**Vertical integration: who will join up primary and secondary care?**

ippr discussion note for **Foundations and Fundamentals**
a seminar series addressing five key challenges for health system reform

### ippr seminar series

ippr is hosting a series of seminars to address five key challenges for health system reform: regulation, commissioning, governance, vertical integration and tariff setting. The seminars will provide an opportunity for policy-makers, public bodies, stakeholder organisations, practitioners, providers and experts to tackle these important yet controversial topics under a ‘Chatham House’ agreement. Ippr will provide discussion notes in advance of the seminars and summaries will be distributed and posted online. A report of the seminar series will be published in April 2006.

We are grateful to Monitor for funding the seminar series, and for respecting the independence of the project.

The fourth seminar, to be held at Monitor on 27<sup>th</sup> February 2006, will explore issues of vertical integration in the NHS. Taking forward the aim of the White Paper to develop person-centre services that are seamless and integrated from a user perspective, this seminar will ask how organisations might be better integrated to break down barriers between primary and secondary care, or whether clearer distinction between community and hospital services would better ensure people are treated closer to home.

### 1. The problem of integration

The White Paper, *Our Health, Our Care, Our Say* (DH, 2006), sets out an ambition for public services that are responsive and fit around people’s lives.

At present, there are organisational barriers between primary and secondary care. Patients have to go to different locations and see different professionals at various stages of their care. Communication between organisations can be poor, care can be fragmented and vulnerable people may fall between the gaps. Organisational barriers may mean that patients are forced to go to a hospital out-patient service when they
would prefer to be treated nearer home, or stay in hospital when they could be going home. Care pathways may be inefficient or achieve poor outcomes. Patients may have to visit a gatekeeper repeatedly each time they have a recurring need.

2. The Kaiser model – learnings and barriers
Other health systems do not have the same fragmented structures. In particular, much attention has been focused on the Californian managed care organisation Kaiser Permanente, which has been found to achieve lower hospital costs per patient within an integrated structure where primary and secondary divides are much reduced. Kaiser has been able to achieve acute bed day use at less than a third of the NHS rate for the same conditions, with both lower admission rates and shorter lengths of stay. These have in part been explained by Kaiser’s integrated model of care allowing better disease and case management, prevention of admissions and seamless care planning so that patients are discharged more quickly (Feachem et al, 2002; Ham et al, 2003).

The argument has therefore been made that the NHS could learn from Kaiser, particularly around improving integration between primary and secondary care. Some attempts are being made to learn from Kaiser, for example by introducing an NHS and Social Care Model for chronic disease management. The strengthening of commissioning roles by PCTs and practices is expected to create incentives for primary care managers and practitioners to keep patients out of hospital, supported by the Integrated Service Improvement Partnership. The Department of Health and Royal Colleges will be specifying clinically safe pathways to maximise out of hospital care, and will test these models in 20 to 30 demonstration sites for six specialties (DH, op cit). Practice Based Commissioning is intended to incentivise practices to design new patient pathways, with more ‘secondary’ care provided within primary care settings.

However, there remain questions about the implementation of these plans, about possible alternative means of integration as well as potential barriers. Light and Dixon (2004) have criticised the earlier NHS reforms for creating a ‘them and us’ structure. Separating the funding and responsibilities of primary care practitioners and hospital consultants creates perverse incentives for specialists to set up private practices. “The new general practice contract is moving closer to a Kaiser model, but the new consultant contract moves specialists away from it by locking consultants into a financial fiefdom rather than a clinical commonality” (Light and Dixon, op cit). The creation of increasingly independent Foundation Trusts makes it harder for
commissioners to achieve closer integration. Acute trusts are currently incentivised to maximise their admissions and to code-up patients to a higher Health Resource Group.

These barriers to integration may be overcome by stronger commissioning, but not without risking losses for acute NHS and Foundation Trusts.

