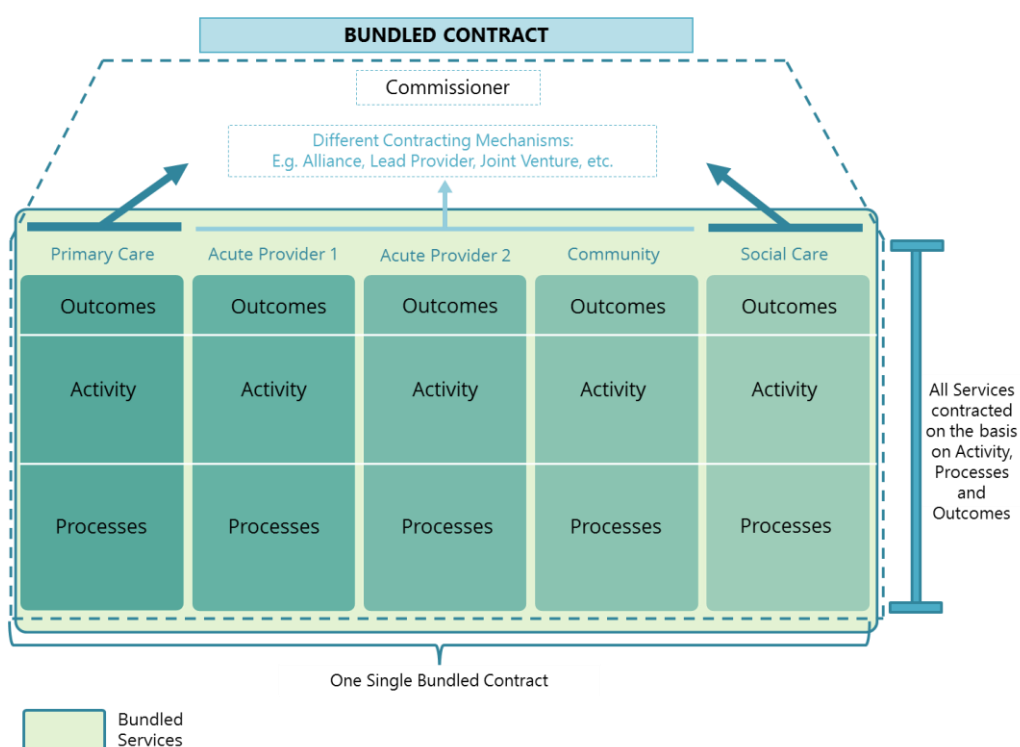
VBC Options

- **Option 1: Full Bundle** - i.e. activity, processes and outcomes bundled into one contract

One route into outcomes-based commissioning for a given segment, is to identify all costs and activity associated with the population in scope, across all providers, over a set period of time- typically a year- and bundling all of those into a new contract. In this scenario, all providers involved in the care-pathway share accountability and are incentivised for the delivery of specific outcomes, as well as allocating payment for activity and processes using one of the contractual routes in the previous section.

