Editorial

Competition supports integrated care (?)

Early in October 2007, the International Network of Integrated Care (INIC) organized a study visit for a group of 75 Europeans to Kaiser Permanente (KP) in San Francisco, USA. Kaiser Permanente is a care organization that encloses a health insurance company (''Kaiser''), primary health care doctors and medical specialists (''Permanente''), and hospitals (''Kaiser Hospital Trust''). These three divisions work closely together and are exclusive partners. The 8.2 million insured persons of Kaiser all visit Permanente doctors and Kaiser Hospitals. Alan Enthoven was one of the KP hosts of the group of 75 Europeans. He is the inventor of the term *managed competition* [1] and editor of the recent book ''Toward a 21st Century Health Care System'' [2]. During the study visit he explained, ''The integration within KP of primary health care and hospital care and between prevention and treatment is devils driven: since the 1990s it is driven by competition. This also counts for the emphasis on self management by patients and the use of Health Information Technology''. Because of this devil, KP is now an integrated care organization delivering one third of the NHS admissions per 1000 persons above 65 years for x (?) chronic conditions [3]. So a (preliminary) conclusion could be: competition supports integrated care.

Then why is KP only concentrated in California? If the KP model is so competitive, why is it not disseminated to the rest of the USA and to European countries such as Germany and Holland that work with insurance companies, group practices and hospitals trusts? Alan Enthoven gives the answer [2]: ''Within the KP model the Kaiser insured persons have to go to the doctors of Permanente. Their free choice is limited. They feel limited because they think that competencies of individual doctors are more important than the integrated systems in which these doctors work. Above that, most doctors think in terms of prices per consult and not in terms of a whole program in which they play one of the professional roles''. Both arguments explain why the introduction of the KP model in European countries and the rest of the USA appears so difficult.

Are there other solutions to support integrated care by competition? In a competitive health services world, *selling points* of products and services are important. These selling points are arguments with which clients can be seduced, convinced or pushed to use the services. Sometimes these selling points are not the main purpose i.e. to promote health of the patients. For example: for health professionals, tobacco use reduction in teenagers is important to prevent cancer in the long run. However, this argument is not a selling point for the young boys and girls. It is better to argue that smoking is not sturdy and kissing a partner who smokes is like licking an ashtray.

It is not my first choice to create a competitive health world. There is a risk that providers are more driven by market share, returns and profits and not by solidarity, equal access for everyone and evidence based medicine. However, if this is the dominant trend, let's cope with it. If you can't beat it, join it. Let me explain here a theoretical competitive model to support integrated care.

The central or federal government in most European countries is selling health policy to decentral public agencies or insurance companies, for instance, to prevent chronic conditions. Often a central equalization funding exists to subsidize the poorer agencies or the agencies with more than average health needs. Is it an idea to give more money from federal sources to decentral agencies and insurance companies if they, for example, do more with patient education? In Germany it works [4]. There insurance companies which promote disease management programs, get more resources from the equalization fund.

Decentral public agencies and insurance companies are the payers of doctors and institutions. Nowadays they are in competition with each other. Often selling points for these providers are the single price of an operation, a nursing day or the fee of a single consultation. Organizations with an integrated care chain, for instance for diabetes-, COPD- or stroke patients, could compete by showing a lower overall price per chronic patient per year than in the usual care setting. They could sell their care program to patient organizations—that advise their individual members—with the argument of better continuity of care and their emphasis on patient education. Perhaps that is a better selling point than telling chronic patients that the long-term health care results are also better.

Facilities and doctors in integrated health systems also compete in this model. They must sell their preventive messages and their referrals to other professionals within a chain. They should not loose patients and income because of this. It is important to make a dis-

tinction in different types of services. If patients don't want to change unhealthy lifestyles, it is up to them. However, if they want to stop smoking, eating fast food and/or drinking alcohol they should get access to special programs and a certificate with which they get some financial stimulating incentives: for instance a lower co-payment rate for PHC visits, such as exists in Germany.

In Holland, many believe that competition frustrates integrating health services. I do not agree! Let us be devil driven as Kaiser Permanente was in the 1990s. We have better selling points for persons with chronic conditions than care as usual has, with our patient education, continuity of care, case managers and integrated patient health records, and to the financers, we can show the lower long run costs. If societies want competition in health services, they can get it, and we will win.

This editorial is the result of thinking after a visit to Kaiser Permanente and reading many papers about KP. I myself am involved with integrated care in Holland. I know there are many thoughts by colleagues about the relation between competition and integrated care. I would be very interested to hear your opinion. I therefore invite the readers of IJIC to react to this editorial and send me an e-mail at ijic@igitur.uu.nl.

Guus Schrijvers
Editor in chief of the International Journal of Integrated Care

References

1. Enthoven AC. The history and principles of managed competition. Health Affairs 1993; Vol 12, Supplement 1, 24–48.
2. Enthoven AC, Tollen LA, editors. Toward a 21st century health system: the contributions and promise of prepaid group practice. San Francisco: Jossey-Bass; 2004.
3. Ham C, York N, Sutch S, Shaw R. Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: analysis of routine data. British Medical Journal 2003 Nov 29;327(7426):1257.
4. Proceedings of the INIC conference Disease management in the European context: concepts, conditions, financing and quality of Disease Management Programmes in Europe; 2007 Jan 11–12; Bonn, Germany. Available from: http://www.integratedcarenetwork.org/.