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Competition and integration

Event report: *Ruth Thorlby and Natasha Curry*

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This event report summarises the presentations and discussion at a roundtable seminar, held on 12 September 2011, organised by the Nuffield Trust and Monitor. The aim of the seminar was to discuss how competition and integration could work together to improve quality and efficiency in the English NHS. It explored some of the challenges that will face Monitor and the NHS Commissioning Board in the dual pursuit of competition and integration. It draws on the latest evidence from international research and on examples from the United States(US), where the government has been experimenting with new pricing and payment strategies to foster more coordinated care.

Background

Extending competition between NHS and independent providers for both patients and contracts has been an explicit policy objective for the NHS in England since the early 2000s. Since 2006 there has been a specific policy of encouraging competition between providers for patients needing non-urgent surgical procedures, with patients offered a choice of hospital at the point of referral by their GP.

In June 2010, the Coalition Government affirmed their belief that competition is an important way of driving quality and efficiency in the NHS, and set out their plans to extend the scope of patient choice and competition beyond elective hospital care, to other areas of hospital and community care (Department of Health, 2010). The subsequent draft legislation proposed the creation of new structures to support competition, specifically a new economic regulator for health (Monitor) with duties to promote competition and a range of powers to combat anti-competitive behaviour. In May 2011, amid rising opposition to some elements of the Health and Social Care Bill – including the plans on competition – the Government suspended the legislative process and commissioned a consultation and review process, known as the NHS Future Forum.

One of the key messages from the NHS Future Forum report, published in June 2011, was that health services in England should be much better integrated (both within health care and between health and social care services), so that patients experience well-coordinated, seamless care (Department of Health,2011). The Forum's emphasis on integration reflected a long-standing desire for better coordination in the NHS, as well as a concern that more competition might fragment services further.

In response, the Government promised a much greater focus on integration and collaboration, and amended the Health and Social Care Bill to insert duties on the NHS Commissioning Board, clinical commissioning groups and Monitor to support integrated working where it is in the interests of patients. Under the terms of the Bill, Monitor now has a primary duty to protect and promote patients' interests, and take action against anti-competitive behaviour in the NHS, while at the same time supporting the integration of services where it improves care. Delivering these dual objectives of greater competition and more integration in the NHS will not be straightforward. Achieving integrated care for patients requires more effective working and information-sharing between all the services and organisations that contribute to an individual's care. Monitor needs to understand how care integration and competition can work together in patients' interests. It needs to resolve the tensions which will arise in cases where efforts to improve integration imply a reduction in competition.

The issue of integration is not unique to health care – in many other sectors the quality of a service or product is dependent on different organisations working together. What is unique is the complexity of the integration challenge in health care. Creating new integrated organisations is often seen as the route to delivering integrated care (the Kaiser Permanente system in the US is among the leading examples of integrated delivery organisations worldwide). Integrated organisations raise particular issues for competition if they either involve a material increase in market concentration, or if through vertical integration patient choice at different points along the pathway is curtailed. Greater integration of services has long been a policy objective within the NHS, but it has faced numerous barriers, including the absence of effective financial incentives, such as appropriate payment systems, which allow organisations to collaborate across boundaries (Ham and others, 2011).

Opening remarks by the Chair

Simon Stevens, President of Global Health, UnitedHealth Group

Simon Stevens argued that the recent debate on competition has ignored an emerging consensus on competition in the NHS – that it is a useful tool, but is not the only tool for improvement. Those opposed to competition ignore the fact that a degree of choice and competition has always been present in the NHS: an original 1948 NHS leaflet stated that patients must choose their GP. It is therefore important to move the debate beyond a 'yes or no' to competition, and reframe it as a discussion about what benefits competition can bring to patients and how it can be practically enabled.

There is some evidence from the US that suggests that where provider consolidation has reduced competition between hospitals, costs rise and efficiency falls. The other key development to observe in the US is the evolution of Accountable Care Organizations (ACOs), an innovation enabled under the 2010 Affordable Care Act. ACOs are intended to incentivise more coordinated care (see below) and it will be important to observe whether they provide solutions or exacerbate the problem.

