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Can competition and integration co-exist in a reformed NHS?



Key points

- There is some consensus among National Health Service (NHS) researchers, managers and clinical leaders that increased integration within the health system will enable the NHS to respond better to the growing burden of chronic illness.
- The current government's planned reforms to the NHS in England aim to integrate clinical and fiscal accountability for the health of a registered population in clinical commissioning groups. But there is some concern that reform policies intended to extend competition and increase choice will impede the evolution of integrated service delivery models.
- The elements of policy design and implementation that may be most critical for fostering development of integrated service delivery include:
 - development of bundled provider payment currencies by the NHS Commissioning Board
 - flexibility in the NHS Commissioning Board and Monitor regulations and guidance for clinical commissioning groups to allow local innovation
 - specialist procurement support for clinical commissioning groups to assist them to design tender specifications and contract models that permit longer-term relationships and flexible, innovative partnerships that share risks and rewards.
- To ensure the NHS has the potential to foster integration of care along pathways or for particular conditions or individual patients, the NHS Commissioning Board and Monitor must have a shared vision for developing bundled provider payment currencies and measures for efficiency, quality and outcomes of pathways.
- To create conditions to allow integrated provider organisations to emerge, the NHS Commissioning Board and Monitor will need to create opportunity for experimentation, feedback and learning in their regulations and guidance.

Introduction

There is some consensus among NHS researchers, managers and clinical leaders that increased integration within the health system will enable the NHS to respond better to the growing burden of chronic illness. To some extent, this consensus is based on international evidence of high performance in systems which integrate some or all of:

- commissioning and provision functions
- primary and secondary care
- community-based and hospital services
- health and social care (Curry and Ham 2010; Suter *et al* 2009).

Some high performing integrated systems have ‘real’ vertical integration of service delivery along a care pathway within a single organisation. Others have ‘virtual’ or contractual vertical links among commissioners and groups of providers.

Curry and Ham (2010) suggest that there are three levels of integration:

- macro-level or systems-level integration, in which a single organisation or network takes full clinical and fiscal responsibility for the spectrum of health services for a defined population (for example, Kaiser Permanente or the Veterans Health Administration in the United States)
- meso-level integration of services for patients with particular conditions, which encompasses a continuum of care for a subset of patients with those conditions – this sometimes involves integrating health and social care
- micro-level integration, which entails the co-ordination of care for individual patients and carers with complex needs.

The complexity of health systems is such that there is no firm empirical basis for advocating a particular integrated service delivery model in all circumstances. However, there is a good case for policy that permits and encourages evolution of integrated arrangements (Curry and Ham 2010; Suter *et al* 2009).

Service re-design initiatives in the NHS are already attempting to address poor co-ordination along the continuum of patient care and inefficient use of resources across boundaries between institutions and funding streams. However, Ham and Smith (2010) note that the pilot integrated care organisations in the NHS in England have identified perverse incentives and procedural barriers to integration arising from existing policies that support competition and choice. These include:

- incentives for hospitals to expand inpatient activity under Payment by Results
- the stronger focus of foundation trusts on their ‘bottom lines’
- the principles and rules of the Co-operation and Competition Panel (CCP)
- divestment of community services from primary care trusts (PCTs)
- aspects of the procurement guidelines for NHS commissioners.

A key part of the Secretary of State’s rationale for extending GP commissioning in the reforms introduced by the Health and Social Care Bill 2011 is to integrate clinical and fiscal accountability for the health of a registered population. This is one of the defining characteristics of integrated care organisations and networks in the US context (Shortell *et al* 2010). The Secretary of State has affirmed repeatedly that he wants the reforms to encourage integration and improve care for people with chronic illness. But many participants in the public debate on NHS reform have voiced concern that reform policies intended to extend competition and increase choice will impede the evolution of integrated service delivery models. It is not yet clear how incentives for co-ordination

across institutional boundaries could be preserved or enhanced alongside policies that expand choice and increase the range of services covered by activity-based payment based on the national tariff. The NHS reforms may create new integration challenges by introducing new fault lines, such as the separation of commissioning for core primary care services, public health and community and specialist health services.

This paper discusses evidence and examples of the relationship between competition of different types and integration of service delivery. It seeks to identify levers and institutions that might emerge as drivers of integration under the reforms of the NHS in England and policies that may foster integration and mitigate risks of increased fragmentation.

Service integration and the nature of competition

The effect of competition on the development of integrated service delivery arrangements depends on the nature of competition. The CCP distinguishes two major types of competition that can have very different implications for patient choice and service integration.

- Competition *for* the market – commissioners use competitive tendering to select and contract a single provider or a limited menu of providers of a service for a given patient population. This has been the main mode for introducing new service-delivery arrangements under practice-based commissioning to date.
- Competition *within* the market – patients and referring doctors choose among competing providers who meet NHS safety and quality standards and are willing to accept NHS prices and contract terms (so-called ‘any willing provider’ or ‘any qualified provider’). In principle, an integrated provider or network could offer packages of services to patients and doctors under this form of competition. Patients or referring doctors who value a more co-ordinated, seamless service can choose an integrated provider for all of the care along a pathway. But under the existing Payment by Results regime in the NHS this mode of competition offers acute providers little reward for co-ordinating patient care across episodes or organisational boundaries, or for investing in, or collaborating with, services that prevent admissions. This scenario is similar to the case-based payment methods used in many social and private insurance systems.