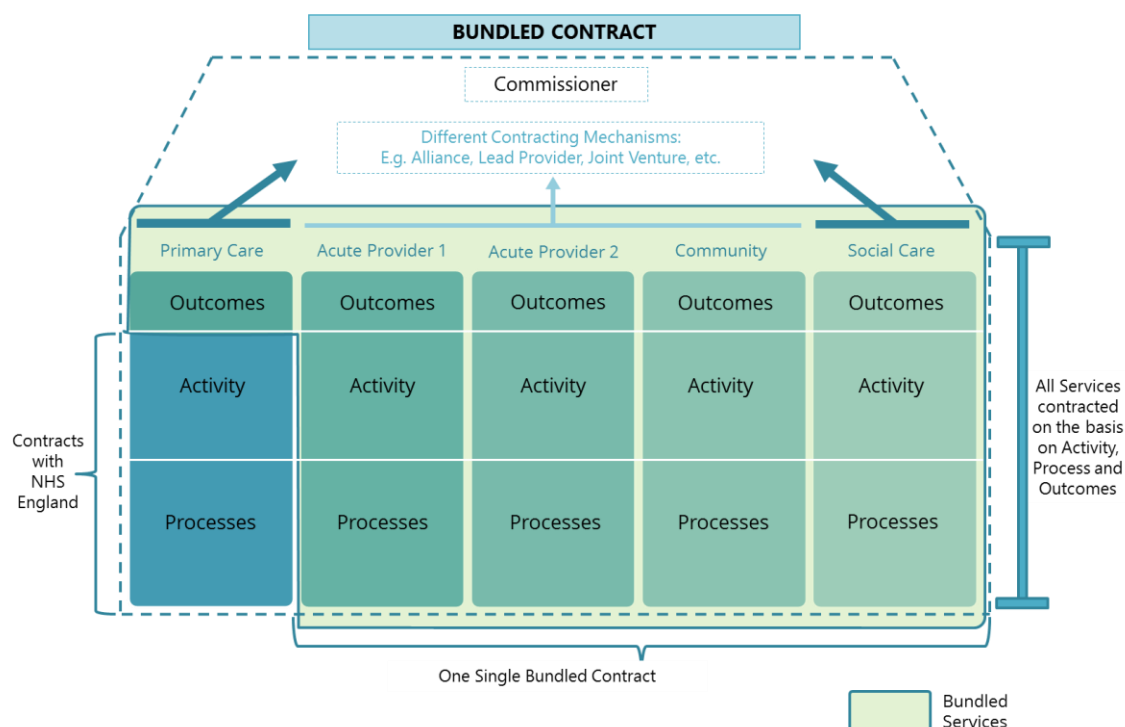
The diagram below depicts a 'stylised' scenario where all services for a given segment are now commissioned under one single contract, from multiple providers with payments allocated according to activity, processes and outcomes achievement.

Diagram 9: Full Bundle



However, this scenario is problematic, given the current legal landscape for NHS contracting, especially related to Primary Care services commissioning. One available option would be to exclude primary care from the bundle and to use an NHS Standard Contract, but this is significantly less likely to deliver the outcomes being sought. Another option is to only include primary care within the outcomes component, leaving all other primary care contracts 'as is' as we have set out below. The involvement of primary care with the other elements is likely to require the use of an overarching contract entered into by all providers and Commissioners with the outcomes element under an NHS Standard Contract via a single provider entity.

Diagram 10: Full Bundle excluding core General Practice Contracts



Where Commissioners are concerned about the ability to substantively change the provider landscape due to the term or nature of existing contracts then they may look to continue with the existing contracts with current providers but use variations/extensions and retendering where appropriate to allow for an initial alignment between providers and common outcomes.

If this approach is adopted, the Commissioners would continue with the existing contracts which are varied to accommodate the required changes (as far as possible). The providers would also need to sign up to an overarching (interface style) agreement to which the Commissioners may, or may not, be a party to incorporate the closer joint working arrangements. Payment incentives and/or deductions may be included in the interface agreement to incentivise more integrated working practices and potentially to introduce the elements of shared outcomes. Variations to existing contracts, for example because a new provider must interface with existing primary care providers, may also trigger procurement considerations. Where an existing contract is varied “materially”, this may trigger a “new contract” under procurement law. That “new contract” must be awarded in compliance with procurement law. What is material is a matter of case law, though as a general rule the lengthening of the term, significant increase in value, increase in service scope or other risk profile changes in favour of the provider are more likely to be considered “material”. Commissioners should be wary that if they vary a number of connected contracts together then the value of these may be aggregated which could make the changes more material and even bring them in excess of the procurement threshold.

Commissioners may be able, in limited circumstances, to rely on applicable exemptions under the Procurement Regulations. This would allow legitimate direct awards of new contracts without any competitive procurement – for example, exemptions include where there is only one provider technically able to deliver the services. Commissioners should treat these exemptions with caution as they are generally narrowly construed by the Courts, but they can be useful to bear in mind, depending on the situation.