3. **Foundations into the community?**
A rational response for forward-thinking FTs, in the uncertain acute market, could be to fulfil the devolutionary aspirations of the White Paper by diversifying into the growth sector of community and primary care themselves. The White Paper announced a new generation of ‘state-of-the-art’ community facilities, providing diagnostics, day surgery and outpatient facilities closer to where people live and work. Details of the tender process are yet to be published, but acute trusts will look with interest at how they can move in on these opportunities, to offset the expected losses from the shift to community care.

There may be advantages associated with the expansion of FTs downwards into community care. Vertical integration could ensure that all professionals are working in the same organisation, with shared values and purpose. It could ensure that consultants buy in to the devolution model, and prevent an expensive bidding war between Foundations and community hospitals for the same skills. The semi-autonomous and entrepreneurial culture of FTs, and their local membership arrangements could help providers respond to local preferences. The philosophy behind FTs as ‘go anywhere, out-performing in partnership’ organisations would suggest that they were ideally placed to provide these new services, and could provide integrated long-term conditions pathways (Foundation Trust Network, 2005a). A consultant neurologist from Addenbrooke’s Hospital is already holding his clinic appointments in GP practices. Royal Devon and Exeter NHS FT is in partnership with East Devon PCT to provide ongoing glaucoma monitoring in the community (FTN, 2005b). These are tentative, primary-care led movements, but they signal a more substantial appetite for expansion.

From a systems perspective, FTs may not always be the right organisation to provide community services. As their acute business will always be more important to their financial viability within the current tariff system, managers and professionals working for FTs will be incentivised to maintain the flow of patients into hospital, rather than engineering a shift out of hospitals. Community hospitals or polyclinics run by
independent and voluntary providers, PCTs or partnerships of primary care professionals may be better motivated to improve health and reduce hospital admissions. There are also risks around creating over-sized providers that become disproportionately powerful and less competitive. For patients, there could also end up being less choice of provider, with supermarket-style super-hospitals with ‘metro’ branches monopolising the market and squeezing out smaller local interests. These questions of market regulation remain to be addressed.

4. Total vertical integration?
The White Paper opens up opportunities for new and existing providers to bid for primary care practice contracts in under-provided areas or where quality and satisfaction ‘triggers’ indicate a failure of current services. FT provider-commissioners would create a closer parallel with the vertically integrated Kaiser model. With a fixed-pot commissioning budget, FTs would have full scope to plan and implement integrated care, and with the ability to retain surpluses they would be motivated to develop the most efficient configuration.

FT involvement in first-stop primary care gatekeeping would raise fundamental questions about secondary care monopolies and conflicts of interest. Applying the integrated model to the NHS would conflict with the economic orthodoxy of separating the primary care purchaser and secondary care provider. Although the White Paper blurs the lines, with continued provision by PCTs and encouragement for practices to offer more services in-house, the total vertical integration from gatekeeping to specialist care might reduce the incentives for secondary care efficiency as hospital consultants would expect to be employed by feeder practices.

The evidence of vertical organisational integration shows it does not necessarily result in the delivery of more integrated care, particularly where divisions and rivalries exist between groups of staff and managers. Despite some successes, vertical integration in the US led to significant losses for most systems due to factors including acquisition costs, lack of productivity and incentives, opposing objectives, clinical disengagement and diseconomies of scope and scale. Experiments in the UK in the 1990s were similarly disappointing (Fulop et al, 2005). In fact, integration can lead to instability and delay organisational development. Monitor’s guidance to Foundation Trusts seeking to merge is relatively sceptical about the value and effectiveness of historical mergers in the NHS, and in effect requires merging FTs to re-apply for FT status as a new organisation (Monitor, 2005).
5. The limits of the Kaiser lessons

As Fulop et al (2005) conclude there may be more important ways to integrate patient care than at an organisational level. Formal and informal clinical integration through networks were more significant factors. Within organisations, clinical services and back-office and functions could also be integrated. Success factors include both systemic integration of rules and policies, as well as normative integration of shared values. They warn that the first lesson for policy and practice should be “don’t start by integrating organisations.” The historic divide between primary and secondary care practitioners dates back to the compromises when Aneurin Bevan had to “cobble together” the “fiercely independent consultants, general practitioners and their professional societies, who were ready to keep the NHS from happening” (Light and Dixon, 2004). This entrenched cultural divide needs to be tackled, but cannot be wished away by organisational change.