Competition for the market

‘Competition *for* the market’ can encourage co-operation and information-sharing among providers along a patient pathway. Providers need to co-operate to put together joint bids and, after initial market testing, the successful bidders will be obliged to work closely together under some form of shared-management or lead-provider arrangement to deliver the pathway. A strategic view of a desired integrated service-delivery model and a defined range of patient choice can be built in to the tender specifications and the award process (for example, a minimum number of providers might be specified for some stages of the pathway to ensure patient choice). The contract could require the winning bidder to permit additional qualified providers to join the provider network on agreed terms. In this type of procurement process, service re-design around disease-based pathways or particular patient groups is undertaken by the commissioners before the tender is launched.

A study of NHS commissioning of integrated care conducted by Ham *et al* (2011) found a small number of recent examples of PCTs using this approach to developing integrated service delivery for particular conditions, including diabetes, cardiac problems and chronic obstructive pulmonary disease. This study and reviews of the 16 organisations piloting integrated care in the NHS in England have identified several challenges associated with tendering for integrated service provision.

- The service re-design and tender specification process is costly, lengthy and requires extensive consultation and provider engagement.
- The time investment by clinicians is not always rewarded. Clinicians involved in service re-design work are often energised and well informed because of their interest in delivering the new service model. However, those who are engaged in designing the tender may be precluded from bidding to provide the service by safeguards against conflict of interest in procurement.
- It is difficult to work out in advance enough detail of an innovative service delivery model to get the tender specification right first time. Learning and adjustment is usually needed during implementation.
- Fears that discussing costs and benefits in the pre-procurement process could contravene the CCP's principles and rules have led to caution on the part of commissioners and providers.

However, the rewards for integration can be high. Studies of the use of competition for the market by US Medicare found potential for substantial cost reductions and quality improvement through competitive bidding for packages of care (McClellan 2011).

EU and national public procurement law and the Department of Health's *Procurement Guide for Commissioners of NHS-funded Services* (2010a) provide immense flexibility for procuring innovative services and for managing uncertainty and risk. Tender specifications can be framed flexibly to focus on objectives, outputs and results as much as possible. This leaves bidders space for innovation, learning and adjustment during contract implementation. Partnership-oriented contracts are permitted, with the financial risk shared between commissioner and providers. Under this type of contract, more of the service re-design work would be carried out by the provider after the tender is launched. This can mitigate conflict of interest concerns. It also enables these providers to benefit from innovating and improving services. But it means that clinicians may have to choose between participating in commissioning and participating in the provider side of tenders. Where clinical commissioning groups want *all* of their member GP practices to participate in a new integrated service delivery arrangement, GPs may have to hand over key commissioning decisions and oversight of contract management to the lay members and out-of-area nurse and hospital specialist members of the commissioning groups' board in order to avoid conflict of interest. This would surely defeat the purpose of clinical engagement in commissioning. By contrast, in high-performing integrated service delivery organisations in the United States the very same clinicians who provide services are engaged in service design, quality and resource management and oversight of performance.

The handful of NHS examples where procurement flexibilities are being used to develop integrated care demonstrate that the challenges are not insurmountable and point to enabling factors that could be fostered by supportive policy and NHS leadership (Ham *et al* 2011). This type of procurement requires sophisticated, specialist, skilled procurement support for commissioners. In practice, experienced procurement advice is scarce within the NHS and there seems to be a culture of undue caution about the use of these flexibilities. It also requires:

- close collaboration between procurement and clinical and technical expertise throughout all stages of the commissioning process
- co-operation among primary, hospital and community care.

Competition for patients within the market

The last Labour government introduced more patient choice for elective referrals to specialists. The current coalition government's policy on choice envisages extending the scope of competition within the market through patient choice of any willing and qualified provider at multiple points on the patient pathway. This will be underpinned by expanding the scope of tariff-based payment for activity (Department of Health 2010b). There would be no need for a tender process: existing and new providers willing to meet the commissioner's price offer, the Care Quality Commission's (CQC) quality and safety standards and Monitor's licensing requirements would be free to offer services to NHS patients and bill their commissioner.

If patients are offered choice for narrow components of service under this type of competition – each outpatient specialist referral, intervention, hospital admission or community care service – and providers are paid per unit of activity, fragmentation is likely to increase and the costs of care co-ordination will rise. Providers will have little incentive to participate in integrated service delivery arrangements if these threaten to reduce their activity or shift care to another provider.

Payment strategies supporting choice among providers of integrated pathways

Patients could be offered choice of integrated providers of a whole pathway or a year of care for a chronic condition. Bundled provider payment currencies and tariff payments – that is, payment covering all the providers involved in delivering whole pathways or years of care for patients with chronic conditions – could support this. Commissioners could contract with a lead provider for bundled packages of services, or networks of providers could form joint legal entities to manage contracts for bundled packages of care. However, providers are likely to find competition *within* the market for bundled service payments by any qualified integrated provider more risky and less attractive than a secure multi-year contract offered under 'competition for the market'.

New providers of integrated services would need to find a way to finance and recover the substantial up-front costs of developing an innovative service. This would be difficult under short-term any qualified provider contracts with no guarantee of volume. Private providers would be reluctant to do this unless they perceive reasonably stable, predictable conditions and have confidence that NHS prices will be maintained at levels consistent with achieving private sector target return on investment. The risk of policy reversals, uncertainty about price regulation and the context of prolonged fiscal constraints create unattractive conditions for private provider entry and expansion of choice. If commissioners want to foster development of new integrated provider networks that bring about major change in how care for a particular condition or patient group is delivered, tendering is likely to be a more effective mechanism. On the other hand, where commissioners and providers have already agreed pathways for particular conditions or patient groups, bundled currencies and bundled tariff payments could provide a more supportive financial environment for implementing the pathway than existing Payment by Results currencies and tariffs.

