



# CLINICALLY INTEGRATED SYSTEMS: THE NEXT STEP IN ENGLISH HEALTH REFORM?

CHRIS HAM, UNIVERSITY OF BIRMINGHAM

## BACKGROUND

To explore the issues involved in the health reform programme in England, the Nuffield Trust held a series of seminars led by experts in this field between June and September 2007. These were:

- Carol Black, Chair of the Nuffield Trust
- Julian Le Grand, Richard Titmuss Professor of Social Policy at the London School of Economics
- Carolyn Tuohy, University of Toronto
- Adair Turner, author of the Health Strategy Review commissioned by the Prime Minister in 2001.

The seminars focused particularly on the use of competition and collaboration to bring about service improvements. This report is a synthesis of the seminars prepared by Professor Chris Ham, chair of the series and adviser to the Nuffield Trust.

## Summary

The main conclusions of this report are:

- the health reforms in England are designed to combine competition in some areas of care and collaboration in others
- to date more emphasis has been placed on the development of competition than collaboration, for example through policies on patient choice, payment by results and increased plurality of provision
- priority has been given to competition because of the emphasis placed on reducing waiting times for planned hospital care such as elective surgery and diagnostic services
- the increasing prevalence of chronic disease, and the need to improve the quality of specialist services like stroke care, will require not only closer collaboration between providers but also clinical integration between primary and secondary care, and the development of clinical networks
- the levers and incentives to promote clinical integration and networks are underdeveloped, despite commitments made in *Our Health, Our Care, Our Say*, and this needs to be addressed in the next stage of reform
- the government and the NHS should use practice based commissioning as a mechanism for developing multi-specialty based commissioning; build on the use of specialist personal medical services contracts in areas like Oldham and Epsom Downs; and take forward the work that has started in the NHS Kaiser beacon sites
- in the longer term, Ministers should explore how the health reforms might support patient and citizen choice between integrated systems in which clinicians lead the quest for service improvement
- the final report of the Darzi Review needs to provide a coherent and credible account of how collaboration, clinical integration and networks will develop in future.



## POLICY CONTEXT

---

The NHS is midway through a ten-year programme of reform designed to tackle long-standing weaknesses in performance. The progress made to date in reducing waiting times and raising standards in areas of clinical priority like cancer and heart disease has resulted from national targets, extra investment and aggressive performance management.

In the next phase of reform, progress will depend increasingly on a programme of changes designed to stimulate competition between providers as the main driver of improvement. In implementing these changes, Ministers have acknowledged that in some areas of care competition will need to be promoted alongside collaboration. As Patricia Hewitt explained in a speech at the London School of Economics (LSE) in December 2005 setting out the future programme of health reform in England:

*'In the new NHS, there will be an element of competition – on quality, effectiveness, responsiveness to patients' needs. And as that drives the less good hospitals to improve – or sees their services replaced by better*

*providers – it will be good for patients. And because competition and diversity of provision must develop on a level playing field, every organisation caring for NHS patients will have to meet minimum standards of safety, quality, and conduct, enshrined in the national contract.*

*But we also want hospitals to collaborate – where appropriate, with each other, and with local GPs and PCTs. So the requirement to share information and work jointly to create integrated services will also be set out in the national contract. And although it may seem odd to expect organisations sometimes to compete and sometimes to collaborate with each other, it's worth remembering that this is exactly what happens in the private sector – with the most successful global organisations, often simultaneously, being competitors, collaborators, suppliers and customers of each other.'*

The question that arises out of this statement is: "Has the government succeeded in putting in place a programme of reform that will enable collaboration to develop alongside competition?"

## THE HEALTH REFORM PROGRAMME

---

In a series of speeches and policy documents, Ministers have explained that the health reforms are based on four key elements:

- more choice and a much stronger voice for patients, connected to strong commissioning by primary care trusts and practices
- a greater diversity of providers, with more freedom to innovate and improve services
- money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve
- a framework of system management, regulation and decision-making that guarantees safety and quality, equity and value for money

These four elements are designed to create the conditions for competition between providers. The ability of patients to choose between a range of

providers and for money to follow their choices under payment by results reflects a belief at the heart of government that competition should be a key driver of reform in public services.

