REFORM

Prescription for Prevention

Supplementary paper: A new funding model for primary care

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ABOUT REFORM

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After a decade of disruption, the country faces a moment of national reflection. For too long, Britain has been papering over the cracks in an outdated social and economic model, but while this may bring temporary respite, it doesn't fix the foundations. In 1942 Beveridge stated: "a revolutionary moment in the world's history is a time for revolutions, not for patching." 80 years on, and in the wake of a devastating national crisis, that statement once again rings true. Now is the time to fix Britain's foundations.

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Reimagining Health is one of the major work streams within this programme.

ABOUT REIMAGINING HEALTH

This paper is part of the *Reimagining Health* work stream. While the National Health Service was once visionary, as demand rises and outcomes deteriorate, a fundamental rethink is needed. The current model no longer works for patients, who too often struggle to access high-quality timely care; for medical staff, who feel disempowered, stressed, and burnt out; or for taxpayers, who foot an increasing bill for a service which is struggling to cope. In short, the structures and institutions designed to meet the challenges of the post-war world are not equipped to deal with our current and future health challenges.

'Reimagining Health' seeks to explore how to transform England's approach to health. It will consider how to move from a treatment-oriented model to one geared towards health creation, the changes necessary in healthcare to facilitate this, and how to build a fair and sustainable approach to funding. This paper is the first of several that seeks to fundamentally redesign the health and care system.

Reimagining Health Council

Reform is grateful to the expert members of the *Reimagining Health* Council who provide valuable insight and advise on the programme. Their involvement does not equal endorsement of every argument or recommendation put forward.

Professor Kate Arden (Chair), Former Director of Public Health, Wigan Council

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Recommendation 2: As regional government matures, NHS budgets should be fully devolved to regional leaders, giving them budgetary autonomy for health. These budgets should remain non-ringfenced, enabling greater investment in health creating services.

To further incentivise the shift from a hospital-dominant to a community-dominant model, central government should implement financial mechanisms that disincentivise hospital admission and reward prevention.

Recommendation 3: ICSs should experiment with different contracting models, including prime contracts and alliance contracts, tailored to their population need. These contracts should be for a minimum of three years, include outcomes-based incentives, and be scaled such that locally-specific knowledge can be used to shape community-level services.

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1. Introduction

Too often, a lack of spending is seen as the root cause of the health system's problems. However the disproportionate focus on the *amount* of money means too little attention is paid to *how* that money is allocated. The current funding model itself is a major barrier to achieving the shift towards prevention and early intervention.

It is well established that how money is allocated in the health system (whether by activity, performance or according to population size) incentivises particular types of activity.[1] As such, there is currently a profound misalignment between the ambition to move care out of hospitals and the activity the funding models in the NHS incentivise. Indeed, ensuring that contracting and funding streams incentivise the right outcomes, across providers and settings, is a recurring challenge.

In the past, such payment models were designed to help meet specific policy objectives, for example to encourage high volumes of activity in acute care and to in turn minimise waiting lists. While this was once effective, it means that the system fragments budgets and applies different payment models to different parts of the health and care system.

In a demographic context where people experience multiple and complex conditions across multiple care settings, a new approach is desperately needed. While this model was once effective for certain objectives, it no longer makes financial or logistical sense to treat each part of the health system and each condition separately.

The current payment models make realising the prevention ambition much harder. Shifting care out of the community has long been an objective of the health system and is consistently undermined by the current contracting systems. Indeed, 'Payment by Results' (PbR) contracts – one of the main funding mechanisms for hospitals – incentivises activity in acute hospitals, with money following activity.

Rather than sharpening incentives to avoid the need for hospital care, as the system desperately needs, it has undermined a shift towards prevention by disproportionately absorbing financial resource.[2] The largest proportion of spending is with acute trusts, which have also seen the largest increases in expenditure over the last five years, compared to other NHS trusts.[3]

Given that the way services are funded drives particular activity and behaviour, it is imperative that the funding model incentivises activity at the earliest opportunity – i.e. upstream. Financially rewarding prevention is an essential pre-requisite for a model that relies on care being delivered in primary care and the community.

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[1] Rosie Beacon, *Close Enough to Care: A New Structure for the English Health and Care System* (Reform, 2024).
[2] Chris Ham and Judith Smith, *Removing the Policy Barriers to Integrated Care in England* (The Nuffield Trust, 2010).
[3] Beccy Baird et al., *Making Care Closer to Home a Reality: Refocusing the System to Primary and Community Care* (King's Fund, 2024).

