Capitation and integrating healthcare

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The NHS can take a number of lessons from Spain where Alzira, a system of integrated primary, acute and community care, has proved a great success in terms of reducing hospital admissions, cutting costs and providing high quality care. But their model needs some translation, rather than being simply transferred to the NHS.

Three factors were vital to the success of Alzira: long-term contracts of at least 15 years duration, capitated budgets and aligned incentives for primary care practitioners. In the UK things are a little more complex. We're moving to capitated budgets but the Five Year Forward View does not commit to long-term contracts, so it's not as easy for organisations that might be investing in integration now and making savings, to be the long-term beneficiaries.

Workforce flexibilities are not as well developed here. Some Vanguard sites are keen to employ staff in different ways but we have many employment models, some staff are subject to national contract frameworks such as Agenda For Change, GMS or others. These may be insufficiently aligned to the goals of the local emerging population health management organisations such as MCPs or PACS.

The company that runs Alzira, Ribera Salud, secured an injection of capital, in their case from the private sector to redesign services, but would there be the same injection from the public purse here, or from a private partner? It's more likely that new organisations will need to be created to deliver integrated care within the existing spending parameters.

In the future we may see Commissioners go out to tender for an organisation or coalition of organisations to deliver primary, acute, community, mental health and social care in totality. The responding organisations could go down one of two routes; some might form some kind of shareholder organisation, or they could pursue a joint venture with a prime contractor who sub contracts services. Whatever else, it's likely that a new legal entity would be better placed than existing ones.

Commissioners will need to have long-term contracts so providers get much longer times to redesign the service. In Alzira, GPs were brought in as direct employees with incentives schemes designed around the success of the system rather than the success of small practices, as is more the case in the UK. At an early stage in their journey, Ribera Salud benefitted significantly from a cash injection from a US insurance company Centene. The injection of capital allowed them to redesign services and align incentives and contracts with GPs.

It's clear that in the UK simply bringing organisations together will not be sufficient on its own to deliver the savings that we need. To make 20 to 30% additional value for every pound we spend, we need to change processes and delivery models. In Alzira, hospitals are a place of last resort. Hospital doctors, like cardiologists, who in the UK would be generating income under tariff for acute trusts, are paid for keeping people out of hospital – if we don't understand and mirror that we may simply be re-arranging the deckchairs again.

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