To date, the health reforms in England have made use of competition mainly in relation to planned hospital care such as elective surgery and diagnostic tests. This is because of the overriding priority attached to reducing waiting times for planned hospital care during the last decade.

Patient choice was introduced initially to enable patients waiting longer than six months to be treated elsewhere, and this was supported by the procurement of additional elective surgical and diagnostic capacity from the independent sector. Subsequently, the policy on 'choose and book' has given patients a choice of provider at the time of referral by their GP, and the range of choices will be expanded as waiting times fall

further. Choice is supported by payment by results, thereby giving providers an incentive to compete for patients and to increase their income as they treat more patients. There has been less emphasis on competition

in other areas of care, with the partial exception of primary care where ministers have emphasised the need to increase patient choice and encourage new providers to enter the market.

### Box 1: The case for competition

The case for competition, as articulated by Julian Le Grand and others, is that it is the most effective approach to public service reform. Le Grand (2007) contends that there are four main ways of delivering public services:

- **trust** in professionals and public service staff, to use principled motivation to bring about improvements in public services
- **command** and **control**, to use targets and top-down performance management to bring about change
- **voice**, to empower public service users to complain and in so doing to exert pressure for reform
- **choice** and **competition**, to create incentives for service providers to be responsive to the needs of users and efficient in the use of resources.

The problem with trust is that it ignores the knavish tendencies of professionals and public service staff. Command and control is problematic because although it leads to improvements in performance it is unsustainable in the longer term, because it discourages local leadership and innovation. Voice is important but tends to favour the more articulate members of society. The advantage of choice and competition is that it provides incentives to improve quality, efficiency and responsiveness for knights and knaves since both (for different reasons) want their institution to survive in the market environment. While all systems have elements of each of these approaches, the most effective is likely to be one with a strong element of choice and competition.



## COLLABORATION AND INTEGRATION

Beyond planned hospital care there is increasing recognition that the provision of services that are safe and of a high quality is likely to require increasing collaboration between providers. Cancer services are an example with cancer networks having been established over the last decade in the wake of the Calman–Hine report and The NHS Cancer Plan to ensure that specialist services are planned and provided in the most appropriate hospitals.

Urgent care is another example, as policy-makers seek to create integrated networks that coordinate the work of the ambulance services, GP out-of-hours provision, A&E services, NHS Direct and other urgent care services. The discussion document on urgent care published in October 2006 emphasised the need for collaboration between different agencies, noting:

*A wide range of partners across health and social care are involved locally in developing and providing integrated urgent care services. They need to work across organisational boundaries through networks with a shared focus on delivery for people. Major partners include patients and the public, local government, social care and independent-sector providers, general practices, pharmacies, dental practices, community nursing, out of hours providers, Mental Health Trusts, A&E and acute medicine, SHAs, and Primary Care Trust (PCT) and practice-based commissioners.*

Subsequently, research by Sheffield University has identified the benefits of urgent care networks and the factors that affect their performance (Turner and others, 2007).

A recent review of the future of the acute hospital undertaken by the National Leadership Network (2006) went beyond the examples of cancer services and urgent care to argue that all local hospitals will need to be active members of multi-hospital networks of care. It commented:

*Urgent care, emergency surgery and trauma (alongside specialist surgery, obstetrics and gynaecology, paediatrics etc.) will need to be provided via well-defined and accountable multi-hospital care networks with mutual support and interdependence becoming essential as several key service areas*

*become difficult to sustain on a 24-hour basis at every local hospital.*

Echoing Patricia Hewitt's LSE speech, the review acknowledged that providers would find themselves competing for activity in some services and collaborating in others, noting:

*the skills of collaboration and integration in effective networks will be every bit as essential to local NHS hospitals as will the ability to compete.*

The emerging interest in England in collaboration and networks is paralleled in Scotland, where managed clinical networks have been championed for a decade.

