



Journal of Integrated Care

Contracting for integrated health and social care: a critical review of four models

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Article information:

To cite this document:

Jenny Billings Esther de Weger , (2015), "Contracting for integrated health and social care: a critical review of four models", Journal of Integrated Care, Vol. 23 Iss 3 pp. -

Permanent link to this document:

<http://dx.doi.org/10.1108/JICA-03-2015-0015>

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Contracting for integrated health and social care: a critical review of four models

Introduction

In the current climate of service reorganisation and sensitivity surrounding cost, it is clear that commissioners and providers in the health and social care economy are striving to strengthen integrated care as a means of improving quality and reducing costs (Curry and Ham 2010; Ham and Walsh 2013). Across England, health and social care systems are having to confront many pressures. For example, most of the funding is tied up in acute and long term social care, current NHS contracts are widely regarded as insufficient for the transformation agenda with block contracts stifling innovation, and Payment by Results does not incentivise the reduction in admissions or social care changes but in fact acts as a perverse incentive (Curry et al 2011). In addition, Advanced Assistive Technology should be embedded within integrated care but is often peripheral.

As a consequence, commissioners must rapidly consider commissioning and contracting arrangements to enable them to drive forward service integration that is innovative, sustainable and transferable. Recently, there has also been support from NHS England Chief Executive Simon Stevens for promoting more flexible approaches to commissioning and contracting, strongly suggesting that CCGs could explore alternative approaches. These ideas have become more formalised in NHS England's *Five Year Forward View*, with Multi-Specialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS) eventually evolving to hold a delegated budget for the health and care of whole populations (NHS England 2014). These new integrated care models require strong relationships and trust between the different organisations and professionals delivering care, which should be underpinned by sound contracting mechanisms that have relational concepts embedded within them. However, there is currently scanty evidence on contracting approaches that would have a good fit with the transformation agenda, particularly concerning how agencies can work towards joint outcomes.

This paper presents the findings of an international literature review of contracting approaches, models and designs, with the aim of critically analysing their suitability to the integrated health and social care agenda. An important feature of this was to capitalise on learning from agencies and industries external to our health and social care systems and to identify in particular evidence of effectiveness and what could be usefully be transposed. The approach and search strategy of the literature review can be found as an appendix.

Findings

While a total of eight models were identified, this literature review will focus on the first four listed given their growing prominence in current commentary, namely a) Accountable Care Organisations, b) Alliance Contracting Model, c) Lead Provider/Prime Contractor Model and d) Outcomes-Based Commissioning and Contracting.

As intimated in the search steps, the literature review revealed some contrasting findings with respect to the nature and origin of data sources. For all four models, there is a concentration of activity over the last two to three years, which reflects the interest and need for information. Some difference between the models were however evident. With regard to ACOs, there was considerable concentrated published debate over a two year period and high level political and operational commentary in reputable journals. With the Alliance model, the larger numbers of articles resulted from its longer history and wider use outside of health and social care, although more current debate and description was gathered through journalistic sources and websites. The Lead Provider and Outcomes-Based Contracting approaches shared some similarity in that there were a few notable commentators (eg King's Fund, Nuffield Trust) leading the field through informative publications and for Lead Provider, dedicated websites provided examples. For Outcomes-Based Contracting, the latest developments were sourced through news items and direct examples of use found opportunistically through their availability on the internet. Of note is the fact that evidence for this review was almost entirely sourced from healthcare journals or related websites (medical, public health, management) with no primary social care commentary apparent in the debates.

a) Accountable Care Organisations

Definition and Purpose: Accountable care organisations (ACOs) were proposed in the Affordable Care Act (ACA), signed into USA law in 2010, as a measure to slow rising healthcare costs and improve quality in the traditional Medicare programme. ACOs are groups of primary and secondary care physicians, and other health care providers, potentially including hospitals, who will work together to avoid duplication of services (Fisher & McClellan 2011), so there is a strong emphasis on integrated care. The goals of ACOs are to align care, reduce costs, and increase quality of care primarily through primary care (Bennett 2012) with the emergence of a coherent vision for chronic disease prevention and population health (Corbett & Kappagoda 2013). While ACOs have been defined and interpreted differently by various leaders in the field, an ACO has been generally defined as "a local network of providers that can manage the full continuum of care for all patients within their provider network" (Ronning 2010, 47). The ACA also introduces the creation of the Shared Savings Program (SSP) for Medicare reimbursement, which is the incentive programme tied to the ACOs. ACOs may be an effective way to begin reforming the US healthcare system because they address both provider payment and delivery system reform (Bennett 2012).

Characteristics: ACOs are expected to coordinate care among health providers to produce streamlined services. Providers are held accountable for achieving measured quality improvements while also reducing the rate of spending growth (McCellan 2010). A driving force to encourage this adoption is payment reform, which aims to gradually shift the focus from a fee-for-service system with shared savings to a more capitated payment system and pay for performance. To ensure these savings are not achieved by reducing needed services, the amount of savings returned to physician groups is affected by the quality of care provided by the group, and there is public reporting of the quality and costs of care (Bernstein 2013). ACOs have at their roots a 'value-based health care' paradigm. Purported by Porter (2012), value in any field is defined around the customer, not the

supplier and should be measured by outputs. As efficiencies are important, the objective becomes to ensure patient health outcomes relative to the total cost.

ACOs must have a leadership committed to improving value for their patients, the skills and infrastructure necessary to manage the financial risk of this new model, an information technology system capable of processing internal and external data, and the ability to deliver key information to providers and patients (Miller 2011). These goals are consistent with the “triple aim” of improving the care of an individual patient, improving the care of the overall population, and reducing health care expenditures (Berwick et al 2008).