Key questions

There are ten questions that need attention if competition and integration are to develop in the NHS:

1. If competition is a means and not an end, what are the areas of patient care that could benefit?
2. What should be the structure of competition? What is the right mix of patient choice-based competition under the 'any qualified provider' programme and the existing programme of choice of elective care or competitive procurement,where a single organisation is granted a right to provide for a population for a fixed term?
3. How can competition be used to overcome the barriers between primary and secondary care?
4. How can competition be used to align staff incentives and avoid unintended consequences?
5. What regulations are required?
6. What is the best division of labour between Monitor, the NHS Commissioning Board and clinical commissioning groups?
7. To what extent will competition be embraced locally? Will commissioners opt for a 'quiet life' of collaboration with their local trust/providers rather than competition?
8. How can we maximise the power of competition while minimising transaction costs?
9. What are the pros and cons of fixed-tariff versus price competition?
10. How can the competition agenda be structured so that clinicians innovate and drive change?

Competition and integration: Monitor’s role and approach

David Bennett, Chair and Interim Chief Executive, Monitor

David Bennett gave a description of Monitor’s role under the new reforms, assuming the Bill is passed. Its primary duties are to protect patients’ interests through its functions of regulating prices, enabling integration, acting against anti-competitive behaviour and supporting continuity of services in the event of failure.

Integrated care and competition can reinforce each other. There can be competition for the market (where providers could tender to run integrated services) and competition within the market (where patients are offered choice and could use personal health budgets to integrate their own care). There is some evidence to suggest that choice and competition (for the market) can drive quality and efficiency, although more evidence is needed about the barriers to competition.

It is important to be clear what integration means, as definitions vary. Integration should be enabled where it can increase quality and reduce inequalities. It is likely to be appropriate in some situations but not others. For example, integration might be most appropriate for the management of long-term conditions, but it can also be delivered across general practice and secondary care (through, for example, information sharing).

Monitor will play a key role in driving integrated care and in sharing examples of good practice across the NHS, but it will not be acting alone. Commissioners should be the main drivers, but providers also need to be encouraged to provide integrated solutions. In addition, patients themselves will be important drivers of integrated care. An early task for Monitor is to understand what patients want in relation to integration. Personal health budgets, where appropriate, will also be an important enabler of integration at patient level.

However, many challenges still remain. A frequently-cited barrier to integrated care is the payment system and a key challenge will be reform of financial mechanisms to enable integrated working. Payment by Results (PbR), as it is currently structured, can act as a disincentive for providers to move care outside the acute sector, so Monitor may consider whether new types of tariffs need to be developed to enable integrated care. A further challenge will be how to translate corporate incentives into individual incentives for clinicians to work across organisational boundaries.

Monitor will need to produce guidance about what is acceptable in terms of integration and collaboration to avoid inappropriate collusion between providers, which could result in reduced choice, increased costs and worse outcomes. There might also be a case for suspending investigations under competition rules for set periods of time, to enable developments and evidence-gathering in integrated care, thus creating ‘safe harbours’ in which to foster innovation. Another option might be for integrated care pilots to be pre-approved to test the risks of reduced competition.

Other questions also need to be explored. For example, will the creation of integrated pathways mean that patients have to commit to the whole pathway rather than choosing to go elsewhere for part of it? Will there be a risk of inequalities if patients can design their own integrated care? Will integration lead to reduced competition, as it may be difficult for a provider to enter a market if they need to offer the whole pathway of care? What is clear is that commissioners will need support and encouragement to design appropriate tenders.