The management of people with chronic diseases such as diabetes and arthritis illustrates why providers need to collaborate to deliver high standards of care. Currently, people with chronic diseases play a major part in their own care through the decisions they take about diet, exercise, medication and so on. They also receive care from the primary care team with which they are registered, with the team being rewarded for the quality of care it delivers under the new GMS contract. In addition, some people with chronic diseases make use of the expertise of hospital-based specialists.

Evidence from outside the UK indicates that integrated delivery systems such as the Veterans Health Administration and Kaiser Permanente achieve good outcomes for people with chronic diseases. In these systems, care is organised around multi-specialty medical groups, in which family physicians work closely with specialists and other clinicians such as nurses and dietitians. Generalising from these kinds of examples, the Institute of Medicine (2001) has emphasised the importance of care that is team-based and integrated if the quality chasm in health care is to be crossed.

Closer to home the white paper, *Our Health, Our Care, Our Say* (DH, 2006), also underlined the need for care for people with chronic diseases to be integrated and to be delivered through multi-disciplinary networks and teams. Work being done in the NHS Kaiser Beacon sites (Ham, 2006) is testing out the adaptation of integrated care in three areas of England.

## Box 2: The case for collaboration

The argument for collaboration, as articulated by Carol Black and others, is that the changing burden of disease, and particularly the increased prevalence of chronic conditions, requires primary and secondary care clinicians to work closely together to meet the needs of patients. Collaboration is explicit in concepts of team working and in the managed clinical network. Major parts of clinical care are provided through pathways, and the journey marked by these pathways traverse networks from which all elements of care can be drawn. The clinical network is not owned by a single agent but unless different agents work together the necessary wholeness and coherence are lost.

Diabetes provides an example. Self-management is at the heart of living with diabetes. The challenge for health, social, and community services is to enable people with diabetes to manage their condition well. Should things go wrong the right service, in the right place, at the right time, with the right expertise is essential. There is a specialist service for every part, but for the best care they need to work together. Patients should not have to make different journeys to see each of them. Neither do they want to be seen as bringing a collection of problems. They want to be seen as whole persons.

John Dean's work on diabetes in Bolton has shown:

- taking specialists out of the hospital setting has made a major difference
- patients find specialists more approachable and because they are not going to hospital they see coping with diabetes as an exercise in staying well, not being ill
- primary care staff are happy to be trained by specialists and to use their experience
- simply by coming outside the hospital specialists have removed a major barrier to team working.

Collaborative organisations that are directly formed by and responsive to patients' needs and aspirations and appeal to the motivations of clinicians, are at least as likely to achieve the desired goals as the mechanisms of competition.

## POLICY CHALLENGES

Notwithstanding the vision set out in the white paper, and the commitment to develop integrated care, it is difficult to identify the levers and incentives that will promote closer collaboration between providers and service integration. The four elements in the reform programme that permeate Ministerial speeches and Department of Health policy documents are designed principally to promote competition and could result in increased fragmentation rather than closer collaboration.

As an example, the use of the independent sector to provide some planned hospital services may make it more difficult to establish the multi-hospital care networks recommended in the review undertaken by

the National Leadership Network. Similarly, the pressure on NHS Foundation Trusts to achieve and sustain high levels of financial performance may lead them to give priority to the development of their own services at the expense of collaboration with other providers in service networks. As far as PCTs are concerned, the combination of payment by results and practice-based commissioning creates an incentive to avoid hospital admissions and provide care in the community, but does little in itself to encourage collaboration between clinicians in primary care and secondary care.