Because of the population health focus, the most innovative ACOs will pursue a range of nonclinical interventions that address social norms at an individual and population level, both because these interventions align with their mission and because they are a cost-effective way to implement prevention (Corbett & Kappagoda 2013). Under the ACA, any of the following arrangements may qualify as an ACO (CMS 2011); professionals in group practice arrangements; networks of individual practices of professionals; partnerships or joint venture arrangements between professionals and hospitals; hospitals employing professionals; other groups of providers and suppliers deemed appropriate. ACOs must report on the 33 quality metrics to participate. These measures are divided into four health domains: patient/caregiver experience; care coordination/patient safety; preventive care; and at-risk population. ACO's performance will be collected using a variety of tools, which could include patient surveys, electronic health records, and claims.

Applications: This is largely an initiative embedded within USA health care systems although there are comparisons being made with the *Five Year Forward View* (NHS England 2014). There are a number of articles emerging describing early implementation models and applications, but this is largely a period of transition for the US healthcare system with few concrete examples of its full application and evaluation.

Shortell et al (2014a) give an account of a taxonomy of ACOs to describe and understand early ACO development and to provide a basis for technical assistance and future evaluation of performance. They report a three-cluster solution from 173 organisations: larger, integrated systems that offer a broad scope of services and frequently include one or more post-acute facilities; smaller, physician-led practices, centred in primary care, and that possess a relatively high degree of physician performance management; and moderately sized, joint hospital–physician and coalition-led groups that offer a moderately broad scope of services with some involvement of post-acute facilities.

A further study by the same authors (Shortell et al 2014b) conducted a National survey of 1,183 physician practices to investigate physician-practice involvement in ACOs between 2012 and 2013. 23.7 percent of reported joining an ACO; 15.7 percent were planning to become involved within the next 12 months but the majority (60.6) percent reported no involvement and no plans to become involved. Physician practices that are currently participating in ACOs appear to be relatively large, or to be members of an Independent Practice Association (IPA) or Physician hospital Organisation (PHO), are less likely to be hospital owned and are more likely to use more care management processes than non-participating practices. Beckham (2014) describes a team-based system at a

clinic focusing on multi-speciality medical practice, and states that a values-driven culture of teamwork is largely responsible for its success.

Benefits/Success Factors: As yet there is no evidence of effectiveness but Song et al (2012) provided some evidence in favour of this approach, analysing changes in spending and quality associated with an ACO-type quality contract and found that the rate of increase in spending slowed compared to control groups. Savings were accounted for by lower prices achieved through shifting procedures, imaging, and tests to facilities with lower fees, as well as reduced use among some groups. Quality of care also improved compared to control organisations, with chronic care management, adult preventive care, and paediatric care within the contracting groups improving more.

Aside from this, a number of 'aspirational' benefits have been put forward. As the basis for any ACO is to provide effective primary care, improving access to primary care (through use of e-mail, telephone support, physician extenders) and coordinating the care of patients with complex illness is hoped to lead to fewer preventable emergency department visits, hospitalisations, and readmissions (Bernstein 2013).

ACOs can provide some benefits to participating physicians. One of the key benefits may be through their information technology systems. Health information exchange can assure that all providers across a community have access to the same patient information to allow better care coordination. In addition, delivering timely patient information to front-line personnel may decrease unnecessary testing and improve chronic disease management (Bernstein 2013). Patient portal and personal health records may lead to increased patient engagement in their own care and educational opportunities (Bernstein 2012).

Use of Incentives: The Shared Savings Program (SSP) for Medicare reimbursement is the incentive programme tied to the ACOs to promote their formation and use, and is completely voluntary.

If an ACO meets certain quality metrics and reduces health care spending to levels below projected costs, it shares the savings with the insurers. ACOs have the potential to align many different incentives in order to improve health system quality and reduce health care costs across populations. Because this model incentivises health systems to maintain the health of large patient populations rather than provide expensive treatments to individuals, institutions have a reason to look at all the factors that might negatively affect patients' health status, including the social determinants of health. They also have incentives to promote healthy choices to their patient population, their employees, and the communities they serve, as those choices reinforce the preventive orientation of the health care delivered within an ACO. The most innovative ACOs will pursue a range of nonclinical interventions that address social norms at an individual and population level, both because these interventions align with their mission and because they are a cost-effective way to implement prevention (Corbett & Kappagoda 2013).

It is not clear that ACOs can do much about changing incentives to physicians to lower costs. There is no doubt that financial incentives can increase the alignment of physician behaviour and the financial and quality goals of a healthcare organisation (Shortell & Casalino 2010; DeVore &

Champion 2011). The question is whether the financial incentives inherent in the ACO program are significant enough to have any impact on physician behaviour.

Critique: According to Reynolds and Roble (2011) the most challenging aspect of creating an ACO is the start-up cost. Their American Hospital Association study estimated that implementation will be much more expensive than indicated and many observers are concerned that the implementation costs will not be worth the potential savings. In addition, Bennet (2012) notes that many providers believe the incentives to participate in ACOs and Medicare's SSP are too difficult to attain and too operationally burdensome to seek. In a survey of its members, the American Medical Association reported that 93 percent would not participate in an ACO (*Wall Street Journal* 2011).

Correia (2011) comments on the quality metrics; their mandatory collection, which will have to be conducted at least partially by the ACO, could pose a significant cost to hospitals. Alongside the quality indicators and other competencies that ACOs have to measure and reach, there are a vast number of legal requirements, 'antitrust' standards, and approval procedures (such as for marketing material to patients) that will put governing and approval agencies as well as potential ACOs under considerable bureaucratic pressure and create delays. Furthermore, he adds that complying to arrangements for patient empowerment and patient centredness will be challenging as these terms are not self-defining and there are a wide variety of approaches to achieving these goals, depending on how they are defined. Correia warns that an ACO that offers a narrow range of services will find it difficult to steer its patients toward efficient ways of receiving care, because the statute guarantees patients the right to go to any provider. It makes it impossible to ensure that patients go to doctors or institutions that use evidence-based treatment protocols, meet minimum quality standards, or follow any of the requirements imposed on the ACO to provide high-quality, low-cost care.