Medicare and some private managed care organisations in the United States are now giving priority to developing new provider payment currencies to support integrated care. They are investing in development of bundled payments for care pathways – episode treatment groups. Payments for whole care episodes and year-of-care payments for some chronic conditions have also been piloted in disease management programmes in Sweden, Germany and the Netherlands as well as in the UK. The NHS is developing a bundled payment currency for mental health services. To date, experience and evaluation of bundled payments has been confined to pilot schemes for selected conditions and

patient groups. Most of the pilots built in measures of efficiency and quality that are reported at the condition level. Some pilots pay bonuses or penalties based on these measures. In the United States, a major barrier to implementation of integrated care is the unwillingness of most patients to accept constraints on choice of provider and of most providers to shift away from fee-for-service payment. Some integration pilots combine free choice and fee-for-service payment with additional incentives for integration through contracts that share savings or offer bonuses or penalties based on indicators of efficiency, quality and outcomes of care across the whole episode.

Enthusiasts for these reforms argue that paying providers a capped price for a whole pathway together with monitoring for quality and efficiency will lead to value-based competition. This would drive clinical and financial integration within provider groups around management of particular conditions (Porter and Teisberg 2006). But there are very complex technical issues to be worked out before these new payment models can be scaled up to cover a wide range of care. The challenges are less significant for conditions where:

- there are well-established clinical guidelines
- there are well-understood service patterns
- disease progression is reasonably predictable
- it is not too difficult to attribute accountability to the providers involved.

These factors tend to be easier for acute episodes of care than for many chronic conditions. The operational requirements for implementing these payment methods – information systems, monitoring and data audit – are very demanding (Pham *et al* 2010; McClellan 2011).

For the growing share of elderly patients with multiple conditions, competition around pathways could carve health services into multiple vertical slices that manage care one condition at a time. Although co-ordination would improve along each pathway, new forms of fragmentation across pathways for different conditions could make care less holistic and harder for the patient to navigate (Ham 2007). Although there is widespread consensus that existing payment methods work against optimal management of care for chronic illness, there is a lack of innovation and development of new payment models for these services (Tynan and Draper 2008).

Bundled payments may help the US health system to address problems of extreme fragmentation and excessive activity. But in the NHS and similar public health systems with many large, locally dominant providers, competition to manage particular pathways or conditions might require a combination of horizontal unbundling of some patient care from hospitals and general practice and vertical re-bundling of care for that condition across different care settings. The international experience with pathway-based payment currencies and performance measurement tools may well be helpful in the NHS for commissioning some priority conditions. But it is not yet clear that pathway-based payment will develop into a new paradigm for payment of care for chronic illness, particularly for the elderly. It will take a great deal of experimentation and evaluation for the NHS to determine the right mix of horizontal and vertical management of service delivery, beginning with conditions and patient groups that are most likely to benefit from stronger vertical co-ordination along a pathway and are least reliant on co-ordination of care for multiple conditions and needs.

Payment strategies for competition among integrated delivery systems

Some researchers of US health systems see episode-based payment as a transition from their current context of highly fragmented care and pervasive fee-for-service

reimbursement, but not as an ideal end-point. Their preferred future scenario involves most providers joining integrated provider networks or integrated delivery systems that take clinical accountability for the continuum of care for a defined patient population and are paid capitation accompanied by performance-related pay (Pham *et al* 2010) Integrated delivery systems combine commissioning and provision in various ways:

- in a single organisation, such as Kaiser Permanente in California
- in close contractual partnership between a health plan and a network of health care providers, such as Geisinger Health System or Intermountain Healthcare
- in groups of medical practices that take on some delegated commissioning functions from a variety of health plans, like many medical groups in California.

Ham and colleagues (2011) have commented on the potential benefits achieved by some high-performing US integrated groups that combine commissioner and provider functions in this way. Being able to take ‘make or buy’ decisions gives them greater freedom to find the most efficient way of achieving:

- alignment of financial incentives
- clinical engagement in service re-design
- co-ordination across care boundaries
- shared accountability.

Is this more ambitious form of integration – a capitation contract with an integrated provider network for comprehensive health services for a registered population – feasible with competition in the NHS, either through competitive tender or through choice of any qualified integrated provider network? There are passing references in the Department of Health consultation documents to this type of integration; for example, in *Liberating the NHS: Legislative framework and next steps* (2010c). In the main, the NHS reform consultation documents and the draft Bill suggest a very different vision of choice, provider payment methods and competition in the provider market. It is difficult to discern a vision for the development of integrated delivery systems in reforms that separate primary care and secondary care commissioning and reinforce the commissioner–provider split.

Will competition law and economic regulation hinder or encourage integration?

Competition law and NHS providers

Much of the public debate about the Health and Social Care Bill 2011 has focused on proposals to give Monitor a duty to promote competition (where appropriate) and to apply national and EU competition law to foundation trusts. Under the revised reform proposals that the government announced in June 2011 in response to the NHS Future Forum’s report on the Bill, NHS competition reforms will be more incremental. Monitor’s primary duty to protect and promote patients’ interests will not now be overlaid with a duty to *promote* competition. The emphasis in Monitor’s competition role will instead focus on prohibiting behaviour that prevents, restricts or distorts competition contrary to the interests of NHS patients. This revised formulation of Monitor’s duties will mirror the language of competition law, instead of using more activist pro-competition language modelled on legislation governing economic regulation of the privatised utilities.