In recognition of this, *Our Health, Our Care, Our Say* stated that the Department of Health would:

### Box 3: International experience

Comparative health policy analysis, as undertaken by Carolyn Tuohy (1999) and others, shows that the challenges facing the NHS in England are found in other countries. At the heart of all health care systems lies a fundamental tension arising from the agency relationship between the providers and recipients of care. Given the imbalance of information held and the high cost of errors, recipients must rely on providers to make judgements as to what care they should receive.

How can providers as agents be trusted to act in the interests of recipients? There are three main ways of holding agents accountable:

- hierarchy or command and control
- markets and the specification of contracts
- peer control.

Of these, peer control is most consonant with the factors that give rise to the agency relationship in the first place, but it continues the potential of conflict of interest by retaining control in the hands of professionals. Hierarchy and markets promise checks on professional power. Under hierarchy, superiors demand services through a

chain of command. In a market, the purchasing function can be combined with the payer, consumer or provider role through specification of contracts. Each is premised on the existence of a sophisticated capacity for making 'purchasing' decisions.

However, developing a sophisticated purchasing function, separate from providers, is the elusive holy grail, and the various attempts that have been made are never fully credible at the crux of the system: the provider-patient relationship. For these reasons the fundamental tension between the need to trust providers and the desire to control them is never fully resolved. Each national system has an internal logic combining the three approaches in different ways and with different weights. Each country tends to cycle through a 'policy repertoire' in search of a better approach. Rarely does this amount to radical shifts, with the NHS internal market being a rare example. Between episodes of reform, policy repertoires are constrained by internal system logics. But cycling through the repertoire keeps health care systems in a state of flux.

*explore whether there are refinements to the current tariff that could provide incentives for...benefit sharing, to support co-operation between commissioners and providers in delivering integrated long-term conditions care.*

More specifically, the white paper noted that there was scope for using the 'year of care' approach being developed for people with diabetes, and for developing the quality and outcomes framework in the new GMS contract to provide stronger incentives for effective management of people with long-term conditions. The white paper also included a commitment to apply the tariff to activity in community settings, to 'unbundle' the tariff to enable activities such as diagnostics and elements of rehabilitation to be provided out of hospital, and to explore ways of basing prices on the most cost-effective way of delivering a service instead of average costs. While some progress has been made on these issues since publication of the white paper, as reflected in the guidance on payment by results published at the end of October 2006, it remains the case that the levers and incentives to promote networks and integrated care are underdeveloped.

The reason this matters is that competition and choice were developed as policies in 2001/02, when the main priority was to tackle long waiting times for planned hospital care. As already noted, the combination of national targets, extra investment and aggressive performance management has enabled the NHS to make significant progress in reducing waiting times. This has led the government to give greater priority to the prevention and treatment of chronic diseases, for example in The NHS Improvement Plan published in 2004.

Chronic diseases constitute most of the workload in primary care and in hospitals, and yet the development of policy instruments to improve the quality of care for people with these diseases has lagged behind their identification as a priority for the future. In this respect, the health reforms remain focused on tackling yesterday's problems rather than those of tomorrow. How then might the reforms move forward from their current position to address this challenge, and make a reality of the priority attached to chronic diseases?

## OPTIONS FOR THE FUTURE

---

One approach would be to use practice-based commissioning as a mechanism for developing multi-specialty-based commissioning. This would involve networks of practices working with clinical colleagues in hospitals to jointly commission and provide services. As such, it would entail the integration of primary and secondary care provision, and the integration of commissioning and provision.

Multi-specialty-based commissioning might be developed initially around chronic diseases such as diabetes and arthritis, where hospital-based specialists are working mainly in outpatient and community settings. Commissioning budgets would be jointly controlled by primary care teams and hospital-based specialists and would include incentives for integrated teams to provide care in the most cost-effective way. Over time it is possible to envisage how specialists might move out of the hospital to work alongside primary care teams while retaining the right to admit patients to hospital when necessary, as in the example of diabetes in Bolton referred to earlier.