1.1 A note on this paper

This paper is published alongside *Prescription for Prevention: A new model for primary care,* which sets out the overarching framework for a new primary care system. For all of the reasons outlined above, the funding model underpinning this will be crucial. In particular, two core elements of funding reform will be key to creating a more preventative system: the consolidation of healthcare budgets, and the consolidation of funding streams.

Healthcare budgets refer to who has accountability for the money and the commissioning of services, and funding streams refer to how the money is allocated to pay for a particular set of services. The location of budgets is important in deciding what *proportion* of the budget is spent on what service. The type of funding stream (block contract, capitation, payment by results, or grant) shapes the *volume* and *quality* of activity.

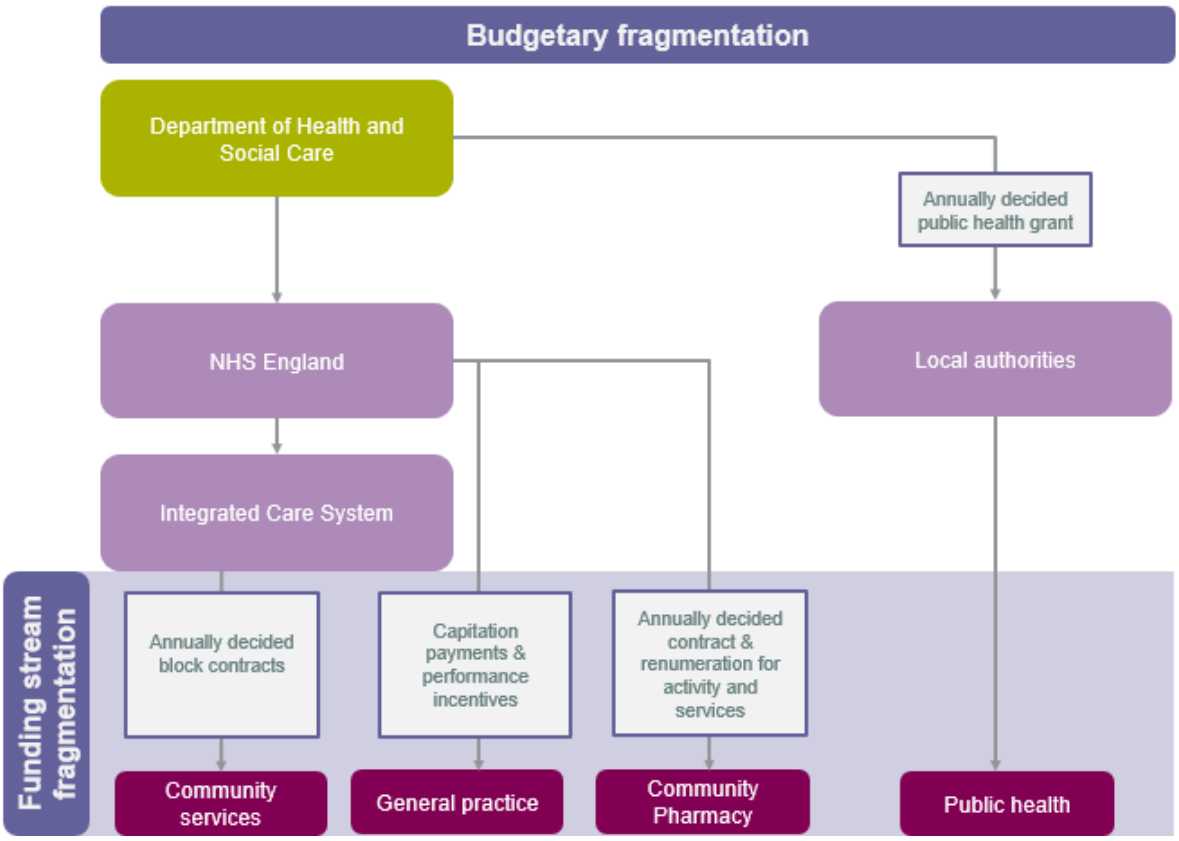
The *amount* of money allocated to the NHS and primary care is out of scope for this paper, as is a detailed analysis of the Quality and Outcomes Framework (there have been calls for QOF to be abolished).[4] However, in the future model of primary care proposed by *Reform* – which places a greater emphasis on commissioning for outcomes – GPs would be incentivised to pursue outcomes set by local leaders, rather than outcomes set out in national formulae.