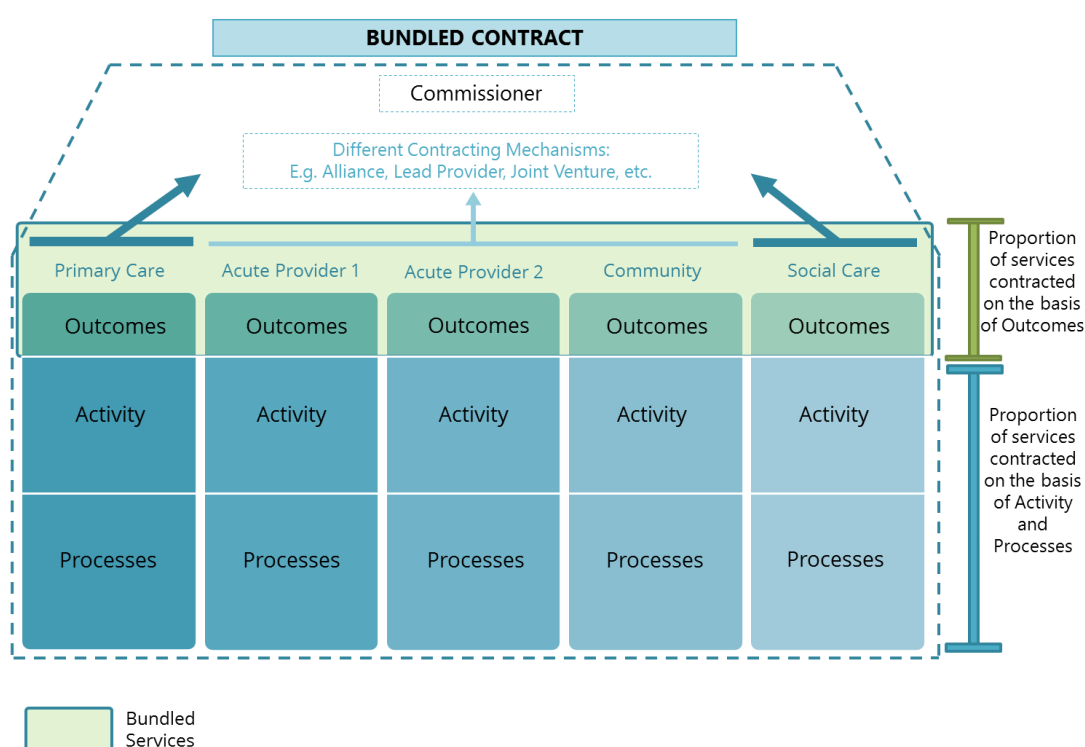
As a general rule, Commissioners should keep a clear record of their decisions and justifications for choice of procurement route, particularly if no prior advertising or process is undertaken. This helps act as a clear audit trail for a Commissioner in case of challenge. Please see NHS England's guidance on the commissioning cycle for further information on the procurement legal obligations on Commissioners³². Presuming that the intent is to bring multiple services including primary care under a single contract document (and we are dealing with new provision rather than varying existing GMS/PMS arrangements) it is possible to do so using a NHS Standard Contract (which contains additional elements to make it compliant with APMS directions).

- **Option 2: Partial Bundle (example below)** i.e. bundle just the outcomes

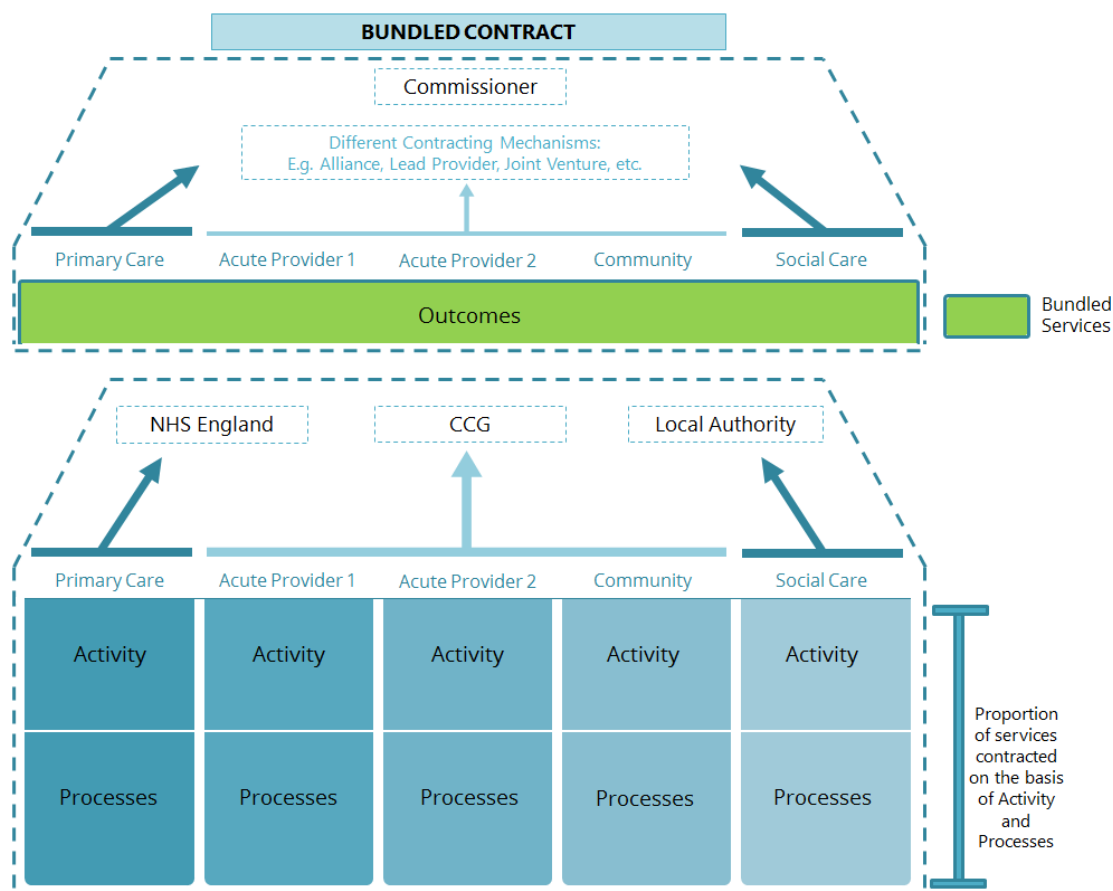
Another route to outcomes-based commissioning for a given segment is to identify all costs associated with the population in scope across providers as above, and then select a share of these costs to be bundled into a new outcomes-based contract.