An alternative route to a similar destination would be to use the flexibilities built into primary care contracting to promote clinical integration. The specialist personal medical services (SPMS) contract is already being used in this way. Examples include an integrated rheumatology service in Oldham and a range of integrated care services in Epsom Downs. A common concern in these initiatives is to find ways of providing more services in the community through closer integration of clinical activity. In embryo, they illustrate how clinically integrated delivery systems might begin to emerge in the English NHS, as primary and secondary care clinicians seek to find ways around the risk that the health reforms will lead to increased fragmentation rather than closer collaboration.

As they develop and are scaled up, both approaches will require medical groups to serve populations of sufficient size to make multi-specialty medical practice viable, and an investment in infrastructure (buildings and equipment) to enable specialists to work outside the hospital. They will also need specialists and GPs to work



as partners in multi-speciality medical groups, sharing risk as well as profit. Such an arrangement would build on the existing model of general practice in the UK, in which GPs hold an equity stake in their practices, and it would be similar to the approach used in some US groups (such as the Permanente Medical Groups) in which physicians are shareholders with a direct financial stake in the success of their organisation.

Two points are worth emphasising about these options. First, by giving control over capitated budgets to multi-speciality medical groups, they create strong incentives to keep patients healthy, and therefore to minimise expenditure on 'downstream' medical interventions. Put another way, they help to promote the maintenance of health rather than the treatment of sickness, an objective that is receiving increasing attention within government.

Second, both options have the effect of turning the hospital into a cost centre whose use should be avoided except where necessary and appropriate. This is quite different from the current approach to health reform in England, in which hospitals are seen as profit centres that generate surpluses to the extent that they attract patients and income as policies on choice and competition gain momentum. This approach may have been appropriate when there was a need to create stronger incentives to increase hospital activity to reduce waiting times for treatment, but it appears outmoded in a world in which

the prevention and treatment of chronic diseases and the avoidance of hospital admission are the key priorities.

The question that arises is, how would multi-speciality medical groups relate to hospitals? One approach would be for hospitals themselves to be joined with medical groups in vertically integrated organisations. An alternative would be for hospitals to remain organisationally distinct and to form long-term alliances with one or more multi-speciality medical groups in a form of virtual integration. Examples of both approaches can be found in the US, with Kaiser Permanente in northern California taking the form of a vertically integrated organisation, and Kaiser Permanente in Colorado being an example of a virtually integrated organisation.

Kaiser Permanente in Colorado achieves consistently high levels of performance among the Kaiser regions. While this might suggest there are advantages in virtual integration, it is worth invoking the experience of another integrated delivery system, the Veterans Health Administration, whose performance has improved remarkably in the period since 1995. Several factors have contributed to the turnaround achieved at the Veterans Health Administration, one of the most important being its conversion from a hospital-centred system to an organisation in which care is organised into regionally-based integrated service networks. The experience of the Veterans Health Administration

#### **Box 4: The transformation of the Veterans Health Administration**

Beginning in the mid-1990s, the Veterans Health Administration undertook a major programme of reform that resulted in reduced use of hospitals and improved patient outcomes. Between 1994 and 1998, the number of acute beds was reduced by 55% and bed day use was cut by 50% (Ashton and others, 2003). These reductions were achieved without adverse effects on outcomes. A separate study has reported on improvements in the quality of care achieved over a similar period (Jha and others, 2003). The transformation of the Veterans Health Administration was led by Ken Kizer, who instituted a series of changes including establishing integrated service networks in place of the previous hospital-centred system, strengthening primary care,

and focusing relentlessly on quality improvement (Oliver, 2007). Kizer placed particular emphasis on devolving responsibility for performance to the leaders of the integrated service networks and then holding them to account through explicit performance contracts. This included using data on the comparative performance of the networks as a tool to drive performance improvements. In so doing, Kizer generated a degree of internal competition between the networks, based on their desire to be at the leading edge of performance within the Veterans Health Administration. At the same time, networks were expected to collaborate with each other in order to share good practice and to address performance concerns.



suggests that vertical integration holds as much promise as virtual integration.

