

# Contracting for new forms of integrated care

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# Agenda

- What do we mean by commissioning and contracting?
- What are we trying to achieve through contracting?
- What forms of contracting and commissioning could we use to develop integrated care?
- Questions to pose when deciding how to contract for integrated care



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# What do we mean by commissioning and contracting?



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# Defining our terms

## Commissioning

- The set of linked activities required to assess the healthcare needs of a population, specify the services required to meet those needs, secure those services, and evaluate outcomes

## Purchasing

- The process of buying or funding services in response to demand or usage

## Contracting

- Technical process of selecting a provider, negotiating terms of the contract, and ongoing management - payment, monitoring and variations
- Contracts define the relationship and risk-sharing arrangements between principals (funders) and agents (providers)

(Woodin, 2006)

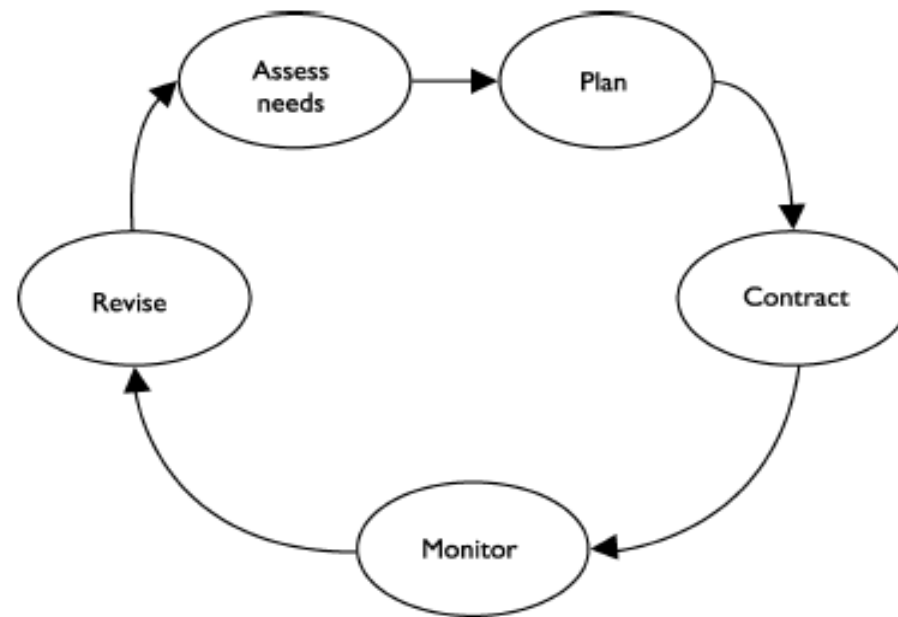


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# Ovretveit's commissioning cycle

A set of linked activities undertaken by those planning and funding services for a population (Ovretveit, 1995)



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# The role of a commissioner of health

‘A commissioner decides which services or health care interventions should be provided, who should provide them and how they should be paid for, and may work closely with the provider in implementing changes.’ (Woodin, 2006, p203)



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# So are we commissioning or contracting here?

- The talk appears to be of contracting
- But it is being used as a means of governing and operationalising a complex network of providers
- And of holding them to account
- So it seems to me to be more than just technical contracting – feels like something more sophisticated and strategic
- This matters, for it takes us into another realm of organisational, behavioural and policy complexity



# Questions to ponder

- In New Zealand, who is commissioning these new forms of integrated primary and community health services?
- Is it the DHB as funder, or has this role been devolved to the BSMC network of providers as a collective?
- If the latter, then we are in the realm of primary care-led commissioning or managed care, with the network arguably being a risk-bearing, capitated organisation



# What are we trying to achieve through contracting?



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# Governance and performance management of complex networks

- Challenge for the funder is how to enforce power within and across a network
- Research evidence supports networks being based on shared values, or self-regulation where possible
- In other words, networks are in themselves a form of governance (Ferlie et al, 2010)
- Evidence cautions against using contracts to hold networks together



‘Networks based on the use of contracts along a care pathway may engender compliance, but evidence suggests [they] are less effective in integrating care provision than managed networks or single organisations.’