In this scenario, providers share accountability for achievement of outcomes, and only the portion of their budget/costs that is linked to collective outcomes achievement is bundled. This can be dealt with readily under the one overarching contract whilst keeping existing core contracts separate. This is permissible because the separate regulatory requirements are met by the existing contracts remaining in place with the outcomes achievement being dealt with separately in the overarching agreement as a separate contractual relationship. This can be beneficial in that the timing of expiry and alignment of existing contracts is much less of a problem and it can overlay existing arrangements and be varied to meet changes in the providers. Given that it is linked to the existing providers contract and the value could be under the procurement threshold (and feasibly no other providers could deliver these outcomes) there should be less concern over procurement and challenge though the Commissioner should still always keep a clear record of their decisions and justifications for choice of procurement route, especially if no prior advertising or process is undertaken.

Diagram 11: Partial Bundle



³² <http://www.england.nhs.uk/2012/09/14/procure-ccgs/>



"Many health care practitioners and policymakers advocate a new bundled-payments model that reimburses providers with a fixed fee for delivering all the services required to deliver a complete cycle of patient care for a specific clinical condition. Bundled payments (BP) have the potential to reward providers that deliver more value to their patients — better outcomes at lower costs."

Witkowski M., Higgins L., Warner J., Sherman M., & Kaplan R., "How to Design a Bundled Payment Around Value" <http://blogs.hbr.org/2013/10/> Harvard Business Review, 91.12 (2013): 24-24.

ii) INCENTIVE MECHANISMS

Options for incentivising achievement of outcomes

- Outcomes Incentive Size



One unanswered and yet important question relating to the design and implementation of performance-based programmes is: does the size of the incentive payments affect the achievement of goals? A number of researchers in economics and psychology have explored this subject but no research has been undertaken to address this specific issue in healthcare³³. There is no empirical evidence around the effect of incentive size, specifically in relation to outcomes-based payments in healthcare. However, where incentives are used, it is generally accepted that if incentives to meet a goal are too small, organisations will make little effort and generate small changes. If incentives are material enough, it drives bigger changes. In other words, the size of the incentive does matter. However research also suggests that incentives which are too large can also lead to a phenomenon called "choking under pressure", when increased motivation and effort can result in a decline in performance.³⁴

There is considerable variance in the size of current pay-for-performance schemes in the NHS. Implemented in 2009/10 covering 0.5% of acute provider annual contract incomes, CQUINs are currently set at 2.5 % contract value for all healthcare services commissioned through the NHS Standard Contract. Primary care QOF payments accounts for around 17% of general practice income³⁵.

Overall, there is no consensus around how much of the healthcare budget for specific segments should be reassigned to being paid on the basis of achieving desired outcomes. That decision should be made at the Commissioners' and providers' discretion, taking into account the factors identified above and local factors.