Which of these approaches is adopted in the NHS will depend in part on geography, with rural areas lending themselves more to vertical integration and urban areas to virtual integration. In urban areas, it is possible to envisage how the evolution of the reforms might support patient and citizen choice between clinically integrated systems with the allocation of public resources following these choices. This would require the development of person-based capitation payments with risk adjustment, and regulation to require mandatory acceptance of enrollees and a standard benefits package. The emergence of competing integrated systems in some parts of the country would enable there to be an empirical test of the role that competition (as opposed to integration alone) makes to performance improvement.

In rural areas, where vertical integration is likely to be more common, the co-location of GPs and specialists in

health centres containing a range of services may be less appropriate than an approach in which specialists serve a number of practices in a 'hub and spoke' model. In this model, one or more practices might occupy health centres able to accommodate facilities for outpatient services, diagnostic tests, and other forms of care, and patients would be referred to these services from other practices. In some areas, it might be possible to develop community hospitals to take on this role. The important point is that the key features of clinically integrated systems identified in Box 6 would need to be adapted to suit different local circumstances.

One of the risks in the approach proposed here is that the population focus of PCTs might be weakened as multi-specialty medical groups assume a more significant role. To avoid this risk, it would be important to retain a role for PCTs in regulating the performance of medical groups and in providing information to patients and citizens about the comparative performance of these groups. PCTs would also continue to lead on the wider

### **Box 5: The case for competing integrated systems**

The Health Strategy Review undertaken by Adair Turner for the Prime Minister in 2001 examined the lessons the NHS might learn from integrated systems like Kaiser Permanente. The analysis undertaken by Richard Feachem and colleagues, published in the *British Medical Journal* (2002), had suggested that Kaiser outperformed the NHS in some areas.

In principle, there seemed to be scope for increasing efficiency and reducing delays in the NHS, especially in the interface between primary care and secondary care. For example, outpatient services typically involve a three-step process (visit to the GP, referral to hospital and visit to the hospital) when often this could be a two-step process entailing the patient seeing the GP and specialist on the same visit. Kaiser's model of multi-specialty medical practice in which family physicians and specialists work in the same medical offices facilitates this type of care.

Another lesson from Kaiser that arose during the Health Strategy Review is that it has no commissioning process because commissioning

is internalised within an integrated system. This was interesting in relation to the arguments of Coase (1937), Williamson (1975) and others about the circumstances in which it is appropriate to use firms and hierarchies on the one hand, or contracting and markets on the other hand. Complex transactions tend to favour hierarchy rather than markets, and health care has been described by Williamson as involving some of the most intractable transactions.

It seems unlikely in this context that the current structure of PCTs and NHS Trusts/Foundation Trusts is optimal. There is an imbalance of power between primary care and secondary care and between commissioners and providers. Also, in the absence of any real possibility of bankruptcies, it is hard to see how a market of any kind will emerge. The thought this prompts is whether it might be preferable to develop a number of competing integrated Kaiser-like systems, as a more effective way of generating change and improvement.



population health agenda through working closely with local authorities and third sector organisations.

A fundamental feature of integrated systems in the US is that they achieve high levels of performance not through contracts and transactional reform, but via engaging clinicians (especially doctors) in the quest for improvement and by aligning the incentives facing the organisation with those of the key front-line decision makers. The relationship between commissioner and provider is in effect internalised within these systems and assumes a different form because they are competing with other systems for market share. In this way, integrated systems leverage the benefits of internal collaboration between clinicians to deliver high-quality care to patients, and it is argued that they do so in part because they operate in a competitive environment (Enthoven, 2002).