Discussion points

- Is there a tension between patients and commissioners designing their own integrated care and commissioners designing their own version? A key barrier is that a commissioner may negotiate an integrated pathway with a provider, but if the patient chooses to go elsewhere, the commissioner may end up paying twice.
- Much more clarity is needed about what integrated care is. Integrated care is not the same as integrated organisations. For instance, goodIT systems can allow different organisations to collaborate across boundaries. This is what the ACOs are aiming to achieve within the US.
- Monitor should not neglect Healthwatch as an important source of information about what patients want, and should be more aware of the large body of evidence about patients' experiences and expectations.
- Personal health budgets have the potential to change everything, but only if good quality information is there for patients to make decisions.
- It is important to ask professional groups what would help them work in an integrated way. A view from an acute NHS trust was that efforts to work with primary care were seen as 'giving away income', while commissioners are often unwilling to destabilise the local acute trust by encouraging competition or tendering for new integrated services.
- Is Monitor's duty to act in the interests of the individual patient or in the interests of the population? For example, individual choice might take patients away from a particular hospital and threaten its survival, but there may be a desire locally to stabilise the local hospital.
- There are examples from the Netherlands where pilots have demonstrated successful innovation among providers.

Integrated health care: what is it and why does it matter?

Jennifer Dixon, Director, Nuffield Trust

There are many definitions and types of integrated care: horizontal, vertical, real, virtual, integration of providers, or integration of payers and providers. A helpful one, however, is 'health and social care provision that is seamless, personalised and flexible'.

What enables integrated care is integrative processes or 'glue'. These could be normative (e.g. vision and values), organisational (e.g. governance), informational (e.g. shared patient records), administrative (e.g. back office functions), financial (e.g. payment mechanisms) and clinical (e.g. guidelines and protocols). For the 'glue' to hold, there doesn't need to be a single organisational entity – these processes can work in networks. International efforts to integrate care include bundled payments (the Netherlands), chronic disease management (Germany) and chains of care (Sweden). All are based on Ed Wagner's model of chronic disease management (see for example Wagner, 2009).

Evidence for integrated care is mixed and weak. Where there has been progress, it has been disease-focused and incremental. Implementation is often difficult because system policies are hostile to integration, or because there is a lack of clear vision. Evaluation is difficult because integrated care is complex. Integration means different things in different situations; papers do not always describe the content of programmes; there are a range of different measures and outcomes; and analysis is often partial. The result is a patchy and mixed evidence base.

Given the mixed and weak evidence, is it worth pursuing? Is there any alternative? What would a serious initiative look like? Could it be evaluated quickly enough? We need to get serious about evaluating integrated care and borrow from examples in Europe and the US.

Next steps in integration in the UK

Paul Corrigan, independent consultant

Integration arrived late in the Health and Social Care Bill debate, as a stick with which to beat competition. Itis therefore portrayed as good, and competition as bad. There is also a belief that our existing NHS monopoly produces integration and that competition will destroy it. The truth is that we have fragmentation of care now and state monopolies are under no pressure to deliver new models of care. It is a myth that single, state organisations, such as local government, necessarily deliver integrated care.

The NHS to date has been poor at integrating services. Mergers of organisations are not the same as integration of care, and the national integrated care pilots (Department of Heath, 2009)are not delivering highly integrated care. NHS providers are rooted in existing models and have little incentive to promote integrated care. We need to see disruptive innovation and a narrative about why integrated care is important. Integrated care needs a new business model and we need to look beyond health, to other industries. For example, in the construction industry, there is no expectation that one part of the industry will coordinate the others. Similarly, it is unrealistic to expect a consultant diabetologist to be good at setting up a new chain of care. What is needed is for someone from outside the business to redesign it; someone who will get those inside the business involved to collaborate. In other words, what is needed is a series of logistics organisations (such as ACOs) with different ideas of how to deliver it and how to reorganise existing providers. There is also a need to reform payment mechanisms in order to enable change. Examples include 'year of care' tariffs and better outcomes-based models of care for older people.

The impact of competition and integration on cost and quality

Professor Carol Propper, Professor of Economics, Imperial College

Evidence on competition between hospitals from the US suggests that quality increases when prices are regulated. When prices are not regulated, anything can happen.
UK evidence shows that at the margins, people have exercised choice (either themselves or via their GPs, using Choose and Book) since the introduction of the policy in 2006. Research has shown that hospitals facing more choice and patient movement increased quality, reduced length of stay and maintained financial balance with no increase in inequalities.