Under these latest proposals for reform, the existing CCP principles and rules, which mirror competition law provisions, may be given firmer statutory footing and the CCP will become part of Monitor. This means that the CCP will continue to review mergers between NHS providers and investigate complaints about anti-competitive conduct

and procurement complaints about NHS organisations. But whereas the CCP's current role is to give advice to the Secretary of State, in future the CCP will advise Monitor's board. Monitor and the competition authorities will make decisions on NHS providers independently of the Secretary of State. Monitor will have concurrent powers with the OFT to respond to complaints about anti-competitive conduct or abuse of a dominant position in the NHS. Monitor and the Competition Commission will have power to conduct market studies. Shifting the NHS processes for competition policy from administrative and advisory to formal and independent processes under Monitor and the competition authorities may lead to more rigorous scrutiny of merger cases and investigation of complaints. The NHS will be challenged to increase the robustness of the evidence presented in cases that undergo review.

The government has also now decided to require Monitor to support integration of services where this will improve quality of care or efficiency, though it will be the responsibility of commissioners, rather than Monitor, to promote integration. Monitor will be expected to determine the best trade-off for patients and taxpayers between competition and integration. This new requirement is a response to widespread NHS perceptions that competition law would have prevented integration and co-operation. Outside observers might be puzzled by this and argue that the requirement is redundant. Vertical links, long-term contractual relationships and exclusive agreements are pervasive in the private sector. In market-based health systems where providers are subject to competition law, vertical integration and vertically linked networks of providers have been allowed by the competition authorities where the arrangements are intended to improve quality and efficiency.

An indication of how our competition authorities treat agreements among integrated health service networks can be found in the guidance the Office of Fair Trading has issued on vertical agreements. This provides some reassurance that a very wide range of agreements between providers along a care pathway would not be subject to review unless they also involve horizontal integration or restrictive agreements that could reduce or distort competition (Office of Fair Trading 2004). Where vertical mergers or vertical agreements are reviewed, the Office of Fair Trading and the Competition Commission apply a cost-benefit or public interest test. In principle, these are the same criteria good commissioners should apply to proposals for service re-design. The competition authorities also consider market failure and appropriate policy and regulatory responses to market failure when they analyse sectors like health. But there is bound to be debate and disagreement about how to apply a public interest test to competition issues in a sector as complex and fraught with market failure as health – in which there is limited evidence of optimal organisation of services or economies of scale and scope, and where technological change can rapidly overtake yesterday's evidence.

The approach the CCP has taken to date to integration of health services suggests that the NHS can expect some continuity. Although it has reviewed only a small number of cases, the CCP has already supported cases of vertical integration of an acute trust with primary and community health services, sometimes with conditions attached to protect the primacy and professional independence of the GP referral role. Taking into consideration the benefits of generating evidence through piloting, the CCP has recommended approval of the one pilot integrated care organisation it has reviewed to date.

Another indication of how the CCP, Monitor and the competition authorities might approach health service integration in the NHS in future can be found in the United States, which has competition law rather similar to ours. 'Virtually integrated' provider groups and health plan-provider networks linked by contracts have generally been upheld by the Federal Trade Commission (FTC) and the US courts, as long as the arrangement is intended to increase clinical or financial integration and there is adequate competition from other groups or health plans. For a long time, the FTC has published

guidance making clear that it will support efforts to reduce fragmentation and increase efficiency. US competition authorities have consistently upheld the right of hospitals to enter into co-operative, often exclusive arrangements with clinicians and clinical groups, as long as they do not dominate local service provision (US Department of Justice and FTC 1996; Gaynor and Vogt 2000; McClellan 2011). A similar approach could be adopted in England with large-scale demonstration projects of integrated care being pre-approved by the new Monitor.

Although regulators ultimately uphold efficient integration, providers and professional bodies in the United States complain that competition regulation leads to caution and uncertainty over innovative integrated network agreements, resulting in costly case-by-case adjudication of novel arrangements (Jost and Emanuel 2008). But recent anti-trust decisions, FTC publications and workshops engaging with providers, and development of guidance on structuring clinically integrated networks have gone some way towards mitigating these concerns (Shields *et al* 2011). Even so, federal policy makers saw a need to counteract the risk of competition law deterring and delaying integration. The Affordable Health Care for America Act 2009 seeks to foster integration by authorising Medicare to forge agreements with accountable care organisations (ACOs), which will take some fiscal and clinical responsibility for a registered or attributed patient population. The Act gives powers for Medicare to grant waivers from some anti-trust and other legislative provisions to approved ACOs. This includes waivers of laws banning gain-sharing between providers and self-referral to organisations in which the doctor has a financial stake. The *quid pro quo* for ACOs will be alternative forms of regulation by Medicare (Greaney 2010).

To date there has been no discussion about the need for other provisions in the Health and Social Care Bill that could, for example, permit Monitor and the NHS Commissioning Board to grant waivers to clinical commissioning groups wishing to pursue larger-scale integration or long-term contracts from being subject to challenge under competition rules, choice policies or procurement guidelines. The government's recent revision to reform proposals suggests there may be potential for the NHS Commissioning Board, in conjunction with Monitor, to give guidance on how services could be bundled or integrated. This type of guidance could give commissioners and providers greater confidence that the particular integrated arrangements covered by the guidance would be supported by Monitor. But there is a balance to be struck. Central guidance supporting particular models of integration may be interpreted as a restriction on other local service delivery innovation.