³³ Gillan S. et al. "Pay-for-Performance in the United Kingdom: Impact of the Quality and Outcomes Framework—A Systematic Review". *Annals of family medicine* vol. 10, no. 5, September/October 2012.

³⁴ Ariely, D., Gneezy U., Loewenstein G., and Mazar N. "Large Stakes and Big Mistakes". *Review of Economic Studies* (2009) 76, 451–469

³⁵ Nuffield Trust. "The NHS payment system: evolving policy and emerging evidence". February (2014)

- Outcomes Weight Allocation



Having established the overall amount available for achievement of outcomes, Commissioners and providers need to agree which outcomes will initially be commissioned for. For example, in North Central London, 29 outcomes indicators organised in 8 groups were identified within the People with Diabetes segment (see Appendix 2). While the Commissioners have indicated their intention to measure all outcomes, featuring all of them in an outcomes-based contract is not necessarily practical in the first instance.

Appendix 3 describes the three broad 'categories' of outcome measures. Some outcomes can be immediately measured utilising data currently collected nationally and that is publicly available (e.g. mortality and complication rates). For these, it is possible to establish a baseline value and initiate monitoring immediately. A number of patient-centred outcomes on the other hand, are not currently being measured. For many, there are tools readily available to start data collection; for others, the development of new measurement tools may be required. Therefore, the availability of measurement tools and ability to establish baseline values might be a significant determinant of which outcomes will initially be included in any outcomes-based contract.

Once the decisions around exclusions are made, Commissioners and providers must determine the weight carried by each of the outcomes included in the contract. The process for defining the weights is at the Commissioners' and providers' discretion, taking into account consultation with patients. A pragmatic approach may be required in the first instance to assign equivalent weights to all outcomes and readjust these in the subsequent commissioning cycles, once the collection mechanisms have been refined and following further consultation with patient representatives.

As a general rule, the weights can be allocated in 2 ways:

- Directly to each of the outcomes indicators
 - o Taken together, each of the outcomes should add up to 100%.
- Directly to each of the outcomes groups, and then to each of the outcomes indicators
 - o Taken together, each of the categories should add up to 100%. Within each category the aggregate of the individual indicators' weightings should also add up to 100%.

The example below compares the 2 scenarios, and illustrates a situation where categories 1, 2 and 3 of the outcomes depicted in Appendix 2 are being commissioned for:

Scenario 1	Weights
1. Mortality	
1a. A measure of mortality rate	25%
1b. A measure of premature mortality rate: years of life lost	10%
2. Health related Quality of Life	
A measure of quality of life	25%
3. Outcomes related to Symptom Control (e.g. hypoglycaemia, lethargy):	
3a. Symptom-free	20%
A measure of symptom control	
3b. Symptom recognition	20%
A measure of the recognition of high/low blood sugar	
Sum	100%

Scenario 2	Weights
1. Mortality	40%
1a. A measure of mortality rate	60%
1b. A measure of premature mortality rate: years of life lost	40%
2. Health related Quality of Life	30%
A measure of quality of life	100%
3. Outcomes related to Symptom Control (e.g. hypoglycaemia, lethargy):	30%
3a. Symptom-free	50%
A measure of symptom control	
3b. Symptom recognition	50%
A measure of the recognition of high/low blood sugar	
Sum	100%

The allocation of weights to each of the outcomes should reflect their relative importance. This process assigns numeric values to judgements, which ideally should be supported by objective information. This decision ideally is made taking into consideration patients' collective views. At the least, it should reflect expert views and be undertaken by a group of people representing all of the interested parties i.e. providers, Commissioners and patient representatives in the first instance.

- Performance and Payment Bands

"The bundle incorporated the [outcomes] metrics in two ways. First, payments would be made to physicians and the hospital only if patients achieved specified minimal performance in each area. Second, if outcomes exceeded a more ambitious performance level, the insurer would make incremental bonus payments" – in reference to Boston Shoulder Institute rotator-cuff repair bundle.

Source: Witkowski M., Higgins L., Warner J., Sherman M., & Kaplan R., "How to Design a Bundled Payment Around Value" <http://blogs.hbr.org/2013/10/> Harvard Business Review, 91.12 (2013): 24-24.