It is still not entirely clear how this has happened. Bloom and others (2010) at the London School of Economics have attempted to explore the 'black box' and suggest that where there is better management in NHS hospitals, there are better outcomes (in terms of waiting times, staff satisfaction and quality). Management tends to be better in competitive areas, so it would suggest that competition between hospitals leads to higher-quality management and therefore better outcomes.

In relation to mergers, US evidence (Vogt and Town, 2006) suggests that hospital consolidation raises prices and has mixed impact on quality. Emerging findings from a new study by Propper of UK hospital mergers suggests a similar pattern. In the UK, there were many mergers of hospital trusts after 1997. In 1990, there were 220 acute trusts; by 2006, over half had been involved in a merger. This is the opposite to competition – it increases market concentration. Propper's research compared hospitals before and after merger, and compared merged with non-merged hospitals. It found that merged hospitals showed:

- lower growth in admissions and staff numbers (however, this was because capacity was taken out, not necessarily because of increased productivity)
- no increase in productivity
- no reduction in deficit (in fact, it tended to increase later)
- no increase in quality on a range of measures
- an increase in the use of agency staff.

This work suggests that hospital mergers can be costly, with few benefits accruing.

Discussion points

- If you control price, organisations will compete on other things, but not necessarily quality. Setting prices at the right level is critical.
- It is important that patients also understand what quality is and demand it.
- The system doesn't welcome disruptive innovation. In the new system, who will be the forces of disruptive innovation: patients, doctors, nurses or managers? There is a need to balance disruptive innovation with building relationships.
- Is new market entry important for quality? New entry in the NHS has been very small-scale so far and little research been done, but it might be possible to look at GP entry into an area.
- Market exit (financial failure) is problematic in the NHS; we need to give teeth to the threat of exit/failure.
- Financial incentives and pay-for-performance have been shown to work in the public sector (for example education) if these incentives are well-designed. Currently we have no way of rewarding patients for looking after their health.

Payment reform, competition and integration

Professor Michael Chernew, Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School

The fee-for-service system that predominates in the US suffers from a range of well-known shortcomings, including creating incentives for overuse (for example via unnecessary readmissions) and an absence of incentives to keep people healthy. It is an intensely 'micro' system, with layers of complexity and detail, which does not support coordination of services across providers.

Setting prices is notoriously tricky. If prices are set too high, it increases supply. If prices are set too low, it discourages innovation. Reforming the payment system is seen as the key to creating integrated provider systems. Bundled payments are the main mechanism to achieve this: either global (capitated) or episode-based (everything needed to repair, for example, a hip fracture). These require organisations to collaborate in order to get the payment. Versions of this are being trialled in US. For example, Blue Cross Blue Shield in Massachusetts have set global payments (with additional financial incentives for quality) for primary care physicians over a five-year period with Prometheus (a payment model intended to provide quality care with improved care coordination[1]) being used for episode-based payments.

There are some concerns about integration. These include potential diseconomies of scale; discouragement of innovation, and the fact that performance management becomes difficult in a big organisation. Integration might also reduce some of the benefits of competition. Competition can force providers to innovate and to be patient-

[1] See www.hci3.org/node/5 for more information.

centred. In theory, competing firms should drive prices to marginal cost, but insurance distorts this as consumers have no incentive to look for low-cost treatment, since they do not have to pay. So prices are high in the US, and there is limited appetite to impose lower prices. There are attempts to control prices, for example through regulation and using co-payments to control consumers' choice of expensive providers. Bundled payments are therefore a good way of controlling prices and driving integration.

Putting it into practice: Accountable Care Organizations

Professor H.E. Frech III, Professor of Economics, University of California, Santa Barbara

ACOs have been created as part of health reform in the US, but are not formally in existence yet. As such, they are still a loose concept. They are intended as a highly regulated device to save money by encouraging providers to collaborate for a global capitated payment for Medicare patients (Medicare is the Government-provided health scheme for the over-65s). The prototype of the ACO was the Independent Physician Association (IPA) – alarge multi-specialty group (across primary and secondary care) in California, who took on full risk-capitated budgets from insurers (see Casalino, 2011). The goals of ACOs are largely the same as managed care, without being managed care.[2]Although managed care is demonised, the majority of patients not in Medicare are in managed care. In other words, the majority of patients trade choice for lower prices.