Economic regulation

The Health and Social Care Bill will give Monitor new economic regulation responsibilities for NHS providers, analogous to those of utilities' regulators: price regulation and powers to ensure continuity of essential services. One important difference between the NHS and the regulated utilities (with the partial exception of railways) is that the NHS is financed almost entirely by public money. Monitor will therefore have to seek the agreement of the NHS Commissioning Board – the agency responsible for managing NHS expenditure within budget – to the regulated price tariff. NHS providers and commissioners will have rights to object to the tariff and if enough objections are received, Monitor will refer the tariff to the Competition Commission for review. The CCP and Monitor will presumably consider costs and benefits to *taxpayers* as well as patients in their reviews and decisions, just as the CCP does now under its existing principles and rules. In conjunction with the NHS Commissioning Board and the Provider Development Agency, Monitor will have to work through the legacy of poorly understood cross-subsidies in NHS pricing, standard contracts and brokerage agreements that obscure the underlying financial position of many NHS trusts. An aggressive push to

reduce cross-subsidies and extend the scope of the tariff would be destabilising, the more so if there is also an increase in the scope of patient choice in the NHS. The NHS has long faced a trade-off between short-term financial stability and incentives to improve efficiency and shift care to more effective, higher quality settings. In the past, the fiscal climate facing the NHS for the next five years would have led the NHS to opt for stability. These are inauspicious circumstances for launching an independent price regulator, with or without an emphasis on competition. There has not yet been any discussion about the need for a longer transition path to full implementation of the price regulation provisions of the Bill.

The role of commissioners

The government does not intend competition law to apply to the NHS Commissioning Board and clinical commissioning groups. Monitor's competition-related powers over commissioners would be limited to acting on complaints of anti-competitive commissioning behaviour and ensuring that commissioners comply with national and EU procurement law. However, the single most important function Monitor will exercise over commissioning will be that of setting the national tariff, in agreement with the NHS Commissioning Board. The national tariff document will be much more than a price list. It will set rules for pricing services not covered by the tariff and provide rules on local flexibility to modify the tariff. It is likely to regulate bundling and unbundling of services covered by the tariff. Similarly, Monitor will have important influence on the NHS Commissioning Board's development of payment currencies. In these roles, Monitor and the NHS Commissioning Board are likely to have considerable independence from the Secretary of State.

Commissioners will play a much larger role in driving patient choice and competition than Monitor. The government's revised reform proposals will strengthen the role of patient choice and also of the NHS Commissioning Board in issuing guidance to clinical commissioning groups on choice, competition and procurement. In response to concern that choice and competition might fragment care, the government now also proposes to introduce a duty for clinical commissioning groups and the NHS Commissioning Board to promote integrated services within the NHS and between health and social care, alongside a requirement for Monitor to support this. It seems likely that the revised Health and Social Care Bill will leave it to the new NHS organisations to work out how to achieve some coherence and balance between the choice and integration imperatives.

The Health and Social Care Bill's provisions for regulating commissioning will be much more important drivers of competition than its provisions for the role of the CCP, Monitor and the competition authorities in the NHS. The mix of different types of competition discussed earlier will be determined by:

- regulations on public procurement
- the Secretary of State's mandate to the NHS Commissioning Board which will set out expectation on patient choice
- the provider payment currencies developed by the NHS Commissioning Board
- the national tariff document produced by Monitor
- NHS Commissioning Board commissioning guidance on choice, competition and procurement
- standard contracts.

The incentives created by provider payment and contracting methods are among the most powerful drivers of or impediments to the evolution of integrated service delivery (Shortell *et al* 1994). The NHS Commissioning Board will be the key actor here. The

local flexibility that will be given to clinical commissioning groups is uncertain and, to a substantial extent, in the hands of the NHS Commissioning Board. The Secretary of State's mandate and regulations on the extent and form of choice and any qualified provider could be a significant constraint on the flexibility of the NHS Commissioning Board to develop currencies, payment methods and commissioning guidance conducive to integration.

Under the government's recent proposals to revise the Health and Social Care Bill, responsibility for determining the nature of competition and choice and the trade-offs between choice and integration will be divided among:

- the Secretary of State (in the role of setting the mandate for choice and competition for commissioners)
- the NHS Commissioning Board
- clinical networks and clinical senates, who will play a role in service pathway design
- clinical commissioning groups
- local authorities and health and wellbeing boards (particularly in relation to integration between health and social care)
- Monitor – and the CCP which will become part of it
- the general competition authorities.

If these key individuals and organisations have very different views on the appropriate role for competition and regulation in the sector and different judgements about the evidence of benefit of service integration, the risk of policy ambiguity, incoherence and regulatory uncertainty will increase. The formal mechanisms for resolution of differences have yet to be articulated. Regulatory uncertainty can be expected to deter private investment and entry of independent sector providers into the NHS.

How could integrated service delivery emerge in the future NHS?

Commissioners

Some practice-based commissioning groups and pathfinder consortia are interested in the development of integrated service delivery. Under current policy, the NHS Commissioning Board and clinical commissioning groups will not be able to provide any services in-house; they will not be free to take 'make or buy' decisions in the way that integrated provider networks can in the United States. Care trusts must choose whether to commission or provide, but may not do both (House of Commons 2011, para 981). Other authors have documented the benefits of permitting some integration between commissioners and providers to:

- align incentives
- share accountability
- foster clinician co-operation and engagement in service re-design and implementation of service improvement (Ham *et al* 2011).