Press et al (2012) have an additional concerns regarding implementation. While structure and incentives may facilitate the delivery of coordinated care, they will not necessarily ensure that care coordination is done well. For that, physicians and other healthcare providers within ACOs must possess and utilize specific skills, particularly in the areas of collaboration, communication, and teamwork.

As ACOs are being rolled out, other commentators such as Stenson and Thompson (2013) describe the potential land mines in the transition to a new paradigm of value-based health care and the principles sponsors should consider in understanding and integrating ACOs into their health care benefits strategy. In addition, Decamp et al (2014) explored the ethical challenges as no framework exists to support decision-making in this area. The authors reveal dilemmas associated with the fair resource allocation, design of professional financial incentives, threats to professional autonomy, and conflicted responsibility for patients versus ACOs. Lewis et al (2012) add another concern relating to vulnerable population groups such as the clinically at-risk and the socially disadvantaged, who may not be incorporated into a new model that is aimed at reducing costs while improving the quality of care.

b) Alliance Contracting Model

Definition and Purpose: The literature on alliances dates back to the 80's. When defining an alliance, virtually all researchers use terms such as cooperation, collaboration, value creation, or similar ones designed to convey that alliances involve a closer and more interdependent relationship than standard supplier transactions (Bruner & Spekman 1998; Zoller 1999; Mayer & Treece 2008). The following statement is typical: "Cooperation and collaboration distinguish the strategic alliance from an ordinary intercorporate transaction" (BenDaniel et al., 2002, p. 363).

An alliance contract is one contract between the owner, financier or commissioner and an alliance of parties who deliver the project or service. There is a risk share across all parties and collective ownership of opportunities and responsibilities associated with delivery of the whole project or service. An alliance contract is a way of working that focuses on relationships and creates an environment of trust, collaboration and innovation. It is seen as ideal for integrated care because it drives collaboration between all parties. Contracts are not separated from improvement and transformation initiatives, they are an integral part of them. <http://halliances.org.uk/>

Regarding their purpose, agencies need to form alliances in order to address complex business challenges. Alliances can complement organisations' core competencies and allow them to jointly answer problems that a client or market has identified and no single entity can serve (Augustine & Cooper 2009). In addition, alliances serve to gain production efficiencies and the resultant lower costs; expedite access to technology, markets, and/or customers; promote organisational learning; expand strategic competencies; launch a strategic response to a much larger, or more nimble, competitor (Lorange and Roos 1993; Bruner & Spekman 1998).

Characteristics: Augustine & Cooper (2009) identify certain types of alliances, occurring between two or more firms:

promotional alliances create brand awareness in a market;

operational alliances are used if there is a need to work closely together to improve the operational efficiency of a company or market;

relationship alliances function to mitigate risk and expand new markets for firms that are relatively equal in size;

strategic alliances are formed to create joint ventures wherein two firms complement each other's strengths, securing, maintaining or enhancing a company's competitive advantage.

Relational aspects relating to trust, loyalty and commitment for the long term are important (de Jong & Klein Woolthuis 2008). In addition, contracts feature highly in the alliance discourse. Alliance contracting is defined as an agreement between parties to work cooperatively to achieve agreed outcomes on the basis of sharing risks and rewards (Gallagher & Hutchinson 2003). Mayer & Treece (2008) among others emphasise that contracts are central parts of an alliance as they both provide a means for enforcement and define the roles and responsibilities of each party. Due to the broader scope of the relationship, alliance contracts tend to have a longer duration, involve more intricate administrative structures and dispute resolution mechanisms, and specify the exchange of much more firm-specific information, technical knowledge and capabilities.

Applications: Alliances in their different forms are found in a wide range of organisations and industries (car, rail, consulting, London highways, film, manufacturing, private finance, IT and

electronic industries). Firms initiate alliances in order to offer a new product or service or address goals relating to revenue growth, competition, and/or market share (Clifton & Duffield 2006; Augustine & Cooper 2009). Alliance activity is reported largely in the USA and Asian economies.

Within the NHS, Alliance contracting is a relatively new concept to healthcare procurement and there is growing discussion and activity regarding implementation (Addicott 2014), but no full and evaluated application so far. It is one of the models of innovative contracting that the NHS Commissioning Board proposes to enable through its NHS Contract 13/14.

Four stages have been put forward to building an alliance contract:

1. *Commissioner readiness*: leadership and capability, clarity on service and outline contract, co-designed outcomes;
2. *Alignment*: choosing the right partners, aligning business and personal drivers, commitment to collaboration, openness and innovation;
3. *Finalisation of [openly negotiated and collectively agreed] contract*: principles for behaviours, performance and commercial framework, governance roles, implementation plan, target costs;
4. *Launch*: staff information sessions, early meetings of leadership teams, continued support. (<http://lhalliances.org.uk/>)

Addicott (2014) describes a number of on-going initiatives in the NHS including integrated personalised support services in Lambeth, and older people's services in Salford.

Benefits/Success Factors: Alliances have been empirically shown to be effective mechanisms for transferring knowledge, spreading risk (Hennart, 1988), and learning (Inkpen & Crossan, 1995). The financial return provided by alliance relationships, as an indicator of goal-based determinants, was found to be the most important factor related to outcome quality (Weaver & Dickson 1998). Addicott's (2014) review of on-going NHS alliance models suggests that benefits include the strong incentives to collaborate, limiting the dominance of a single organisation, strengthening relationships between commissioners and providers, and retaining the active involvement of commissioners. Most of the literature however reports on process factors that will support an alliance, revealed through 'lessons learned' of their implementation. There is very little that could provide an evidence-base of effectiveness.