ACOs are seen to pose risks to competition as they require collaboration between competitors. They spur mergers, which has a negative effect on price. The experience in California showed that, where there were IPAs, prices were high. Most integrated delivery systems (such as Kaiser Permanente) have collaborative organisations of physicians. In these scenarios, the law allows physicians to bargain as a group if they accept financial risk.

Health care in the US is subject to economic regulation (competition law). The competition authorities have been working on proposals to respond to the ACO model. Their draft anti-trust (competition) policy on ACOs dictates that a mandatory review (a review by the authorities to establish if there is a specific, actionable risk to competition) is required if a proposed ACO accounts for more than 50 per cent of the market share. If the ACO will account for less than 30 per cent of the market share, it is ensured a 'safe harbour' from regulatory scrutiny. Overall, it seems that the prospects for ACOs are limited. The incentives are relatively weak, but overall the regulatory framework is cumbersome.

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[2] Managed care is an approach to health care that developed from the 1970s, with the aim of controlling costs. It uses a range of techniques to control demand, such as limiting patients' choices, co-payments and restrictions on physicians' freedom to refer. By the 1990s, managed care had become unpopular with patients and consumer groups: see, for example, Bodenheimer (1996).

Payment reform in the NHS: the future of Payment by Results

Richard Murray, Chief Economist, Department of Health

Current methods of payment in the NHS include PbR, GP and dental contracts, local discretionary contracts, and needs-weighted allocation. Future payment mechanisms include PbR, bundled payments such as 'year of care', the quality premium, pay-for-performance and personal health budgets. PbR was introduced to increase choice, competition and quality. It was also intended to free commissioners from negotiating prices (so they could focus on quality and integration) and to increase transparency as to where the money goes. But PbR did not allow price competition. Evaluation of PbR has shown that it led to small cost reductions, but that it had no impact on quality. Activity in elective and non-electives increased in the wake of its introduction. The question then arises: was the price set right?

In the future, the priorities for reforming PbR are to ensure that it increases quality and improves outcomes. Options include increasing efficiency and value for money by setting the tariff below average and building in big assumptions about efficiency, as well as extending the use of best practice tariffs. Best practice tariffs have been structured and priced to encourage patient care that is both high-quality and cost-effective, rather than standard pricing tariffs based on the national average of reference costs.

Integration will be supported by introducing measures of reablement and 'year of care' payments, and by extending the scope of the tariff into community services, critical care and renal dialysis. The policy that commissioners will not pay for emergency readmissions within 30 days should prompt collaboration between hospitals and primary care, as should the formal duty for clinical commissioning groups to integrate. In the future, personal health budgets will let people make their own choices about how to coordinate their care. Finally, quality will be improved by not paying for 'never events' and, under Commissioning for Quality and Innovation (CQUIN), 1.5 per cent of a contract can be withheld unless quality is achieved.

There are certainly still challenges ahead: some of these reforms come with big administrative overheads. For example, efforts to unbundle the tariff in order to avoid double payment – as commissioners have asked – are extremely complex and come with heavy data requirements. 'Year of care', which is currently under development, has proved very challenging and has taken a long time to develop.

Discussion points

- There has been debate about the use of patient incentives. In the US, insurers are using financial incentives to make it more expensive for patients to go to a poor quality provider. If the patient still chooses a poor-quality provider, there is a co-payment. Could this work in the NHS? A response to this point raised the fundamental issue that co-payments tend to be regressive and, therefore, means-testing would be necessary.

- One attendee offered a view from the acute sector: we are not gaming to bring in income; it is not a case of acute hospitals running rings round commissioners. At present, it feels like commissioners are no more than contractors. What is needed is a smart system that incentivises quality. The feeling on the ground has not been reflected in the discussion today.
- There are practical steps that Monitor and the shadow NHS Commissioning Board could be taking. Good information about performance and outcomes is key to bringing about change.
- Monitor needs to remove barriers to entry. Organisational integration will happen by default, so it is important that we try to guard against that becoming the only way to integrate.

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