Some alignment of clinical and financial responsibility could be achieved in the governance links between clinical commissioning groups and their member general practices. The 'quality' premium that commissioning groups will be able to earn by improving health care quality and outcomes and reducing inequality may strengthen these links if it can be used to reward member general practices for their contribution to effective commissioning. However, use of the premium will be governed by regulations yet to be drafted, and there seems to be an intention to ensure that GPs

do not benefit personally from it. Although clinical commissioning groups will have closer links to their member practices than PCTs have, there will be constraints on the freedom of commissioning groups to buy services from their own GPs. Conflict-of-interest safeguards for public procurement normally require arm's-length relationships where GPs want to participate in tenders for contracts for integrated service provision. Commissioning groups are unlikely to be free to enter into exclusive agreements with their member practices.

Even if the government were to allow clinical commissioning groups to 'make' as well as 'buy' services, the groups will not have strong financial incentives to integrate service delivery. The financial framework for commissioning groups – which is in essence the PCT financial framework – is not conducive to innovation or high performance in service delivery. Clinical commissioning groups will be within the Department of Health budget boundary. The NHS Commissioning Board will be the residual claimant on commissioning groups' surpluses and will have responsibility for financing their deficits. In addition, the NHS Commissioning Board will exercise wide-ranging powers over clinical commissioning group allocations, resource use, capital expenditure and cash management. Clinical commissioning groups and their member GP practices will not have the capital or asset base to finance major up-front costs or take major financial risk – necessary characteristics of successful, large integrated service delivery schemes. Existing examples of PCT commissioning of integrated care illustrate the potential for smaller-scale commissioning of integrated pathways and services for specific conditions and patient groups (Ham *et al* 2011). But the very small number of these examples points to the obstacles and lack of incentives for local commissioners to pursue integration.

Clinical commissioning groups will be able to foster integration through procurement-based commissioning for non-tariff services. However, as the scope of NHS activity covered by the tariff is expanded from its current share of around half of acute trust activity, the opportunity for commissioning groups to shape the market and innovate through design of tenders for services may decrease. Monitor and the NHS Commissioning Board could increase local flexibility for groups to commission integrated services by allowing them to bundle tariff and non-tariff services together where this is important for improving clinical and financial integration. The NHS Commissioning Board and Monitor could offer a menu of options for future payment currencies and payment terms from which commissioning groups can choose. The NHS Commissioning Board could create opportunities for groups to pilot contracting and payment options that are more conducive to integration. Providing these kinds of flexibilities could be one way for the NHS Commissioning Board to demonstrate compliance with its duty to promote autonomy for clinical commissioning groups. On the other hand, the NHS Commissioning Board and Monitor will want to retain national approaches to developing standardised metrics for use by all commissioners to monitor performance across pathways and population groups.

The NHS Commissioning Board's approach to guidance and Monitor's approach to regulating commissioning, will make a profound difference to the scope clinical commissioning groups have for local innovation and exercising leadership of local service re-design. If Monitor and the NHS Commissioning Board are very cautious about the risks of market failure, they may well want to constrain commissioning groups through more detailed regulation of local variation on currencies, tariff prices and contracts. If Monitor, for example, takes a restrictive approach to longer-term agreements and partnership contracts, the scope for commissioning groups to drive more integrated market structures through procurement would be more constrained.

Is it conceivable that the NHS Commissioning Board or larger clinical commissioning groups could move beyond smaller scale meso-level integration and attempt to develop fully integrated systems under capitation contracts with integrated provider networks to

deliver comprehensive health services? Could commissioning groups and their member general practices develop into integrated provider networks, combining commissioning and provision?

Although such approaches have been developed in the United States, there are major differences between the NHS and the US health system that make it difficult for commissioning groups and their member practices to link commissioning and provision and organise themselves as flexibly as US health plans and medical groups. Table 1 summarises some of these. To make the comparison as relevant as possible, the US comparator is the tax-financed health Medicare programme for the elderly, which allows the elderly to choose an integrated care plan offered by a health maintenance organisation (HMO) as an alternative to traditional fee-for-service Medicare.

Table 1 NHS-US differences in conditions for the development of integrated systems