These supportive process factors start with the importance of securing good management arrangements, which is seen as vital, such as having departments dedicated to alliance management (Kale et al., 2000). In addition, it is important to clarify roles and responsibilities, consider conflicts of interest, anticipate and manage comparisons between alliances. Alliances must be continuously evaluated with regular reporting on performance – this includes the quality of individual alliances and their respective alliance portfolios (Augustine & Cooper 2009). Devlin & Bleackley (1988) state that a rigorous search for the right alliance partner must be made to ensure compatibility over a long period. There must be clear lines of accountability and responsibility and ways of establishing information retrieval processes. Alliances must bring sufficient resources to the alliance from the onset and recruit or 'fast track' high quality staff, using it as a career enhancing opportunity. It is also important to have a positive attitude and recognise limitations. Further to this, if alliances are

compatible in terms of 'softer issues,' they can coordinate more easily. This refers to the organisations' cultures. Corporate culture affects many critical aspects of management and operations, such as how deadlines are perceived, decisions are made, and clients are treated (Kale et al 2002). In complex alliances that cross national boundaries longer, rather than shorter, periods of time might be needed to establish a web of interpersonal ties among key managers, to build a more accepting environment for cultural differences, and to nurture the trust and commitment that are essential alliance ingredients (Bruner & Spekman 1998).

When it comes to governance arrangements, relational embeddedness, based on personal ties, and structural embeddedness, based on ownership ties, can support the employment of formal governance mechanisms. Attention must be paid to the moderating role of network embeddedness in diminishing the relationship between transaction hazards and formal governance mechanisms (Lin et al 2011).

Use of Incentives: Mayer & Treece (2008), studying the jet engine industry, report that the payment mechanisms in these contracts are structured so as to spread risk and create strong incentives that link each party to the success of the overall engine development program. This arrangement serves to align incentives for the parties as the in the alliance everyone is paid at the same time. They also share the risk of customer default.

Critique: Augustine & Cooper (2008) report a high failure rate of organisations in alliances, largely due to the fact that competition between alliance partners jeopardises the alliance. Alliance partnerships differ in the amount of pressure the firms feel to cooperate versus compete. These competitive forces are affected by contracts existing between the parties, the amount of product and service overlap, as well as the amount of trust in the relationship. In addition, other challenges include competing interests within firm leadership, negotiation of alliance agreements, and alliance promotion.

Added to this, the attributes of individual firms, partnerships, or networks of alliance relationships can hamper alliance performance. The performance of an alliance can be affected by the larger network of relationships in which the alliance is embedded. If a company has multiple alliances, these alliances may compete with one another if they are formed to fulfil the same purpose (Augustine & Cooper 2008).

Central to alliances is trust, cooperation and collaboration, however mistrust of alliance partners can occur through suspicions of power-seeking through knowledge sharing. Alliances can breed misalignment of mission, ideals, economics and culture. As a result they are formed with difficulty, and are easily strained. As conditions change, the alliance must adapt (Bruner & Spekman 1998).

When it comes to alliance contracts, they are seen as an imperfect safeguard against opportunistic behaviour because the parties cannot foresee all possible contingencies which makes all contracts incomplete. The ambiguity in how alliances are defined makes them difficult to study because the results will depend critically on the definition that the author has used (Mayer & Treece 2008.)

c) Lead Provider/Prime Contractor Model

Definition and Purpose: This model is concerned with service integration and transformation and is seen as a vehicle to tackle the long-standing problems with integration in the past. It aims to deliver genuinely integrated care, based around both the needs of patient groups and individual patients. It will also have to respond to powerful incentives to keep patients at home and out of hospital. An additional aim is to prevent commissioners having many different contracts with several providers (Corrigan & Laitner 2012; Corrigan 2013; Addicott 2014; Flynn et al 2014).

In this model:

- one provider is given the responsibility through a contract for subcontracting to other providers for the various aspects of care to both deliver care and also to ensure all different aspects of care are fully integrated, bringing together the previously episodic providers of care into a single pathway;
- commissioners will commission Programmes of Care via an Accountable Lead Provider. The power needed to provide accountable integrated care can only be delivered from a provider within the pathway of care, ideally in the centre of the pathway between primary care and hospital inpatient care;
- an outcome based contract with the Accountable Lead Provider will be set up and through this contract clinical and financial incentives will be aligned in the Lead Provider's management of the programme.
- the Lead Provider will support primary care in its part of the pathway whilst at the same time managing unwarranted variation in primary care referrals. They will also help manage the gateway into hospital based in patient care.

The other major driver towards this form of delivery is purported to be the economic imperative to deliver significantly better health care outcomes for the same resource. Existing provision of integrated care is rarely achieving this outcome. This will need contracts across different parts of the system rather than contracts with individual organisations only. The major efficiency improvements will come from better management of the interfaces across the care pathway (Corrigan & Laitner 2012).

The literature reveals the use of alternative different terms for similar roles and models. Addicott (2014) from a King's Fund perspective for example refers to a prime contractor model, where the CCG contracts with a single organisation (or consortium) which then takes responsibility for the day-to-day management of other providers that deliver care within the contracted scope or pathway. Addicott also describes a significant variation on the prime contractor model - the prime provider model - that stipulates that the contracted organisation also provides services directly. In addition there are accountable prime provider, active integrator, and non-lead provider references which all appear to be variations on the above (eg O'Flynn et al 2014).

Characteristics: Authors such as Addicott (2014) have attempted to build typologies of the above named models that clearly describe their characteristics and suitability to different contexts. However, it is apparent that there is no clear demarcation between these named models and how they are being used in practice; many of the terms are used interchangeably. In fact, Addicott suggests that naming models up front can even be distracting and unhelpful. Rather, there may be

greater value in determining how the principles or ambitions that underpin the desired transformation can in general be built into the terms of a contract.