A fuller reading of the reasons for Kaiser’s success also suggests that total organisational integration is not the only key to success and may not be transferable to the NHS.

Kaiser’s membership base is not universal – Kaiser can target the ‘best risk’ groups in their marketing. People join to managed care in order to benefit from lower costs compared to mainstream insurers, and are therefore more likely to estimate their own risk as lower. Moreover, Kaiser’s recruitment and selection process screens out professionals who do not buy into the managed care philosophy. By contrast, the NHS has been under-staffed since training places were cut back in the 1980s, so professionals tend to choose employers rather than the other way round. The NHS has to accept all comers including high risk patients and people who have not ‘signed up’ to a programme and may be less co-operative with a more managed model of care (Shapiro and Smith, 2003; Donaldson and Ruta, 2005). The outcomes of the Californian population who are uninsured or under-insured, or who are impoverished by insurance premia, tend not to be included in evaluations of the efficiency of Kaiser. Overall the US health system is less efficient than the NHS, achieving poorer health at higher cost.

Light and Dixon (2004) cite the development of whole-system clinical governance as a key precedent for integrated care. They may be too quick to blame Ministers and civil servants – the new consultant contract they criticise was, after all, hard-won by clinicians. Light and Dixon’s – and Donaldson and Ruta’s (2005) – recommendation is to look north of the border for lessons on clinical integration. Handing over
integrated health to trans-specialty clinical boards and trans-sector management teams, as in Scotland, is hoped to overcome internal schisms. But whilst it is important to ensure that the British health systems learn from each other, all four countries' reforms are currently 'unproven.' Health policy divergence is deeply embedded in national mindsets and institutions, political and policy legacies that cannot be transferred with ease (Greer, 2005). This lesson applies equally to cherry-picking policies from the USA.

6. Conclusion
The question of integration still presents important challenges for the English health system. The answers may lie not in emulating the organisational structure of the Kaiser system, which is dependent on a non-universal and less equitable health system, but in integrating cultural values, engagement and shared purpose that ensure professionals and patients work together to improve outcomes, efficiency and equity. As Shapiro and Smith (2003) proclaim, “the challenge is to recreate the sense of pride and identity in the NHS” – although this may be a rose-tinted view of a golden age of altruistic professionals and a fully engaged public.

The concept of 'membership' by staff and professionals is being explored through Foundation Trusts, but the key would seem to be establishing that buy-in across primary and secondary sectors. The success of Kaiser’s managed care model is in part due to co-production by patients who commit to the ethos and manage their expectations. Patient and public engagement through choice and voice will be important to engage people in their health and care.

Better aligned incentives for primary and secondary care to work together for a common aim will remain key to more integrated care. Stronger commissioning by PCTs and primary care practices should be the most effective method for integrating care pathways from the bottom-up. Patients should be more involved in setting and evaluating commissioning objectives. They are best placed to feed back on how well care pathways are designed around their needs. Regulation should also focus more on pathways rather than individual organisations. Refinements to primary care tariffs that encourage co-operation and benefit-sharing between commissioners and providers, including year of care budgets, are being considered. The concept of in-kind individual budgets for some long term conditions was rejected, but could have created stronger incentives for joined up care. The White Paper sets a high ambition, but the details of implementation will be the test.
Questions for discussion

- What are the goals of integration – from systems and patients' perspective?
- To what extent is organisational integration desirable? What are the costs and benefits?
- How can integration be achieved from the bottom up, by commissioning and extended primary and community care?
- How can integration be achieved from the top down, by partnership or expansion by Foundation Trusts?
- What are the trade-offs between different options?
- What other levers can create virtual integration for patient-centred services?

References

- Foundation Trust Network (2005b) NHS Foundation Trusts… Making a difference London: FTN.

ippr discussion note by Joe Farrington-Douglas February 2006

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