Determining the size of the incentive and outcomes weights are initial steps towards designing an outcomes-based payment system. Another key step is to determine the desired performance levels and the remuneration associated with different achievement thresholds, i.e. performance and payment bands.

It is beyond the remit of this paper to explore the evidence around the ideal number or design of performance bands. There are a number of examples in the NHS consisting of different approaches to payment and performance band design. The most common and simple method consists of a 3-band schedule, such the example below:

- ✓ Band A – desired performance
- ✓ Band B – minimum acceptable performance
- ✓ Band C – unacceptable performance

However, more important than determining the number of performance bands, or their descriptions, is to determine:

- **The desired performance threshold associated with each band**
- **The monetary incentive/penalty associated with each band**

When baseline measures for the outcomes are defined and ready to be monitored, Commissioners and providers must agree on the desired performance levels that will trigger payment. This can be defined as a percentage change relating to previous year baseline scores or with desired absolute scores. Either way, the most important decision is around where to set the lowest and highest performance band limits, and defining the **type of incentive** according to the lowest and highest payment band associated with desired performance. The table below sets 3 examples of performance banding and associated pay using a percentage change model. This is for illustrative purposes only; the numbers associated with each performance and payment band were selected randomly.

Incentive	Outcomes	Indicator		Performance Band						Payment Band		
TYPE	Mortality	Description	Baseline	A		B		C		A	B	C
A. Just Gain, No Pain	A measure of mortality rate	Number of deaths in people within segment within defined period of time	X	≤	90%*X	≤	100%*X	>	100%*X	110%	105%	100%
B. Incremental Gain	A measure of mortality rate	Number of deaths in people within segment within defined period of time	X	≤	90%*X	≤	100%*X	>	100%*X	105%	100%	95%
C. Just Pain, No Gain	A measure of mortality rate	Number of deaths in people within segment within defined period of time	X	≤	90%*X	≤	100%*X	>	100%*X	100%	95%	90%

Each of the above incentive categories can be employed, independent of what contractual route is selected or type of reimbursement “bundle” (partial or full bundle), since the incentive is applied exclusively to the outcomes portion of the contract. Evidently the “proportion” of the baseline budget/costs that will be allocated to outcomes achievement will determine the size of the financial impact for each of these choices.

It is worth taking into account whether any investment in transformation will be required when considering whether to choose between the three broad types of incentive described below:

- **A. “Just Gain, No Pain”**

In this type of incentive model the lowest performance band is not set in order to penalise providers for non-achievement of outcomes: providers are reimbursed in full (100%) for any given outcomes achieved, while the real incentive is in the incremental pay they receive for achievement higher levels of performance.

- **B. “Incremental Gain”**

Under this scenario, payment bands are set so as to incentivise providers for achieving desired outcomes, but somewhat penalised if minimum requirements are not met.

- **C. “Just Pain, No Gain”**

In the most austere model, providers do not receive any additional payments for outcomes achievement. All funding for this model must come from within existing budgets. The incentive is in achieving minimum requirements in order to recover the part of their budget that was linked to outcomes and in not getting overly penalised for meeting very low performance standards.

The decision around performance thresholds i.e. difficulty in achieving each performance band relative to baseline, will also influence how each of these incentive categories affect providers.

IV. FURTHER CONSIDERATIONS

Although beyond the scope of this paper, prior to agreeing any outcomes-based contract, the following considerations are also required:

Cash flow: A good understanding of the impact on provider cash flow in relation to variable performance against the outcomes thresholds over the course of the contract is required, and needs to be documented as appropriate in the contract. This includes decisions on prospective or retrospective payments for outcomes, and financial reconciliation points over the course of the contract.

“Going into the price negotiation, the Boston Shoulder Institute’s aim is to achieve better patient outcomes and thereby earn a margin over the actual costs incurred. This will come in several ways: the bonus payments for consistently producing superior outcomes; more business driven to them by the insurer because of the better outcomes; and, with a higher volume of patients, more cost-efficient processes” – in reference to Boston Shoulder Institute rotator-cuff repair bundle.

Source: Witkowski M., Higgins L., Warner J., Sherman M., & Kaplan R., “How to Design a Bundled Payment Around Value” <http://blogs.hbr.org/2013/10/> Harvard Business Review, 91.12 (2013): 24-24.