Corrigan & Laitner (2012) provide an initial outline of certain principles of 'lead providers':

- Commissioners let a contract for an Accountable Integrated Programme of Care (AIPC), each containing a number of related pathways, to a single organisation that will then both provide specialist ambulatory care whilst also integrating existing and other providers into a programme of care for a defined patient group.
- Lead providers will develop fully integrated care using different contract mechanisms that can take on programme risk and accountability. This will need different forms of contract pricing and much less pathway micro-management. The model will need a budget that is based around the existing budget for a total programme of care and not just the reproduction of episodes.
- The Lead Provider model provides strong power for the integrator, since they have both the clinical and financial accountability (and budget) for the whole programme of care and can create the new integrated incentives that will make integrated care possible.
- The model will retain most of the existing providers of the different aspects of health and social care in the new integrated patient pathways (eg GPs, community nurses, A&E staff, social care staff). Hospital outpatients are likely to move over time to a community based, ambulatory, specialist, multidisciplinary model.
- The Lead Provider may wish to create some form of Joint Venture between provider partners such as social care, third sector organisations and independent providers, or it may wish to have only lead provider/subcontractor relationship.
- The model will need a budget that is based around the existing budget for a total programme of care and not just the reproduction of episodes. This model is connected to the Year of Care tariff (Year of Care 2011), where Implementer sites are working out the costs of a year of care for a long-term condition patient.

Applications: Although it has been used in industry and education for a number of years (eg Leicester Youth and Community services, lead provider service model for education 2001 <http://politics.leics.gov.uk/mgConvert2PDF.aspx?ID=1524>), this is a new model in health and social care provision and as yet has not been established in the UK. In Australia this approach is more established. Here, the government contracts with a lead or prime provider and the models tend to be locally based, partnership-type approaches delivering services to a specific client group, initiated by community or not-for-profit organisations rather than being driven by government (O'Flynn et al 2014). In the UK there are some examples of strategies, plans in progress and intentions of how it will be used emerging. These range from small local initiatives to region-wide intentions. An outcomes-based commissioning approach is strongly linked with this model.

QIPP Right Care has been developing significant stakeholder interest in the Lead Provider model, involving Royal Colleges, National Clinical Directors, Clinical Commissioners and several patient groups. (www.rightcare.nhs.uk) and have some case studies that are being monitored, with variation in how the 'lead provider' role is not only named but operationalised. This includes integrated GP-led diabetes care in Bexley, a community-based self-care support service for adults with persistent

pain in Somerset (Corrigan et al 2012), and for prime contractor models, a case study of an integrating pathway hub in Pennine MSK Partnership (Corrigan et al 2012) and cancer and end-of-life care services in Staffordshire (Addicott 2014).

Typically, case studies are reporting 'lessons learned' as the models are rolled out. In the case of the Bexley example for instance, it became clear that the integrator must be a strong individual and have a high level of formal contractual power and the project benefitted from a GP champion who saw their role as developing their colleagues, and healthcare professionals who recognised the need to create a new service.

Benefits/Success Factors: There is no evidence of effectiveness, but there are suggestions of factors that need to be considered or in place when implementing this model. Corrigan & Laitner (2012) assert that the model is a new, sustainable approach to commissioning care and also a mechanism to transform pathways of care in terms of quality and productivity. The details of how this can be operationalised will be largely left to the new implementers of this model, however some 'how to' indicators can be extracted from their report, such as framing the contract at the right level of patient need, and ensuring with knowledge transfer that there is a commonality of language and meaning from each of the contractors in the pathway. Addicott (2014) suggests that prime contractor models are simple for commissioners to manage, enable pathway management and shift clinical accountability onto integrator and providers. With respect to the prime provider model, she outlines the strengths as having increased direct control over provision across a pathway, enabling money to move within the pathway, and a clear governance arrangement through contractual/subcontractual mechanisms. O'Flynn et al (2014) see the perceived benefits of prime provider models for government including greater coordination of local specialist providers, reducing administrative costs and enhancing opportunities for innovative service delivery resulting from economies of scale.

'Bearing Point' has an interactive forum focused on how to commission a lead provider pathway, bringing together 'thought-leadership', looking at managing risks and building on lessons learnt. The website states there are distinct elements to developing such a model such as pre-qualification analysis of the contract process, stakeholder engagement, scoping key clinical specifications and market shaping through analysing provider organisations and networks.

Use of Incentives: Corrigan & Laitner (2012) describe a new set of systematic and rigorous incentives that need to be developed to overcome the existing incentives, cultural and organisational barriers that have created the fragmented professional care in the first place. The main difference in the Lead Provider model compared with other models is that different aspects of care will be incentivised by the lead provider to work together into a coherent patient pathway, making clear that each aspect of the work will be incomplete unless integration with each other takes place. This provides the lead provider (with its subcontractors) the ability to construct an overall pathway of care with incentives that provide the commissioner with the outcomes that they want. The Lead Provider will take overall leadership and accountability for the commission, then sub contract the aspects of care to different providers and incentivise those providers to drive towards that desired outcome. The commissioner will have one contract for a whole programme of care which contains multiple providers.

Critique: It has proved difficult within the NHS to understand who will be actually carrying out the integrator role. Corrigan (2013) states that one major challenge will be to decide which organisation will be the lead provider. The existing NHS institutional framework consists of large institutions that provide secondary and tertiary care and mainly very small institutions that provide primary care. Within primary care, some Mental Health Trust may be of sufficient capacity, and if there was a large federation of GPs to provide primary care services, they may be able to take on the risk. But in most parts of the country organisations in primary care lack the size to take this difficult task on.

In Australia where this model is more established, O’Flynn et al (2014) describe the challenges for government as the hollowing out of capabilities and provider or market failure. In addition, the authors note that prime providers themselves are faced with challenges relating to managing potential risks and liabilities as well as contract and performance management.

Within UK commentary, Corrigan (2013) notes that the lead provider model is a challenge because the contract is for health care outcomes that are essentially outside the control of the hospital, and the acute provider will find themselves part of a very different non-hospital based business model. Most of the integrated pathways that will be created will seek to move some existing healthcare away from the hospitals and establish it within the community which will create tensions. The hospitals may well organise any integration around its own needs and not act as an honest broker ().