(Goodwin, 2006)



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# What could help to make contracted networks work?

- ‘Boundary spanners’ – clinical/managerial linkers
- These are difficult roles and need support, and also resource and role legitimacy
- Small team-based ways of working – distributed leadership among duos and trios in service change (Fitzgerald et al, 2006)
- Should avoid highly individualistic leadership approach
- The ability to manage in a soft-hard way, e.g. using national targets and standards and also local initiatives and plans
- Adequate administrative and management support

(Ferlie et al, 2010)



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# **What forms of commissioning and contracting could we use to develop integrated care?**



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## 'If the goal is integrated care...

- We are concerned with care that 'imposes the patient's perspective' (Lloyd and Wait, 2005)
- The main options would seem to be:
  - A series of contracts with providers, held by a single funder
  - A managed network led by a single organisation acting under contract to the funder(s), with a range of sub-contracts
  - A new organisational form created to represent or 'be' the network, and to hold its contract
  - A health maintenance organisation or 'local clinical partnership'
  - A shared or 'alliance' contract



# A series of contracts

- This implies a single, powerful and sophisticated funder who is able to understand and shape the network
- Likely to be complex to put in place and performance manage multiple contracts
- Relatively high transaction costs
- Issues about boundaries between the different contracts
- Can make it hard to elicit joint action by providers
- Relatively easy to remove a partner from the network, without too much impact on the others



# A managed network

- Has the advantage of hierarchy and leadership
- A clear organisational core, where the contract is held
- Members cede some control and authority to the core
- This makes accountability and performance management more straightforward for the funder (and the public)
- The members of the network know who to hold to account for overall network performance
- Research suggests such networks are effective at delivering programmes of care



# A new organisational form

- This enables existing organisations to retain their own governance and structures
- They devolve some responsibility and resource into a new entity that will govern and manage the network
- Can enable economies of scale
- This new entity can then hold contracts for shared services
- It can also sub-contract with the members of the network
- Examples include care trusts in the English NHS, IPAs in New Zealand, Divisions of General Practice in Australia



# An HMO or local clinical partnership

- A collective of providers who come together in a network in order to hold a capitated budget for a population
- The contract held by the group is for some or all health services required by the registered population
- Enables providers to take 'make or buy' decisions and exercise flexibility in how they use the resource they have been given
- Recent thinking by the Nuffield Trust and NHS Alliance called this the 'local clinical partnership' (Smith et al, 2009)
- Could also be a 'local community partnership'



# An alliance contract

- A collaborative contract across organisations
- A form of gain-sharing and risk-bearing arrangement
- A strategic planning and service development alliance
- Based on extensive clinical engagement and leadership
- Appears to require significant organisational development support if to really enact behaviour change
- Questions about how this differs from other HMO or local clinical partnership arrangements
- And about how accountability will work, and to whom



# Questions to pose when deciding how to contract for integrated care



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# Questions (1)

- How will the approach deal with changes to local needs and services?
- What happens if providers in the network struggle or fail?
- How can you build in local and community accountability?
- How far does it preserve the autonomy of providers?
- What levers are there to change how providers deliver care?



## Questions (2)

- Can it use a range of payment methods, depending on what it wants to achieve?
- Can the approach enable cross-boundary and integrated care?
- Are there IT systems in place to support the approach?
- What is the impact of the approach on transaction costs?
- Are the clinical and general leadership skills available to work the approach?



# Overall messages

- It is important to understand what type of network you are working within
- It is highly unlikely that one contracting approach will be appropriate in all contexts (Smith et al, 2010)
- And the appropriate approach will change over time
- Relentless tracking of patient experience, financial performance and health outcomes is vital (the 'holy trinity') (Rosen, forthcoming)
- The contracting approach is only a means to an end – if it becomes the end, that will be the end of the network



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