England clinical commissioning groups	US HMOs providing integrated plans to Medicare	Implications
Clinical commissioning groups have to be statutory bodies, publicly accountable to parliament and locally accountable because of the discretion they have over public spending priorities and rationing. They have delegated responsibility for setting health priorities based on local needs. They have authority to use 'blunt' rationing mechanisms (for example, denial of care) subject to national guidance and performance management.	Medicare is managed by a government body, publicly accountable to Congress. Congress and an arm of the Department of Health and Human Services define national benefits in detailed regulation. HMO plans are held accountable under regulations and contracts. The capitation budget for HMO plans is based on actuarial costing. If blunt rationing is necessary, cuts have to be approved by Congress.	Medicare commissioning responsibilities are divided between core statutory functions managed by a government body, and functions which can be delegated to HMOs and integrated provider networks under regulations and contracts. This mode of accountability permits HMO plans to be given freedom to innovate in integrating health systems without the restrictions NHS commissioners face as statutory bodies .
If a commissioning group faces a budget shortfall, there is an implicit expectation that the NHS Commissioning Board will ensure resources are sufficient to maintain comprehensive, free services in the short term and replace the failing group's management in the medium term. The NHS Commissioning Board has rights to re-distribute any surpluses commissioning groups generate to help balance the NHS budget.	A HMO can exit the market for Medicare services if they cannot manage patient care within the capitation budget. In this event, Medicare patients and their doctors must transfer to another HMO or to traditional fee-for-service Medicare.	An individual clinical commissioning group does not have a firm budget constraint - it cannot be allowed to fail. As a result, commissioning groups cannot be given a high degree of financial autonomy. Clinical commissioning groups will have relatively weak and short-term incentives for efficiency.
Clinical commissioning groups cannot accumulate reserves to finance up-front investment in innovative service development. Their members are small businesses with a small and fragmented capital base. Their managerial and capital capacity is constrained.	HMOs can accumulate reserves and fully integrated delivery systems include large provider networks with a substantial asset base. They are well placed to invest in service re-design and systems that will yield benefits over a long-time horizon. HMOs have substantial management capacity.	It will be difficult for clinical commissioning groups to lead development of large integrated systems. Within the NHS, only the NHS Commissioning Board or large foundation trusts would have the scale and managerial and capital capacity needed.
Public procurement guidelines for avoiding conflict of interest limit the flexibility clinical commissioning groups can have to commission from their own GPs. GPs cannot participate in procurement and contract management of services provided by their own practices or organisations in which they have a financial interest.	Integrated provider groups can set their own procurement policies and enter into selective contractual agreements with physicians and providers. Clinicians in medical groups can engage in service design and participate in group 'make or buy' decisions. Medicare can grant groups waivers from competition law and laws banning self-referral and gain-sharing to increase clinical and financial integration.	Public procurement safeguards will prevent clinical commissioning groups from functioning like a US medical group, buying services from all of their general practices as well as engaging GPs in commissioning other services. Commissioning of services that involve all their GPs would need to be overseen by the non-GP members of the group's board or an organisation above the level of the group; for example, by the NHS Commissioning Board.

<p>Clinical commissioning groups will cover defined, non-overlapping geographic areas and will not compete with each other. Most patients will not face a choice of commissioner.</p>	<p>HMOs and integrated provider networks have overlapping geographic coverage, and often cover very wide geographic areas. Patients have a choice of integrated provider networks. They also have choice of HMO plans or traditional fee-for-service Medicare.</p>	<p>Because HMOs and integrated provider networks face competition, Medicare and the US competition authorities are less concerned about vertical agreements and exclusive relationships within these systems. The CCP and Monitor will be more cautious about permitting commissioner-provider links in the NHS because clinical commissioning groups could use their local monopoly of commissioning to restrict provider competition.</p>
<p>Most specialist doctors are salaried employees of large acute trusts. Integration across the primary-secondary care divide will usually involve agreements with an acute trust. Many trusts may be dominant in the local market for some specialist services.</p>	<p>Most specialists work in independent practices, often small partnerships or groups. These practices and groups have many potential competitors. Many specialists have admitting privileges in more than one hospital.</p>	<p>The NHS cannot easily emulate the multi-specialty group model that is the core of many US integrated provider networks. In many parts of the UK, integrated networks that link clinical commissioning groups to market-dominant acute trusts may trigger review by the CCP and Monitor.</p>

This comparison highlights that in the NHS context, the NHS Commissioning Board needs to play the key role in leading and creating the conditions for development of capitated integrated systems. Comparison with the United States also highlights that some major policies need consideration before the NHS could safely open the way to this type of integration. In many US states, specific regulatory regimes have been developed for integrated provider networks and other managed care organisations to ensure patients are not denied care as a result of incentives to minimise costs or ‘cherry pick’ low-risk patients. Patient choice of integrated care organisation is not regarded as a sufficient safeguard. Capitation contracts with integrated provider networks and internal agreements with the providers and professionals that make up the group are immensely complex, and feature increasingly sophisticated metrics for monitoring quality, efficiency, patient experience and health outcomes. Governance and ethical frameworks for integrated provider networks and other managed care organisations have been researched, debated among the professions and public, and are subject to regulation and guidance. Public and professional concern about profits being made from commissioning and providing health services is very evident in much of US health sector regulation.

If NHS commissioners want to delegate many commissioning functions to general practices and other independent provider groups, they will need to unbundle commissioning functions to distinguish those that must be carried out by a statutory body from those that may be delegated under contract to providers. There will also be a need for a more explicit regime for addressing legitimate public concern about how best to prevent profit-driven behaviour in health service commissioning and integrated service delivery through regulation, governance and ethical codes.

Clusters of GPs

Emerging pathfinder consortia are having to decide how to balance the benefits of scale (which increases capacity to take on clinical and fiscal accountability) with the advantages of small like-minded medical groups (which fosters agility, innovation, personalised service, effective professional collaboration).

Across most of the country, GP clusters underneath commissioning groups seem to be emerging as the organisations with the latter characteristics. It is not yet certain if the NHS Commissioning Board will authorise the smaller pathfinders as fully fledged clinical commissioning groups. Impediments to innovation arising from the legal and financial framework for commissioning groups may lead small pathfinders with a primary interest

in service re-design and co-ordination of care to conclude that they will be better able to pursue their goals as provider networks rather than commissioners. This could deprive commissioning groups of valuable input from some of the most engaged and able GPs (Ham *et al* 2011).

GP clusters could seek opportunities to expand their provider network and scope of services incrementally, through, for example:

- participation in clinical commissioning group and local authority tenders
- sub-contracting to other providers
- providing health and social services to patients holding personal budgets.