There has been some commentary that depicts the Lead Provider as dangerous to patient care, claiming that the loss of direct relationship between commissioner and provider will destabilise institutions. There is also the possibility that at the moment the institution bound clinical governance of work provides safer quality care that would be lost if they were subcontracting to a lead provider (Corrigan & Laitner 2012).

d) Outcome-Based Contracting and Commissioning

Definition and Purpose: Outcome-based contracting and commissioning (used interchangeably in the literature) are designed to:

“...shift the focus from activities to results, from how a programme operates to the good it accomplishes.” (Plantz et al 1999 p11).

The purpose is to define the funding to be given not in terms of outputs achieved or processes to be followed but what outcomes might be expected. So outcome criteria will include measuring the extent to which for example a health condition, or behaviour has improved and the evidence that the implementation/intervention processes have achieved this outcome (Kerslake 2006).

There is very little evidence of effectiveness and the concept is relatively new in the UK, but there is a general consensus that commissioning services at the individual service user level on the basis of outcomes rather than tasks is a precondition for service change and achieving person-centred care for all service users. It involves shifting the power from commissioners to providers in a major way and empowering them to be responsive and flexible in the light of service users’ shifting needs and shifting views of their own needs. Whether referring to a change outcome or a maintenance

outcome it must be driven by the service user's own expression and aspiration, and not something imposed upon them (Paley and Slasberg 2007).

Characteristics: Outcome-based contracting and commissioning has become popular in the USA and it underpins Accountable Care Organisations and Value-Based Health Care. It is also often referred to as 'performance-based' contracting focusing on results rather than activities, defining clear performance expectations and measures, providing incentives and monitoring performance (DeMaio et al 2002).

Kerslake (2006) identifies components for a transferable UK framework for implementing outcome-based commissioning and contracting. The aim is to produce outcomes that are desired, achievable and measurable but at the same time are sufficiently testing to offer real incentives and achievements to the service providers. He describes the importance of agreeing the parameters within which a contract will be framed, assessing provider experience and past record in producing outcomes; developing an action plan, and commissioner testing of the response to tender such as assessing risk.

Commissioning for Outcomes-Based Incentivised Contracts (COBICs) (Corrigan and Hicks 2012) is an approach developed at the Nuffield and first used in 2011 in Milton Keynes, focusing on integrated care. It has been influenced by Porter's (2012) work on value-based healthcare, notably that value and outcomes improve when services and service lines are organised around patient and patient pathways, rather than around provider interests. Key points about the COBIC contract include introducing incentives into the market in new and innovative ways and using contractual forms that are new to the NHS, a single integrated tender with a single organisation that has the responsibility for integrating services. The only way a range of different providers can respond with an integrated pathway is by developing a partnership with each other. The contract also moves the focus away from inputs to outcomes and this is a radical shift for the NHS. Payment for outcomes forces health care providers to work outside of their particular part of the pathway and to think of how the whole outcome is achieved. Proponents of COBICs advocate the Accountable Lead Provider model as the best fit within which to operationalise the approach.

In general COBICs will require a monumental change. Commissioners need to recognise that they are creating a new market in outcome based health care and will need to enter into much more discussion with existing and new providers. A competitive dialogue process for example may help commissioners to work with providers in developing outcomes that can be delivered and measured.

Applications: Corrigan and Hicks (2012) report that COBICs are being generated across the country, including the example below, but as yet there are none fully operational. From February 2014, NHS England unveiled a set of procurement rules that required commissioning support service providers to offer commissioners help with drawing up innovative outcomes based contracts (Williams 2014) which has provided an imperative to developing this contracting approach.

Oxfordshire commissioners are one of several (Northumberland, Cambridge, London and Surrey) who have developed COBICs. Oxfordshire's focus on maternity, adult mental health and frail older people's services (HSJ Local Briefing May 2013). Outcomes for the latter have a set on staying healthy, a second on improving the recovery process and a third emphasising the patient's

experience of care and their ability to live independently after treatment with the aim of keeping people with long-term conditions stable, and returning the patient back to a normal, stable condition as quickly as possible after a crisis. It is hoped this will incentivise efficient working, and will represent a shift away from simply paying providers more if activity levels rise, without a full transfer of financial risk to the provider that a simple block contract approach could bring about. However, it is also the case that outcome based commissioning is not an answer to more immediate issues such as the financial squeeze and pressures on the acute sector. In addition rolling out COBICs has not been without more significant challenges, as will be described below.

Benefits/Success Factors: There is no evidence of effectiveness but there are some suggested success factors in defining outcomes with providers. Kerslake (2006) for example emphasises the importance of describing the rationale for the outcomes, allowing sufficient time for outcomes to be tested through stakeholder involvement, and linking them to business plans, organisational goals and any inter-agency strategy. Other success factors include time and thought, training, support and realistic timescales.

Use of Incentives: COBICs have been generated in Milton Keynes for the substance misuse service retendering that combine capitation and rewards for improved outcomes. Money for services was reduced but providers were allowed to keep the money generated by not delivering unnecessary care (Corrigan & Hicks 2012). The effectiveness of such an approach long term is yet to be established.

Critique: With outcomes-based commissioning in general, Kerslake (2006) again highlights a few challenges that may be encountered from a UK perspective. For example he states that there are few practical examples of UK outcome based contracting on which to draw, and the suspicion is that this may be more difficult to deliver than to describe. In addition, getting sound measures can be difficult. For example, changing behaviour across a whole local authority area may be hard to attribute to the activities of any one project. In such a situation it is easy to fall back on measures of process or activity, such as how many people have been seen. Agreeing 'hard' measures where there is already existing data may be easy, what may prove more difficult is developing good measures of 'soft' or more subjective data. This can be not only much more difficult, but also more expensive if accuracy and reliability are to be achieved. Some providers may have previously defined their success in terms of the quality of the service they have offered and may have received widespread support. A change of approach and the need to provide additional justifications for their work may not always be welcome to an organisation and its supporters.