“Two issues had to be addressed. First, although the bundle is tied to achieving measurable outcomes during the year, no business organization in any industry will wait that long for payment. Harvard Pilgrim agreed, therefore, to pay most of the bundled price 30 to 60 days after the surgical event; the remainder would be held back until the guaranteed outcome could be assessed at the 365-day mark.” – in reference to Boston Shoulder Institute rotator-cuff repair bundle.

Source: Witkowski M., Higgins L., Warner J., Sherman M., & Kaplan R., “How to Design a Bundled Payment Around Value” <http://blogs.hbr.org/2013/10/> Harvard Business Review, 91.12 (2013): 24-24.

Fund Allocation:

Commissioners and providers will need to determine whose responsibility it is to define how to allocate outcomes-based payments amongst different providers involved in the bundle. There are a number of relevant considerations irrespective of whether Commissioners or Providers see it as their role, including equitable management of under and over-performance among the providers. Various metrics can be used to support equitable allocation including activity levels, cost levels, resource utilisation, relative performance on underpinning care processes and others.

V. APPENDICES

APPENDIX 1: VBC PROGRAMME

The five Clinical Commissioning Groups (CCGs) in North Central London (NCL): Haringey, Barnet, Enfield, Islington and Camden, representing a population of 1.4 million people, are collaboratively developing a “Value-Based Commissioning” (VBC) Programme for 3 defined population segments with similar needs:

- Older people living with frailty,
- People with mental health problems, and
- People with diabetes.

The aim of the programme is to incentivise all providers (who deliver care across a whole care cycle for a patient) to deliver outcomes that matter to people by developing outcomes-based contracts.

The VBC Programme started with the ‘Measuring outcomes and cost for every patient’ component of the Value Agenda in September 2013. Outcomes were co-produced together with patients at Outcomes Workshops.

Short video of the workshops can be accessed via: www.camdenccg.nhs.uk/publications/camden-ccg-listening-events-november-2013

A co-produced list of outcomes was produced and as well their technical measures for each population segment. These are outcomes that matter to the very people they concern; thus unlike top-down managerial or clinician driven changes, these outcomes are more resilient to public challenge. Furthermore these outcomes have been co-produced with professionals and organised with a workable hierarchy that makes them meaningful, practical and useful in Value-based commissioning. They represent patient views, and when measured can give providers and Commissioners a view on whether the care they are delivering is making a difference.

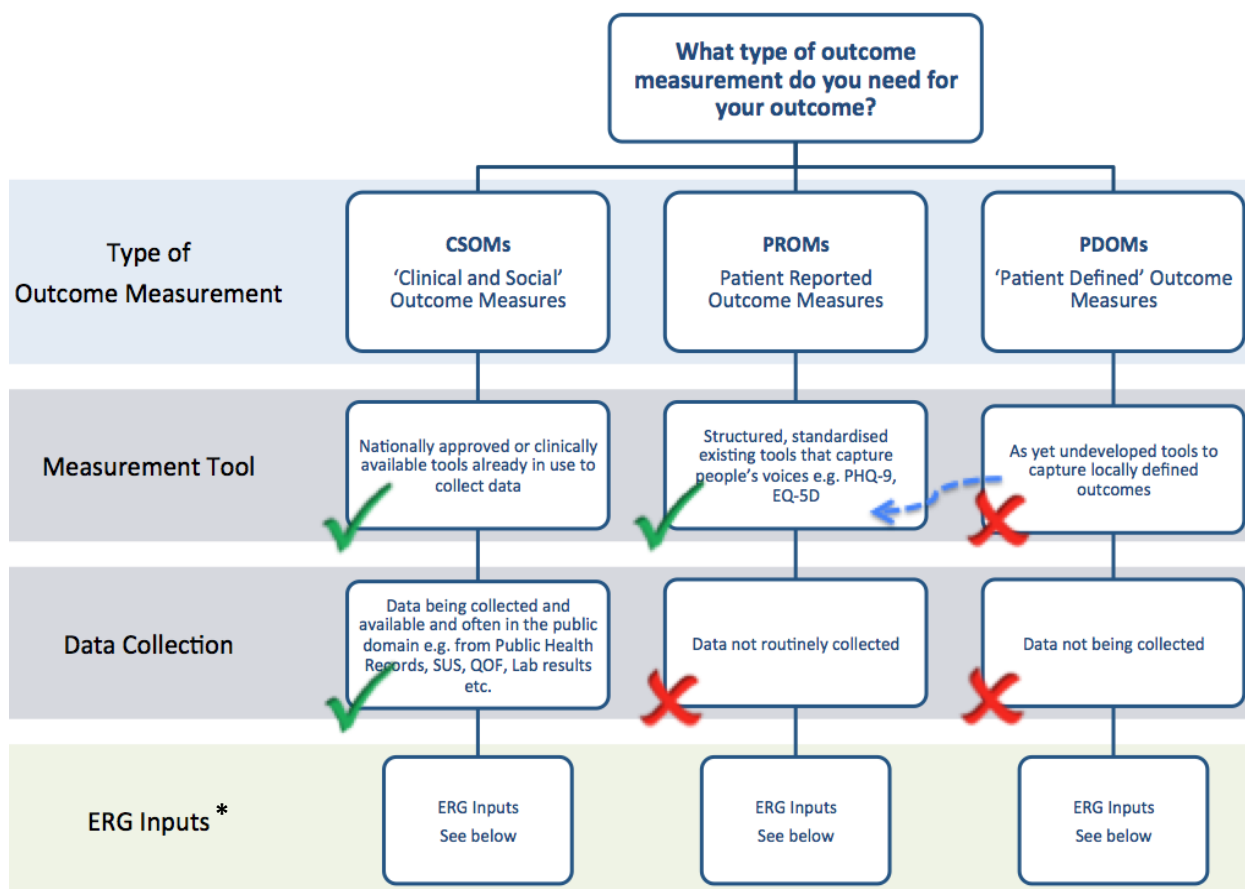
The outcomes are designed from the patients’ perspective, so naturally span provider boundaries, and therefore require shared accountability to achieve; something that is leading to genuine integration of care across full care pathways. Re-designing care around people’s needs is a radically different approach to improving health outcomes. By engaging in systematic outcome measurement, this programme will have a significant impact on the lives of people within NCL, resulting in care which is genuinely organized around the outcomes which are important to them.