[4] *Quality and Outcomes Framework (QOF)* (British Medical Association, 2024).

2. Summary of the problem

The complexity of payment mechanisms operating within primary care makes it more difficult to align and integrate services around a population group; and for local system leaders to adjust funding allocations to maximise a chosen set of outcomes. Collectively, these payment mechanisms create an inertia towards the existing balance of provision between primary and secondary care settings and towards particular providers within primary care itself.[5]

Figure 1: Current location of budgets and funding streams for primary care



As the above figure illustrates, in primary care, funding mechanisms vary by provider. GPs, for example, receive a capitated (per patient) budget, alongside incentive payments based on clinical, quality and public health outcomes through QOF (the Quality and Outcomes Framework).[6] These include payments for vaccination and screening programmes, maintaining healthy blood pressure and reducing rates of smoking; and payment for over 50 clinical indicators, including conditions such as hypertension and chronic kidney disease.

[5] Baird et al., *Making Care Closer to Home a Reality: Refocusing the System to Primary and Community Care*.
[6] NHS England, 'Quality and Outcomes Framework 2022-2023', Webpage, 17 June 2024.

This model incentivises highly specific outcomes, which to their credit, have improved the management of long-term conditions over time, although success is variable.[7] But creating highly specific incentives within one service continues to undermine the shift to dealing with a multi-morbid population who experience multiple episodes of care across multiple services. It should also be noted that general practice is the only part of the primary care system where the funding reflects the number of patients registered for the service.

Meanwhile, providers of community services in primary care (such as district nursing which is essential for the care of those most likely to end up in hospital), are funded through block contracts. This means they receive a fixed annual sum regardless of volume of activity or particular quality metrics. Therefore, if a provider ends up seeing more patients or undertaking more activity than they were contracted to, they must absorb the cost of this. This impacts the quality of care provided. This is often done by reducing the number of staff, changing the skill mix of staff or raising the eligibility criteria for access to services.[8]

Community pharmacy – a service of growing importance – has highly complex income streams with a variety of incentives. This includes fee per activity for dispensing prescriptions, payment for other commissioned services such as vaccinations, reimbursement for prescription medicines, and retail and private services income. The complexity of these funding streams cannot be solved entirely by new commissioning models – given that drug reimbursement is reliant on negotiations at a national level – but some of the contractual complexity can be simplified.

Lastly, public health is funded by an annual grant to local authorities, as well as additional funds for specific areas such as drugs services and weight management services. This illuminates a problem within the primary and community care model: the prevalence of annually negotiated contracts or funding settlements. This acts as a blocker to commissioners and providers engaging in long-term system planning.

Similarly, ICSs, and the vast majority of local authorities, are constrained in their ability to finance long-term prevention and health creation programmes, with single-year financial settlements drawing their attention towards short-term pressures and immediate crises.[9]

[7] Lindsay JL Forbes et al., 'The Role of the Quality and Outcomes Framework in the Care of Long-Term Conditions: A Systematic Review', *British Journal of General Practice* 67, no. 664 (November 2017): e775–84, https://doi.org/10.3399/bjgp17X693077.
[8] NHS Providers, *The State of the NHS Provider Sector*, 2019.
[9] Ibid.

3. Toward a new model

Experiments in contracting at a local level suggest that alternative payment systems – which directly incentivise outcomes and encourage closer joint working between providers – ought to play a greater role in how primary care is funded in future.

A future model of primary care contracting would need to reflect three key principles:

- Incentivise outcomes, rather than activity
- Focus on population groups, rather than disease pathways, in turn incentivising integration between services
- Enable long-term planning

Designing a financial incentives system that reflects this is multifaceted. This chapter will focus on two core elements of this system: the consolidation of budgets and the funding of individual services. Budgetary consolidation is a substantial structural reform, ideally involving more formal devolution of healthcare, but how individual services are funded can be reformed without necessarily consolidating budgets first.

That said, as outlined in *Reform*'s previous paper, *Close enough to care,* budgetary consolidation is a necessary precondition to a genuinely preventative health care system due to the financial incentives it creates – if a commissioner has responsibility for an entire budget, they are more incentivised to make the most cost-efficient interventions to maximise savings.[10] Nevertheless, the financial incentives in the system can change with some reform to the funding streams and payment mechanisms for different services.

This chapter will first outline the case for consolidating health and public health budgets, and then focus on how to reimagine the funding streams for different services.