Further to Kerslake's reflections, Bovaird & Davies (2011) undertook an analysis of outcome-based commissioning and delivery in the public sector in the UK, asking the question of whether it made a difference. Many of their conclusions echo Kerslake's. They state that an outcomes-based approach has attempted to be incorporated into public services for a number of decades but with limited success. This is due to difficulties specifying and measuring outcomes, alongside interpretation of the results, as typically many influences other than public policy will have contributed to these outcomes. The biggest problem is attribution. This paper is useful in that it thematically analyses

different manifestations of outcomes-based commissioning, but concludes that all commissioning strategies put forward by the DoH in recent years (eg World Class Commissioning) urgently need rigorous evaluation.

Regarding the COBICs however, their implementation has been testing. Being one of the largest commissioning groups, Oxfordshire's experiences have particularly come under the spotlight, reported in the Health Service Journal as a 'standoff' between the CCG and its main acute and mental health providers as they strive to move away from activity-based contracts (McLellan 2014). While initially untroubled by the radical CCG plans, providers detailed their fears in a communication warning of dire consequences, which resulted in a stalling of the implementation. Commentators cite pre-election sensitivities alongside the delicate nature of current NHS finances, but McLellan notes that CCGs are unlikely to be able to proceed without central government backing.

Discussion

This paper presented the findings of an international literature review of contracting approaches, models and designs, and sought to critically analyse their characteristics, applications and suitability to the integrated health and social care agenda in England.

What was clear within all the models was that, when it comes to contracting and commissioning, there is a need to change the current state of play to secure a better fit with the requirements of integrated care and the transformation agenda. The common focus on leadership, relational aspects between sectors such as trust and partnership, and emphasis largely on outcomes-based commissioning reveal distinct ambitions for and 'great expectations' of these approaches. At a time when commissioners are calling loudly for assistance, the supporters of these models marshal their arguments well and put their cases forward in a convincing way. However given their relative newness, some of the literature about models has been largely dependent upon a narrow range of commentators and at present the debates are not broad enough. In addition, for all models, data sources for the review had their aetiology embedded within the health arena; this may reflect the contracting drive that is being led by CCGs or may be due to the lack of visibility or access to social care commentary on this issue. Either way social care is crucial to enrich perspectives and provide uniform applicability and must be provided, especially if there is continued interest in developing joint outcomes.

Of all the models, the spotlight is increasingly being placed on ACOs, given the influence of this model in English policy, predominantly the Five Year Forward View, and with this comes the increased focus on incentives and other financial drivers that are firmly embedded within the American health system (DeVore & Champion 2011). Writing in 2008, Deloitte & Touche stated that there is a body of empirical evidence that individuals, teams and organisations in the public sector, do respond to formal incentives and that incentives can promote effort and performance (e.g. Lazear, 2000, Prentice et al, 2007). In a review, they cautioned however that although agents will often change their behaviour in response to sanction/reward mechanisms, this is not always in desired ways. These mechanisms can have consequences quite different from those intended by their designers. Careful design and implementation, and the tailoring of the mechanism to fit the

particular circumstances of an organisation, is crucial in ensuring correct incentives and an effective sanction/reward scheme (Deloitte & Touche 2008). Incentive systems are not new to the English health care system, with the introduction of Commissioning for Quality and Innovation (CQUIN) in 2008 where a proportion of a provider's income is made conditional on achieving a set of measurable quality related goals set each year (DoH 2008). But incentives take on a different hue when placed within an integrated setting, where there is a need for group accountability for outcomes and a focus on 'risk and reward' sharing, and alongside this the implementation pathways are far from clear.

In general the suitability of ACO transfer to the English health and social care context, alongside other models, needs further assessment. While historically some 'implants' have created new health movements, such as the American evidence-based practice agenda introduced by New Labour in health and education (Hulme 2006), adoption of international initiatives is often viewed with scepticism and not helped by the political tendency of rolling them out before testing (Billings 2013).

Paradoxically, while the evidence-based agenda has been embraced, a striking feature of the models as implied above is any firm indication that they actually work. While some authors are hopeful and can point to positive evaluation of similar schemes (eg Song et al 2012 for ACOs), there is significant critical commentary that they may not work and some soft evidence that they do not. For example, the relational aspects connected to risk and reward sharing particularly in Alliance models are frequently seen to break down in the industrial context more often than not, where parties 'revert to type' due to pressures of competition. Whether or not this may be a concern in the health and social care setting remains to be seen.

Yet despite this lack of evidence, the models appear to make significant claims about what they can achieve; these include the universal imperatives of fewer preventable A&E visits, hospital admissions, and readmissions; major efficiency improvements; gains in productivity; and transformation of services. It is clear that contracting models are central to any change, but attributing these ambitions to integrated care contracting processes is complex and testing, and may be too remote from the reality of what integrated care can achieve. This is being explored through recent publications such as Mason et al's (2015), where the authors provided an evidence review of the reported effects of 38 integrated financing (key to most of the models) and integrated care schemes and found that no scheme achieved a sustained reduction in hospital use, nor did they significantly improve health or reduce costs. So it is evident that there needs to be a clearer connection between the 'real' and the 'imaginary' when it comes to what the contracting models can achieve. As Addicott (2014) notes the contractual frameworks themselves do not automatically stimulate greater integration of services or explicitly hold the contract-holder to account for improving outcomes. It is also interesting that there are more ambitions for service outcomes than there are for the citizen in receipt of services, where reference to aspects such as increased positive experience and quality of life is often given as an afterthought.