APPENDIX 2: PEOPLE WITH DIABETES OUTCOMES

This table was developed as part of the North Central London Value Based Commissioning Programme.

1. Mortality	5. Outcomes related to Clinical Outcomes/Complications:
1a. A measure of mortality rate	5a. Lower limb amputation/PVD
1b. A measure of premature mortality rate: years of life lost	A measure of lower limb amputation /PVD rate
2. Health related Quality of Life	5b. Preventable blindness
A measure of quality of life	A measure of preventable blindness / retinopathy
3. Outcomes related to Symptom Control (e.g. hypoglycaemia, lethargy):	5c. Renal Disease
3a. Symptom-free	A measure of renal disease
A measure of symptom control	5d. Stroke (CVA)
3b. Symptom recognition	A measure of stroke
A measure of the recognition of high/low blood sugar	5e. Heart attack (MI)
4. Patient Identified Outcomes	A measure of MI
4a. Control	5f. Erectile Dysfunction
A measure of feeling in control of diabetes	A measure of erectile dysfunction
4b. Confidence	6. Amount of time out of normal routine
A measure of feeling confident in managing diabetes	6a. Disruption
4d. Support	A measure of disruption by care to life
A measure of feeling supported in managing health	6b. Impact on people around me
4e. Fear/anxiety	A measure of whether family/carers are supported
A measure of feeling free from fear/anxiety	7. Experience of Care/Treatment Process:
4f. Happiness/Mood	7a. Care Coordination
A measure of mood	A measure of feeling that care is more coordinated
4g. Self-management: Monitoring	7b. Access
A measure of being able to monitor diabetes	A measure of timely and organised access to services
4i. Self-management: Understanding	7c. Right person, right time
A measure of being able to understand how to manage diabetes	A measure of feeling that I can access the right person/service at the right time
4j. Self-management: Managing	7d. Planned Care
A measure of how to feel more able to self-manage diabetic care	A measure of feeling involved in care planning
	8. Clinical Outcomes/Complications over time (ie delayed onset)
	8a. Amputation/PVD
	A measure of the onset of amputation/PVD
	8b. Preventable blindness
	A measure of the onset of preventable blindness
	8c. Renal Failure
	A measure of the onset of renal failure
	8d. Stroke (CVA)
	A measure of the onset of stroke
	8e. MI
	A measure of the onset of MI

APPENDIX 3: OUTCOMES MEASURES CATEGORIES



* Expert Reference Group

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