Light and Dixon (2004) have summarised the experience of Kaiser Permanente in the following way:

*The root lesson from Kaiser Permanente is that clinicians need to run the health service – all of them together – with shared bottom-line responsibility. The primary and*

*secondary doctors at Kaiser have decided that the most cost-effective way to allocate their shared budget in an era of sophisticated specialty medicine is to have patients diagnosed and treated in multi-specialty health centres where primary care teams work, lunch, and socialise with specialty nurses and doctors, laboratory and imaging technicians, and with the pharmacy team. Patients choose their own primary care doctor, but rapid referral and assessment to the more common specialties and testing is done on-site. Recently, this arrangement has been further integrated by a shared electronic data system' (p. 764).*

As indicated earlier, in the context of the English health reforms, it should be possible to compare the performance of clinically integrated systems in areas where patients have choice with their performance in areas where there is only one system. The performance of clinically integrated systems in rural areas where the opportunities for choice and competition are limited could then be compared with the performance of systems operating in a competitive environment. In this way, yardstick competition would serve as a proxy for real competition.

## Box 6: Key features of clinically integrated systems

- Primary care teams and many specialist teams would work together to provide services to patients.
- These specialist teams would be co-located with primary care teams in health centres that would provide outpatient services, diagnostic tests and urgent care.
- The specialist teams working in health centres would be decoupled from the hospital and would have an incentive to provide care in the community.
- Multi-specialty teams would control a capitated budget for the provision of services and would retain budget underspend.
- Clinicians would lead the commissioning and provision of services for the populations they serve.
- Hospitals would become cost centres instead of profit centres and would focus on providing only those services requiring specialised inpatient facilities.
- In some areas, patients would have a choice between integrated systems and would use information about the performance of these systems in making their choice.
- The performance of integrated systems in rural areas and areas with limited choice would be compared with the performance of systems operating in a competitive environment.
- Capitation payments would follow patients to the system of their choice.
- Social care teams would be included in this model where there was local support for health and social care integration, building on the experience of care trusts.
- Specialised hospital care would be planned as part of acute hospital networks to avoid duplication and to facilitate the concentration of care in areas where this brings benefits to patients, such as cancer care.

## NEXT STEPS

---

The challenge for the NHS, in the context of Lord Darzi's review of the next stage of NHS reform, is to find ways of learning from the experience of these integrated systems and adapting this learning for the benefit of patients. As a recent report from the NHS Confederation and the Joint Medical Consultative Council (2007) has argued, clinicians in the NHS aspire to work in a system that is integrated and networked. While this does not exclude the use of choice and competition in some areas of care, it suggests that much more attention needs to be given to developing the mechanisms for turning policy aspirations for collaboration into reality. It also suggests that the structure of the market is a central consideration.

Specifically, competition between clinically integrated systems holds out more promise than a market that sets primary care clinician against secondary care clinician, and that creates incentives that make it more difficult to

develop the seamless services needed to deal with the increasing burden of chronic diseases.

The interim report of the Darzi Review (2007) reiterated the commitment to integrate care around care pathways, with the aim of developing "a single health and well being service in every community, shaped around the user, not the organisation" (p. 32). The final report needs to provide a coherent and credible account of how this will happen in practice.

**Chris Ham**  
**Professor of Health Policy and Management**  
**Health Services Management Centre**  
**University of Birmingham**  
**c.j.ham@bham.ac.uk**

December 2007

## AUTHOR'S NOTE

---

The ideas in this paper have been germinating for several years. They originated in an article I wrote for the Health Service Journal in July 1997, optimistically entitled 'Big bang reforms bow out', in which I argued for entrepreneurial clinicians and managers to be empowered to bring about service improvement. Specifically, I suggested that the government should promote 'integrated resource management' in which GPs and specialists would control a budget with the aim of delivering care outside hospital wherever appropriate (Ham, 1997). The relevance of these ideas was reinforced by my subsequent research with colleagues into Kaiser Permanente (Ham, York, Sutch and Shaw, 2003) and visits I made to Kaiser, the Veterans Health Administration, Group Health Co-operative and other integrated systems in the US. On these visits, I gained a greater understanding of the importance of clinicians

themselves leading change (Ham, 2003), and gathered important insights into the benefits of integrated delivery systems. The experience of these systems reinforced doubts about the design of the health reforms in England, and especially the weight attached to commissioning as a driver of change. In a previous briefing paper for the Nuffield Trust (Ham, 2007) I articulated these doubts and began to sketch the ideas set out in more detail here.