Some reflections on leadership conclude the discussion. The complexities surrounding the changes processes required to implement a new contracting system require optimal leadership, arguably pivotal to their success or failure. Yet difficulties with selecting who is most suitable emerge within the commentary, and this is compounded by the confusion over terminology. For example the title

'Lead Provider' was used in different ways in the examples cited – accountable prime provider, prime contractor, and active integrator - and while Addicott (2014) elaborates on this, it is not entirely clear what the differences are. Regarding leadership of this model in particular, Corrigan (2013) gives examples including GP federations, but the constantly moving backdrop of NHS reform continues to make it hard to predict with any degree of certainty who should take this role. Hawkes (2014) for example remarks on the ambiguity surrounding federations and reports the challenges of forming them with respect to size, geography, legalities and how to measure success. So the chances of a federation achieving the required maturity to take on this leadership role may currently be limited.

Conclusions

Although the literature review has illuminated upon the main contracting models under current debate, there still remain a number of uncertainties regarding their applicability and utility for the health and social care agenda, particularly when aspiring to a whole systems approach. What appears to be happening in practice however as identified within a number of descriptive case studies is an organic development. With the growing number of examples emerging in health and social care, there is hope that these may act as 'trailblazers' and support further development.

But instead of looking at individual models and assessing their transferable worth, there may be a place for examining principles that underpin the models to reshape current contracting processes. This is a view supported by Addicott (2014), who suggests that a number of ambitions can be built into the terms of a contract in order to elicit collaboration and quality improvement, while retaining patient choice. In addition to this, such an approach would enable contracting to be more tailored to the aspirations of local commissioners and providers and create a model that moves away from a focus on services towards one which is more person-centred.

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Appendix

Literature Review: Approach and Search Strategy

The approach taken to the literature review was narrative or traditional, the purpose of which is to critique and summarise a body of literature and draw conclusions about the topic in question, in order to provide the reader with a comprehensive background for understanding current knowledge (Cronin et al 2008). This review was undertaken at time when there was considerable discussion and opinion about contracting models (which is continuing), and a narrative approach enables the inclusion of looser commentary, and descriptive case studies found more in grey literature. Most guidance recommends a step-by-step approach which was followed as below:

Step 1: Definition of search keywords. Search terms included integrated care, health care, social care, contracts, commissioning, collaboration, partnering, partnership, alliance, lead provider, accountable care organisations, outcomes, systems approach, incentives.

Step 2. Identification of relevant scientific databases and search engines. Table 1 below indicates key scientific and grey literature databases, the latter was important to identify news items. In addition to these, Academic Search Complete (University accessed) was used to identify contracting models outside of health and social care, within different industries and legal settings. This particular database is multidisciplinary and hosts over 13,000 indexed and abstracted journals.

Table 1: Scientific and Grey literature databases

Scientific Literature	
PubMed/MEDLINE	http://www.ncbi.nlm.nih.gov/pubmed
CINAHL	http://www.ebscohost.com/nursing/products/cinahl-databases/cinahl-complete
EMBASE	http://www.elsevier.com/online-tools/embase
PsychINFO/PsychArticles	http://www.apa.org/pubs/databases/psycinfo/index.aspx
Science Direct	http://www.sciencedirect.com
Google Scholar	http://google.co.uk/ ; http://scholar.google.co.uk/
Directory of Open Access Journals	http://doaj.org/
International Society for Third Sector Research	http://www.istr.org/
Journal of Innovation & Entrepreneurship	http://www.innovation-entrepreneurship.com/
Health evidence	http://www.healthevidence.org/
Centre for European Policy Studies (CEPS) publication database	http://www.ceps.eu/books
Grey Literature	
Google	For online and published commentary and articles (eg Health Service Journal) http://google.co.uk/
OpenGrey	System for Information on Grey Literature in Europe, open access to 700,000 bibliographical references. www.opengrey.eu/
Health Management Information Consortia	Department of Health and King's Fund libraries/services http://www.library.nhs.uk/help/resource/hmic

OECD library	http://www.oecd-ilibrary.org/
Non-governmental organisation search engine.	Websites of NGOs affiliated with the UN Economic and Social Council and The World Association of Non-Governmental Organizations. https://www.google.com/cse/home?cx=012681683249965267634:q4g16p05-ao
Eldis	Contains over 26,000 summarized documents from approximately 7,500 economic, legal and social development organizations worldwide. http://www.eldis.org/

Step 3. Database Search. Using the above, 1048 international references, abstracts and other items were obtained and scanned for relevance according to the aims of the literature review.

Step 4. Refinement of search results. Due to the need to collate a wide range of information about existing and emerging models from multi-disciplinary sources within and outside of health and social care, the inclusion and exclusion criteria remained broad. From the initial hit it was clear that refinement needed to consider examples that had been applied in practice and those that had not, as well as current thinking and debates surrounding contracting models, and theoretical approaches. In addition, some models had a long history so the search time span was 1980 to present to accommodate this. Similarly, although a key feature of the project was to identify evidence of what works, it quickly became clear that many models were scientifically unevaluated. Grey literature became an important source of information about how models were being taken forward. Refinement resulted in the identification of the following eight models with numbers of articles in parenthesis: Accountable Care Organisations (15), Alliance Contracting Model (16); Lead Provider/Prime Contractor Model (11); Outcomes-Based Commissioning and Contracting (22) Partnering Model (13); Value-Based Healthcare (11); Incomplete Contracting (6); and the Alzira Model (4). As incentives were identified as being purported to be central to the success of contracting models, addition literature specific to this topic was gathered (6).

Step 5. Evaluation and synthesis of relevant findings. A number of selected publications following refinement were examined to isolate key relevant themes under which the information could be categorised. These broad themes were eventually developed:

Definition and Purpose (the key functions and aims of the model);

Characteristics (a description of component parts);

Application (examples in practice and any application to the NHS and Social Care)

Benefits/Success Factors (evidence of effectiveness if available, anecdotal benefits, ambitions, 'how to' indicators);

Critique (critical discussion of the models highlighting challenges);

Use of incentives (how staff, services and/or organisations are incentivised to work together to produce outcomes and fulfil the contract).

Acknowledgements

The authors are grateful to Kent and Medway Commissioning Support Unit (now South East Commissioning Support Unit) for supporting this work.