3.1 Consolidating budgets

Creating a funding system that is oriented around outcomes, rather than activity, requires both budgetary and funding stream reform. If the desired outcome is to decrease avoidable and unnecessary hospital admissions, the entire health and care system needs to be mobilised in a different way.

The logic of consolidating budgets and all health and care services under one decision maker – whether that be the combined authority or the ICS – is that it changes the incentives within the system and enables a different set of choices. In this case, it encourages:

- Cost saving, as the commissioner can keep the savings to spend how they wish
- A focus on reducing demand (and therefore cost) by improving outcomes (e.g. reducing hospital admissions) rather than delivering high volumes of activity

This also overcomes the challenge of a non-integrated system in which each organisational silo faces a different, and sometimes competing, set of constraints and incentives.

[10] *The Math of ACOs* (McKinsey & Company, 2020).

At a minimum, integrating funding pools between primary and secondary care is paramount. The financial incentive would be two-fold. If the budget holder is responsible for a single budget, they are able to retain savings but also be responsible for overspends. This would then incentivise a shift away from the current (costly) hospital centric model, towards a (less costly) community and primary care dominant model.

Ideally, budgetary reform would extend beyond that, so that areas could pool spending on services which treat illness (largely provided by the NHS) and those which boost health (largely provided by local government). The current siloed model affects both patients' experience of care and the ability of decision makers and commissioners to develop services that are preventative and suited to the needs of local populations.

The overall incentive would be for the system to invest in lower cost health and social care interventions upstream, and as savings are secured from reduced acute demand, authorities could increasingly invest in health *creation* initiatives. Given their control of many of the services which act as core levers for improving population health, including housing, children's services, leisure and cultural services, planning and local transport, local authorities may choose to prioritise non-healthcare spending to boost outcomes.

Indeed, local authority public health interventions are significantly better value for money, with each additional year of good health achieved in the population by public health interventions costing £3,800.[11] This is three to four times lower than the equivalent cost resulting from NHS interventions of £13,500 per additional year of good health.[12] Currently, there is no requirement for ICSs to pool budgets, most activity is funded through nationally agreed contracts, and crucially the funding models for each remain separate.

One of the disincentives for preventative action is that it may not necessarily lead to directly 'cashable savings' (immediate reductions in what local providers, commissioners or central government need to spend on providing services). For example, with such long waitlists, creating capacity by reducing one source of demand will simply mean other sources of demand fill that space. This would still be a good outcome – more people receiving care – but it would not lead to savings.

Or often, one service will make the initial investment (e.g. local authorities) whilst another service benefits from the savings (e.g. hospitals). There is also a risk that integrating funding pools between primary and secondary care may still see the latter prioritised over the former. However, as in the below case studies, incentives can be explicitly designed into the system to prevent this.

[11] David Finch, Anna Gazzillo, and Myriam Vriend, *Investing in the Public Health Grant* (The Health Foundation, 2024).
[12] Ibid.

Figure 2: International examples of financial incentives for community based care

In Denmark the regions are responsible for hospital and other specialised care, while the municipalities are responsible for a majority of out-of-hospital care, as well as prevention, health promotion and rehabilitation outside of hospitals. In order to incentivise preventive services and reduce hospitalisation, a system of municipal co-financing, where municipalities must pay a share of the costs each time an individual is admitted to a regional hospital, was implemented.

There has been limited research on the effectiveness of co-financing, but the empirical evidence that does exist is tentatively optimistic. Research in 2013 showed that 48 per cent of local authorities estimate that the local co-financing has had an impact on their health strategy to some extent, while 22 per cent estimate that it has had a substantial impact on their health strategy. This is matched by growing expenditure on public health among the municipalities – overall it appears that the municipalities increased their public health efforts after the reform.[13]

Figure 3: International examples of financial incentives for moving care out of hospital settings

In 2019, Denmark also introduced a new scheme for national funding which is contingent on five general criteria: fewer hospital admissions per citizen, less in-hospital treatment for chronic care patients, fewer unnecessary readmissions within 30 days, increased use of telemedicine, and better integration of IT across regional and municipal sectors.[14]

In Israel, the drive to keep people out of expensive hospital settings is furthered by central government controls over hospital resource expenditure and resources. There are rigorous controls on key inputs such as hospital beds and expensive medical equipment, and caps on physician and nurse positions in hospitals.

This, again, is designed to free resources to invest in comprehensive primary and community care services.[15] The result is a significant proportion of speciality care provided in community settings. Many surgical and diagnostic procedures, specialist follow-up care, and complex chronic care management takes place in integrated multi-speciality clinics provided by the health plans.