In policy-making, timing is everything, and only recently has it seemed that a window has started to open that might be receptive to integrated resource management, or what in this paper I have termed multi-specialty-based-commissioning, being taken forward. I hope this briefing paper helps to stimulate debate and action on how this might happen.

## REFERENCES

- Ashton C and others (2003) 'Hospital use and survival among Veterans Affairs Beneficiaries', *New England Journal of Medicine*, 349: 1637–46
- Coase R (1937) 'The nature of the firm', *Economica*, 4: 386–405
- Department of Health (2006) *Our Health, Our Care, Our Say: a new direction for community services*.
- Department of Health (2007) *NHS Next Stage Review: Interim Report* (Darzi Review).
- Enthoven A (2002) 'Commentary: competition made them do it', *British Medical Journal*, 324: 143
- Feachem R, Sekhri N and White K (2002), 'Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente', *British Medical Journal*, 324: 135–43
- Ham C (1997) 'Big bang reforms bow out', *Health Service Journal*, 24 July: 20
- Ham C (2003) 'Improving the performance of health services: the role of clinical leadership', *The Lancet*; 361: 1978–80
- Ham, C (2006) 'Developing Integrated Care in the NHS: adapting lessons from Kaiser'. Health Services Management Centre, University of Birmingham
- Ham, C (2007) 'Commissioning in the English NHS: the case for integration'. The Nuffield Trust
- Ham C, York, N, Sutch, S and Shaw R. (2003) 'Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare Programme: analysis of routine data', *British Medical Journal*, 327: 1257–60
- Institute of Medicine (2001) *Crossing the Quality Chasm*. National Academy Press
- Jha A and others (2003) 'Effects of the transformation of the Veterans Affairs health care system on the quality of care', *New England Journal of Medicine*, 348: 2218–27
- Le Grand, J (2007) *The Other Invisible Hand*. Princeton University Press
- Light D and Dixon M (2004) 'Making the NHS more like Kaiser Permanente', *British Medical Journal*, 328: 763–65
- NHS Confederation and Joint Medical Consultative Committee (2007), *A Clinical Vision of a Reformed NHS*.
- NHS National Leadership Network (2006), *Strengthening Local Services: The Future of the Acute Hospital*. See also <http://www.nwlh.nhs.uk/changeforthebetter/documents/FutureOfTheAcuteHospital.pdf>
- Oliver A (2007) 'The Veterans Health Administration: an American success story?', *The Milbank Quarterly*, 85(1): 5–35
- Tuohy C (1999) *Accidental Logics*. Oxford University Press
- Turner J (2007) *A Preliminary Study of Emergency and Urgent Care Networks*. Sheffield University Press
- Williamson O (1975) *Markets and Heirachies: analysis and antitrust implications*. The Free Press

## ABOUT THE NUFFIELD TRUST

The Nuffield Trust is one of the UK's leading independent health policy charitable trusts. It promotes independent analysis and informed debate on UK health care policy and acts as a catalyst for fresh ideas.

As a point of principle, the Nuffield Trust does not exert any form of censorship or control on the academic freedom of the author to express his or her view or opinions. Therefore the views stated in this publication are the author's and do not necessarily reflect the views of the Trust.

### For more information contact:

The Nuffield Trust  
59 New Cavendish Street  
London W1G 7LP

Tel: 020 7631 8450  
Email: [info@nuffieldtrust.org.uk](mailto:info@nuffieldtrust.org.uk)

[www.nuffieldtrust.org.uk](http://www.nuffieldtrust.org.uk)

© Nuffield Trust 2007



The Nuffield Trust  
FOR RESEARCH AND POLICY  
STUDIES IN HEALTH SERVICES