How true outcomes-based commissioning can really 'liberate' healthcare services

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ABSTRACT

Healthcare systems all over the world face the challenge of variable care quality, inefficiency and increasing costs. A potential solution is value-based healthcare, where the aim is to achieve the best outcomes at the lowest cost. However, the measurement of outcomes that really reflect what matters most to patients is currently rudimentary. The International Consortium for Health Outcomes Measurement (ICHOM) has been developed to create globally consistent sets of outcomes that reflect what matters most to patients. Incorporating such sets of outcomes into capitated outcome-based and incentivised contracts will incentivise better outcomes and greater cost efficiency.

KEYWORDS: Outcomes, commissioning, patient-centred, comparisons, international

Introduction

The problems facing healthcare in most, if not all, developed countries can be summarised as an excessively variable quality of care associated with inefficiency, increasing costs and pressure to limit spending.[1] In response, the aims of healthcare systems are increasingly being described in terms of value, where value is defined as the ratio of benefit (change in health achieved) to resource consumed (usually defined in monetary terms). A goal of any healthcare system is succinctly captured by Porter as 'achieving the best outcomes at the lowest cost'.[2] Traditional solutions to the efficiency problems have largely focused on enforcing compliance with processes: setting limits of utilisation, mandating use of drug formularies and excluding 'low-priority' treatments, for example.[3] This often results in: (i) incentives that are unaligned with system goals. For example, for decades, the health systems of many countries have rewarded healthcare activity (consultations, interventions and investigations), regardless of the benefit achieved, thereby incentivising the delivery of lower-value unnecessary care (overuse) and failing to penalise poor care (misuse);[4] (ii) care that is often inconsistent with evidence of what works and with slow adoption of new evidence;[5] (iii) many patients and/or service users complaining that they were not properly involved in the decisions about their care and, if they had been, they would have made a different decision.[6] Furthermore, despite multiple interventions, those responsible for healthcare resource use can seldom genuinely demonstrate to their populations and funders the improvements in health status of individuals or populations that they have achieved with the resources invested.

Changing the currency

The systematic measurement of patient-defined outcomes is rudimentary, and the consistent and widespread use of such outcome measurement to catalyse improvements in the structures and processes of healthcare is all but non-existent. We believe that this needs to change if health systems are to achieve the goal of maximising value.

One of the challenges is the lack of consistent and agreed 'currencies' of health outcomes for different population and disease groups. Existing metrics tend to capture inputs, process and costs. The International Consortium for Health Outcomes Measurement (ICHOM) has been established to begin to address the need for globally consistent and agreed outcome measures, as seen from the perspectives of the system, clinician and, most importantly, the patient. We believe that using indicators that are more in tune with patient and publicly defined system goals than the currently used activity and process measures, will begin to align a healthcare system with improving patient health and wellbeing, and will reduce the barriers to clinicians doing the 'right thing' for the patient, thus empowering and motivating altruistic staff. Furthermore, globally consistent sets of outcomes will enable health systems all over the world to compare their outcomes and learn from each other how best to improve.

In Milton Keynes, UK, refocusing a sexual health service with rudimentary outcome measures triggered the service to move from a hospital-centric clinical model to a consumer-centric high street-based model and to introduce one-stop advice on both sexually transmitted infections and contraception (which was previously seen as 'impossible' by local providers), while reducing the costs of the service by 15%. The Cleveland Clinic, an Academic Medical Centre in the USA and, in Germany, The Schön Klinik (a chain of specialist hospitals) are providers that have embraced value-based healthcare, including outcome

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reporting, leading in these cases to 'striking improvements in outcomes and efficiency'.[7]

Commissioning for value

Some provider systems have the leadership, energy and vision to maximise value without payer prompting. However, relying on exceptional leadership to deliver altruistic behaviours that conflict with the financial incentives and performance targets placed on organisations is unlikely to enable most healthcare systems to deliver the best outcomes at lowest cost. By creating incentives for individuals and organisations that are more closely aligned with system goals, the circumstances are created in which it is easier for provider organisations to innovate and transform services to deliver better outcomes and better value, and far easier for the altruism and expertise of staff to influence organisational behaviour. The impact of outcome measurement comes from commissioners or payers incentivising providers with financial rewards for improving health and wellbeing status. Emerging evidence already demonstrates the potential that this approach has to transform systems.[8]

Value is maximised when the best outcomes are delivered from any given level of resource. To align incentives with this goal requires the incentivisation of both better outcomes and greater cost efficiency. These incentives can be introduced into a health economy by combining capitation with strong outcome incentives. In the UK, an increasing number of commissioners are developing Capitated Outcome-Based and Incentivised Contracts (COBIC) of this form. When let in longer contract terms (at least five years in duration), they give providers confidence to make upfront capital investments to generate outcome-related benefits that might not be realised for several years. This has the added benefit of strengthening incentives for preventive services. However, this approach will be most effective when a wider range of valid, relevant outcome measures is developed that reflect the outcomes that matter most to people who use the services.