GP clusters with a small local patient population, a loose network of small providers with limited management resource and very small balance sheets do not have the profile needed for the development of integrated delivery systems of comprehensive care, such as those seen in the United States. Clusters are more likely to achieve success by building on the range of activity undertaken by GP fundholders and practice-based commissioning to integrate across primary, community and social care, and develop integrated services for pathways for conditions managed predominantly in the community (Smith *et al* 2004). If the NHS Commissioning Board were to pilot bundled currencies and payments for chronic conditions, for example, opportunities would increase over time for GP clusters to grow their businesses and partner with specialist and hospital service providers.

Foundation trusts

Some acute trusts and some independent sector NHS provider groups are in many ways better positioned, resourced and managed than primary care to establish and lead development of integrated provider networks in the NHS. Given the current structure of health service delivery, it is difficult to see in the near future any other route to development of comprehensive integrated delivery systems capable of taking risk and clinical accountability. Conceivably, in some major urban areas, a hospital-led integrated network could face sufficient competition to address potential competition regulation concerns. Many in the NHS would have concerns about hospital-led delivery systems. But a trust-led network does not need to be hospital-focused, if the role of non-hospital providers in the network and its governance and management arrangements are strong.

Conclusion

The provisions in the Health and Social Care Bill that will play the most important role in determining the form of competition and the financial incentives for service integration in the NHS are those that regulate commissioning. Policy design and implementation elements that may be most critical for fostering development of integrated service delivery include:

- development of bundled provider payment currencies by the NHS Commissioning Board
- flexibility in NHS Commissioning Board and Monitor regulations and guidance for clinical commissioning groups to allow local innovation, such as broader scope to use tenders for re-designed service delivery arrangements, flexibility to combine tariff and non-tariff services, and room for piloting innovative contract design
- specialist procurement support for clinical commissioning groups to assist them to design tender processes and contract models that permit longer-term relationships and flexible, innovative partnerships that share risks and rewards.

The role of the CCP, Monitor and the competition authorities in applying competition principles to NHS providers is likely to be a less important driver of the extent and nature of competition and choice in the NHS than the policies and regulations governing procurement, competition and choice in commissioning. If vertical mergers and vertical agreements among integrated provider networks become subject to scrutiny by the CCP, Monitor and the competition authorities, the analysis of the costs and benefits of business cases for these service changes will become more demanding for the NHS, but it should not stand in the way of genuine clinical and financial integration. Introducing a statutory requirement for Monitor to support integration where it would improve quality and efficiency may help to increase the confidence of NHS organisations to commission and develop integrated services.

The inertia created by the existing organisation of service delivery and organisational cultures may be the greatest hurdle to service re-design and innovation. NHS commissioners have been constrained in their ability to bring about change by their obligations to maintain financial stability in the local 'NHS economy'. By deepening the separation of commissioner and provider and assigning responsibility for the trust failure regime to Monitor, the NHS reforms reduce commissioners' responsibility for the financial well-being of NHS providers. This aspect of reform may make commissioners more willing to innovate and shift the locus of service delivery than they are now.

If the NHS Commissioning Board and Monitor are to create conditions to allow integrated provider organisations to emerge, they will need to create opportunities for experimentation, feedback and learning in the way they develop and revise regulation and guidance. Consideration will need to be given to what kind of commissioning functions can be delegated to integrated provider organisations under contract.

The emerging architecture of the NHS seems to have the potential to foster integration of care along pathways or for particular conditions or individual patients, provided that the NHS Commissioning Board and Monitor have a shared vision for developing bundled provider payment currencies and measures of efficiency, quality and outcomes of pathways. GP commissioning experience to date suggests GP clusters could provide the engine for smaller-scale integration for small patient populations for primary, community and social care and some minor specialist services. Groups or clusters of general practices on the provider side of the commissioner-provider divide seem to be more promising organisations to take the initiative in integration of service delivery than clinical commissioning groups.

It is difficult to see how larger-scale comprehensive integrated delivery systems could emerge in the NHS in the foreseeable future unless commissioners and Monitor are willing to allow acute foundation trusts to initiate such arrangements. The CCP and Monitor will review these arrangements using NHS principles and rules for choice and competition that mirror competition law principles. Monitor and the competition agencies could well have concerns about networks that have exclusive agreements with large, market-dominant hospitals. If integration would lead to an excessive market share for some services, Monitor may require some unbundling or divestment of trust services to reduce market power before allowing this kind of integration to go ahead. Or it might put in place heightened regulation to give competitors access to essential services. Where GPs participate in integrated arrangements, Monitor is likely to ask for additional safeguards to protect the independence of the GP's role in advice to patients on choice in referred services.

The provisions in the Health and Social Care Bill that could give rise to inefficient fragmentation and impede integration are those that regulate how commissioners purchase and pay for services, rather than those that apply competition law to NHS service providers. In these crucial areas, policy content will be set out in regulation and guidance. It is not impossible to imagine a scenario in which:

- a Secretary of State mandates choice of any qualified provider at multiple points on patient pathways
- the NHS Commissioning Board extends the scope of narrow activity-based commissioning currencies to cover a large share of hospital and community health services and makes only limited progress in developing bundled payment currencies for chronic illness
- Monitor gives local commissioners very little scope to commission outside of standard contracts and tariff.

The government's NHS reforms leave considerable latitude for policy to be shaped over time in very different ways by different Secretaries of State, regulators, the NHS Commissioning Board, clinical commissioning groups and the other bodies that will play a role in commissioning: clinical networks and senates, health and wellbeing boards. The reforms introduce a risk of future divergence of views among the multiple individuals and independent organisations that will make decisions affecting the role and type of competition and regulation in NHS commissioning and provision, and the balance between central and local action. Policy ambiguity and regulatory uncertainty will not be conducive to competition or integration of service delivery.

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