[13] Karsten Vrangbaek and Laerke Mette Sorensen, 'Does Municipal Co-Financing Reduce Hospitalisation Rates in Denmark?', *Scandinavian Journal of Public Health* 41, no. 6 (2013).
[14] Roosa Tikkanen et al., *International Health Care System Profiles: Denmark* (The Commonwealth Fund, 2020).
[15] Ibid.

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To elevate the role of local government and give additional weight to upstream spending, each local authority covered by the ICS should be represented on the ICB, and therefore involved in spending allocation decisions. To achieve this, NHS England should update the statutory guidance on the constitution of ICBs to stipulate that each regional authority and upper tier local authority whose population is covered by the ICS have a statutory position.

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3.2 Funding services

As outlined in Figure 1, there are two major pillars of funding to consider: budgets and funding streams. Once the commissioner has the budget, they still need to allocate money in a way that financially rewards early intervention and prevention, and wherever possible focuses on the whole patient not a specific disease. In both cases, this benefits the individual receiving care.

Funding streams, and contracting models, can be designed to reward several different things: integration, outcomes, and/or activity. Some will reward certain elements over others, depending on the policy priority. There are several options for ICBs to consider, and decisions should be based on a thorough understanding of their local populations.

3.2.1 Commissioning for populations

One approach to local contracting is known as 'prime contracting'.[16] In this model, the ICS would contract with a single organisation for a specific population group, which then takes responsibility for the day-to-day management of other providers to deliver care. Depending on the size of the population group, a local authority, charity or social enterprise could each act as prime contractor. The prime contractor then manages services through individual subcontracts with individual providers to deliver specific outcomes.[17]

Alternatively, rather than commissioning a single (prime) contractor, the ICS could commission a group of organisations who have come together to form a legal entity (commonly known in other public service contexts as a joint venture model). This is known as alliance contracting,

[16] Rachael Addicott, *Commissioning and Contracting for Integrated Care* (The King's Fund, 2014).
[17] Ibid.

and while in this model multiple providers are sharing risks and responsibilities, in reality it is the same contractual arrangement for the commissioner. And here too the alliance may choose to sub-contract with hyper-local or specialist organisations.

Usually, given the scale of organisation required to manage integrated care for a population, the prime/alliance contractor would have to be large enough to meet the needs of thousands of patients, but smaller than an ICS, and therefore more familiar with the specific health requirements of the area they are sub-contracting for.[18] Crucially, the contractual body operates at a scale that is more suited to designing services to maximise the health of a community – and have locally-specific knowledge about the providers most capable of doing this – than an ICS.

The ICS meanwhile retains overall accountability for commissioned services through its direct relationship with the prime contractor, while the prime contractor holds each of the subcontractors (providers) to account.

Under the current model of community service contracting, commissioners report not having the necessary levers for more ambitious transformation. Similarly, Clinical Commissioning Groups (CCGs) – the bodies responsible for commissioning when prime contracting was first introduced – identified that they did not have sufficient experience of pathway management, nor strong financial incentives to do it themselves.[19] There were also some implementation issues from some of the CCGs that did experiment with it, chiefly sufficient procurement processes and adequate commercial expertise.[20]

This model would fix some of the problems of the existing payment landscape by more effectively promoting integration between services while incentivising whole patient care and specific outcomes, but only if these issues are addressed.

International examples of prime contracting in health systems most often focus on whole population groups for which the commissioner is responsible, such as Accountable Care Organisations (ACOs) in the United States. Whereas examples in England have tended to have a disease or pathway-specific focus. The latter is rightly criticised for ineffectively managing co-morbidities, but could be effective where an ICS has specific concerns over the quality or efficiency of a particular clinical or service pathway.[21]

In general, however, ICBs should follow the ACO model and contract for populations, incentivising integrated services that intervene at the earliest possible stage and are patient not condition-specific.

3.2.2 Incentivising outcomes

In 2019, NHS England developed a blended payment approach for emergency care and adult mental health services, to move trusts off block contracts and activity-based payment models. Blended payments were also included in the National Tariff Payment System (NTPS) in 2020-

[18] Addicott, *Commissioning and Contracting for Integrated Care*.
[19] Addicott.
[20] *UnitingCare Partnership Contract* (House of Commons Committee of Public Accounts, 2016).
[21] Addicott, *Commissioning and Contracting for Integrated Care*.