The work of ICHOM is adding to the currency that can be used by commissioners to bring providers together in the delivery of common value-based objectives. In Bedfordshire, the clinical commissioning group (CCG) included the outcome measures of ICHOM for lower back pain in its new contract with an accountable lead provider for the delivery of an integrated system of musculoskeletal care. This contract is underpinned by a single programme budget, combining the entire spend of the CCG on musculoskeletal services. Over the course of the five-year contract, the commissioners will be able to directly link their investment in musculoskeletal care with the ability of the providers to (among other things) increase the proportions of patients referred with back pain who are able to work and are able to live with minimal or no disability. To achieve the expected improvements in patient outcomes and stay within the programme budget, the providers need to collaborate with each other and with patients as co-producers of their own care. Furthermore, measuring a globally consistent set of outcomes means that Bedfordshire will be able to interact with other systems around the world to figure out how best to improve its outcomes. Prevention of, and early intervention in, deteriorating clinical or health status become more important as objectives for the whole system. The consequence is that the model of care moves away from predominately hospital-based care that can reinforce the 'sick role', and into community and home-based care that supports people with musculoskeletal problems to meet their individual goals.

Experience from Bedfordshire and the growing number of other health economies in the UK now applying this contracting approach highlights key elements to the approach of the commissioners for maximal benefit (Box 1).

Although the first such outcome-based contracts are already emerging in the healthcare market in NHS,[10] it is an approach contested by some, especially where it challenges current power structures, existing ways of working, the distribution of resources within a health economy and, therefore, requires significant change from all parts of the provider system. A value-based approach makes new demands of providers. It requires providers to understand their own costs of delivering

Box 1. Key elements to the approach of the commissioner.

Ensure the scope of the population covered under the contract is clearly defined.

- This can be by disease or clinical pathway, age group or geography.
- The larger the population covered, the greater the opportunity for providers to find the scope for innovation and reinvestment of resources.
- A group that is too large can make the scale of the redesign paralysing.

Ask the population what they expect services to deliver for them (not how they want services to be structured).

- Combine what people tell you with the clinical outcomes required.

Imaginative redesign of services.

- This can be the most energising part of the process and should be a core component of service change. It becomes a process led by knowledgeable clinicians.

Use the scope of the contract to decide on the amount of money available to the providers to spend on it in totality.

- This means careful analysis of existing contracts to pull out the funding combined with a value judgement by commissioners of the proportion of their allocation they want to spend on the relevant segment of the population. This informs the creation of a single funding budget for the new population-based service.

Take the decision on whether competitive procurement is necessary and the form of contract.

- Commissioners need to choose whether to use a competitive process to let the contract for the new service. Competitive and non-competitive processes are both possible.
- The choice of contract form (alliance, prime contractor or other) should be based on what is best to bring the right culture of innovation and leadership into the area.

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care and to endorse the opportunities for increasing return on investment by reallocating resource to different parts of the 'supply chain'. A COBIC-style contract also requires the accountable provider to be able to coordinate the care of individual patients along pathways and across settings, and, because the capitated element of the contract transfers some financial risk to the provider, requires them to understand and practise population health management. Therefore, and perhaps more difficult to achieve quickly, existing cultures need to change. Providers have developed in an environment of competition even when the language is of collaboration with other providers, where relationships with commissioners can require combative negotiating tactics, and where patient experience – never mind actual outcomes – is only just becoming accepted as being of sufficient importance to routinely measure. These contracts also invite hospital-based clinicians to add a population perspective to their work and to find new ways of using their expertise to inform practice beyond the boundaries of traditional hospitals. All three parties – commissioners, providers and the public – will need to redefine their relationships with each other. The public must become accustomed to being (and in fact demand to be) asked 'what matters to you'.[11] Providers must have the confidence and trust in each other to collaborate rather than expect arbitration from commissioners, who in turn must resist the temptation to over specify and fill outcome-based contracts with details of expected processes that leave little flexibility for providers and patients to develop the necessary new ways of working. At the same time, commissioners must be alert and take action to address the inevitable 'unintended consequences' that can arise by such fundamental redesign. Defining scope based on population groups can run counter to the interdependencies necessary to run more generic clinical services, such as diagnostics or emergency services. Commissioners may need to be prepared to consider whether the cross-subsidisation engendered within providers by nationally set tariffs needs to be rebalanced in the creation of capitated budgets, to more fairly address the true costs to providers of delivering the right care in the right place to the right part of the population.

Value-based healthcare coupled with COBIC commissioning fundamentally changes the relationship between payers, providers and patients, but in a positive way such that all parts of a health economy are incentivised both to deliver high-quality care that achieves a shared set of outcomes that matter to their patients, and to make best use of the limited funding available. The work of ICHOM combined with new contracting opportunities means that an outcomes currency can now have value across the NHS in England. Together, they enable our fragmented health and social care system to come together in new ways to work collaboratively to deliver the outcomes that matter to the public. We believe that this can be an example to other systems across the world. ■

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