

Competition and Cooperation - are we getting the balance right? 6th May 2009

Professor Chris Ham, Health Service Management Centre, University of Birmingham

Bob Ricketts, Director of System Management and New Enterprise, Department of Health

Three years since the introduction of choice at the point of referral, there are now a wider range of providers competing for patients, more active commissioning and a rules-based system overseen by a new Cooperation and Competition Panel. As the panel takes root, this seminar took stock of where the NHS is now, and where it is going in the next three years. In particular we will ask how the drive for clinically led change, new professionalism and integrated care, as set out by Lord Darzi, can be delivered in a more competitive environment.

This note represents a non-attributed summary of key themes from a discussion held at the NHS Confederation.

Recent policy emphasis

There is agreement that both competition and cooperation are needed in the health system. The two are not contradictory and there is a need to improve skills in both.

From a policy perspective it was argued that there had been more effort focused on competition including choice, payment by results, independent sector treatment centres and Foundation Trusts. It was generally accepted that this has had a positive impact on elective care, and was having some impact in primary care as well.

It was argued, however, that there was now a need for the same policy effort on collaboration. In particular, we do not currently have the right incentives and levers to support cooperation.

The Healthcare Commission report into Birmingham Children's Hospital was an example of the impact of a lack of cooperation between commissioners and clinicians. There were no incentives for children's and teaching hospitals to share information, let alone between primary and secondary care.

It was conceded that there was a good case at a high level for markets in healthcare. However when you get one level down from the policy debate – to the practice of designing markets – the capacity for marketisation is not there. This is one policy area where the devil is in the detail.

Reference was made to recent literature. Porter and Teisburg's book on the US health system showed that there was the wrong kind of competition in the US. Furthermore, Chistensen's book on *The Innovator's Prescription* highlighted the need for disruptive innovation through integrated systems rather than further fragmentation.

The literature suggests that choice might be more appropriate between integrated systems.

The guidance from the Cooperation and Competition Panel was criticised for arguing against bundling up prices. It was argued that more bundling rather than less was needed.

There is a need to look at efficiency along the whole value chain – whilst competition could achieve optimal parts of the value chain, it could add up to a sub-optimal total. Fragmented systems could thus have more problems.

Where does competition need to be enhanced?

Whilst there was agreement on the need to refine policies for cooperation, it was maintained that there was not yet 'enough' competition in the system. Even in elective surgery competition is still very limited, with markets relatively concentrated and large areas without choice. Whilst there had been some market entry and changed behaviour, this was still limited. 'Any Willing Provider' policy has only been in place for a year, information for choice is poor and many incumbents have been unchallenged for up to a century.

There are lots of different forms of competition in theory. However the application of competition has been very limited in practice. There is in particular little evidence of how you incentivise whole system change.

Some health economies are still provider dominated with single large acute providers with whom commissioners cannot bargain. However we are in danger of creating more large monopolies by going for mergers of underperforming providers.

Market analysis by one SHA showed for example that diabetes care provision was dominated by acutes, with poor results and value for money. The answer in those areas would be to bring in disruptive new entrants to the market. Similarly in end of life care and dementia some PCTs have the wrong model. It was argued that there was a need to stimulate markets across the country.

The policies for competition were developed during the boom when systems were not under pressure. The challenge is to ensure the right kind of competition, particularly in the context of a recession.

Competition in elective care was strongly driven from the top, including subsidies for new entrants. PCTs and SHAs still look up to Government for the lead on market innovation, not out to patients. Personal budgets may shift this. It was noted that PCTs were fairly resistant to cooperation.

It was suggested that providers were looking across and out more than commissioners were. However it was also argued that FTs still look to Government and Monitor for direction. There is a need to do what we can with the talent we've got.

It was argued that in the Geisinger health system doctors didn't know whether their patients were Geisinger patients or not. Long term conditions care was more efficient. However it was countered that this was not due to competition, and that people working in Geisinger said that competition had no impact.

It was also argued that there was still no level playing field for non-NHS providers, with state subsidy of around 25 percent.

Policy proposals improving collaboration

It was suggested that major structural reform would be a distraction. Organisational integration (as in Scotland) may not be necessary. Clinical integration could be improved without restructuring.

Practice based commissioning could be a route for achieving this, if it took a different shape than at present.

The Department of Health has conceded the need for more explicit principles and rules for cooperation along the value chain. This needed good examples, including Integrated Care Pilots. Lewisham and Merton and St George's were cited as good examples.

Collaboration for Long Term Conditions was seen as necessary. Integration might help to sweat the acute sector. It needs to incentivise all players. Front end providers could compete for the market.

However existing providers can be suspicious of new models. We need new entrants to broker that change. Commissioners don't have that expertise, it was argued.

There was debate about the strength of evidence for integration. One participant argued that an evidence review found no basis for integration, whereas another said health and social care integration and integrated medical groups had been successful.

It was also argued that we should not just look to competition as the driver for integration. The benefits can be achieved without competition, with a combination of leadership, information systems and aligned incentives (e.g. Geisinger). Disruption does not have to come from fragmented new entrants. Improvements in diabetes care could be achieved without competition if these principles were applied.

It was argued that there was an over-emphasis on commissioners/ payers leading reforms. There is a lack of evidence of this working elsewhere. Similarly, it was suggested that PCTs had wider responsibilities for improving health and specifying outcomes and the direction for future services; market management may never be their strength.

Relationships under competition and cooperation

Choice can threaten clinical relationships, e.g. between GPs and consultants. In particular hearts and minds had not been engaged in the idea of competition. GPs and patients are not looking for private provision.

However it was also argued that uncompetitive systems do not have better cooperation. Competition has brought people to the table.

Some relationships within organisations are failing.

Payment systems

The direction for Payment by Results was towards greater granularity and more HRGs. PBC clusters were pushing for this. However PbR was introduced to incentivise increased elective activity, whereas now the need was to disincentivise acute care and look at whole pathways.

It was agreed that there was a need to address the payment system to encourage more value-chain rather than silo improvement.

US examples that are often cited, e.g. VHA and Kaiser Permanente, were havens of integration in a dysfunctional fragmentary system. We should not be looking at their structures, but can learn from their clinical integration. One could conceptualise tight integration and looser forms of cooperation such as clinical networking.

Competition for insurees

US evidence suggested that patients don't switch between providers. If it doesn't work there it is unlikely to work here. The Dutch model may be more effective – they were experiencing 3 percent switches of patients between insurers which was enough to drive competition.

It was suggested that some European systems, e.g. Germany and the Netherlands, had competition for insurance customers. However it was also pointed out that the Netherlands has also struggled to translate competition into impact on behaviours.

Other drivers of improvement

It was argued that other drivers may be more important, including 'targets and terror' and regulation. Where was the regulator that was driving integration and health and wellbeing (rather than overseeing FTs)?

A key challenge will be to be able to discern cooperation and collusion.