21 to combine payments to providers working across patient pathways for maternity care (though not, in the end, implemented).[22] This model can involve a number of components:

- Fixed payments – the cost of delivering the basic level of activity, which would be determined by the ICB (or, for example, a prime contractor commissioned by them)
- Variable payments – this can be used to incentivise activity, allow funding to follow the patient, mitigate financial risks of activity above or below plan, or provide incentives to collectively manage demand

Under a blended system, providers are paid a fixed amount for a forecast level of activity, and then share risk, including potential excess costs with commissioners – receiving rewards where health outcomes improve.[23]

Instead of a block payment between a commissioner and provider, this model bundles payment for the care provided across an entire patient pathway – for example, the costs associated with maternity care. Again, this funding model can enable a more patient (rather than provider) centric approach and incentivise particular outcomes as a result of activity paid for.

This approach relies, however, on comprehensive, high-quality data about the cost of any services that are likely to be provided within a patient pathway – to calculate the fixed payment component – and clearly defined quality or outcome goals for the variable component.[24]

However, NHS England's analysis of a programme to introduce blended payments in 2020-21 drew attention to the complexity this can introduce if commissioners or providers are engaged in arrangements for different services. For example, if the blended payment contracts in a place are not well-aligned – or worse, are in tension with one another – providers could, counterproductively, have weaker incentives to prioritise particular goals.[25]

This is why it is crucial that the commissioner – the ICB or the organisation they are contracting to manage services – takes into account how providers and contracts interact and can take a strategic view of the outcomes being sought.

3.2.3 Enabling long-term planning

Critical to enabling investment in prevention are longer term funding settlements. This is partially because it takes longer to see a return on investment in prevention, but also because it enables long-term planning, which is a more cost-efficient way to commission services.

Creating longer term payment settlements applies both to budgets and to funding streams. On budgets for example, the public health grant is paid to local authorities from the Department for Health and Social Care and is allocated annually. This is used to provide vital preventative services that support health. But the annual allocation makes it difficult to plan, something which is particularly important for public health since it targets structural health determinants, with related interventions often taking a number of years to produce measurable results. It is

[22] *Developing the Payment System for 2021-22* (NHS England, 2021), 2020–21.
[23] *Blended Payments: Will a New Payment System Help Deliver the Long Term Plan?* (NHS Providers, 2020).
[24] *UnitingCare Partnership Contract*.
[25] *Developing the Payment System for 2021-22*.

also worth noting that the allocation for the public health grant in 2024-25 is £3.9 billion,[26] while the overall NHS budget is £168.8 billion.[27]

Longer term payment settlements in funding streams would depend on the type of contract being used. Particularly with prime contracts, these contracts would ideally need to be for a minimum of three years. In order to attract the right organisations, provide financial security, and allow for services to be restructured around particular outcomes (including the time it takes to subcontract).

If longer contracts are agreed (perhaps five or six years), break clauses could be built in by the commissioner as an assurance against providers failing to achieve specific, indicative outcomes or deliver an adequate rate of progress. Likewise, three-year contracts could, for example, have milestones that need to be met by providers to extend the contract to a full five years. Ambitious outcomes-based incentives, which ramp up over time, can also be built in to these contracts, to stimulate continuous improvement.[28] Combining greater security of funding, and therefore incentivising more systemic interventions, with hard outcome-focused incentives could drive a much more patient-centric approach.

Recommendation 3: ICSs should experiment with different contracting models, including prime contracts and alliance contracts, tailored to their population need. These contracts should be for a minimum of three years, include outcomes-based incentives, and be scaled such that locally-specific knowledge can be used to shape community-level services.

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[26] *Public Health Ring-Fenced Grant Financial Year 2024 to 2025: Local Authority Circular* (Department for Health and Social Care, 2024).
[27] *Our 2023/24 Business Plan* (NHS England, 2023).
[28] Addicott, *Commissioning and Contracting for Integrated Care*.

4. Conclusion

Realising the long-held ambition to focus our health system much more on preventing illness and addressing the social determinants of ill health must begin with primary care. An essential component of this is a funding model that not only enables a shift in spending towards community and primary care but actively incentivises it. That means changing how budgets are allocated and spent.

Prescription for Prevention sets out a new vision for primary care in which the system intervenes before illness occurs, detects health needs early to reduce harm, and acts to prevent deterioration. To achieve this, an honest conversation is needed about how money is allocated within, and flows through, the system. This paper puts forward recommendations for a new approach that should underpin a more preventative, patient-centric and sustainable health and care system.

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