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Is good healthcare a matter of competition or collaboration?

Anna Prenestini and Stefano Calciolari

1. Introduction

In the last half century, legislation in several countries has converged to establish a relevant role of the public subject in several sectors (e.g. railways, local transportation, education). Currently, the prescription of fixing major problems by treating such sectors in a more business-like manner is quite popular (Mendoza 2015). As far as healthcare is concerned, it is rare to find a Western country where the policy maker does not significantly limit this business with a heavy regulation and direct interventions in the financing and provision of services. Therefore, the recipe of fostering business-like dynamics has many champions in healthcare.

At this point, any physician could assimilate such a recipe to a drug prescription and legitimately ask: if this is the cure, what is the diagnosis? Anybody less knowledgeable about medicine may recall the answer of the Cheshire Cat to Alice's request: "Would you tell me, please, which way I ought to go from here?", "That depends a good deal on where you want to get to." If the "where" is not much of a problem, then uncertainty only concerns how long it will take to get somewhere. However, can patients wait until a reform will get the system somewhere?

The uncertainty around (and the burden of) any reform is sustainable if its changes, at the very least, are designed to address specific problems. Therefore, we suggest starting by summarizing the main challenges of advanced health systems and then providing recommendations about appropriate changes aimed to enable health systems to deal with such challenges.

2. A brief diagnosis: what are the priorities?

The uncertainty around health reforms orientation is partly due to a rapidly changing context in terms of both social pressures (Guidotti 2015; Resnik 2007) and financial constraints (Anessi Pessina & Cantù 2006; Lega & Calciolari 2012). This tends to generate a sense of urgency for major interventions but without suggesting priorities to shape a coherent vision.

Health systems are facing complex challenges largely driven by two main sector-specific catalysts: technological development (Anessi Pessina & Cantù 2006; Glendinning 2003), epidemiologic and demographic trends (Lega & Calciolari 2012).

The first driver, together with the rapid expansion of medical knowledge, is responsible for the major advances in medicine but it is also associated with the growth of clinical specialization and the consequential fragmentation of patient care in advanced health systems (Calciolari & Ilinca 2016; Lega & Calciolari 2012).

As far as the second driver is concerned, population ageing is a pervasive and enduring phenomenon with profound implications for healthcare – not to mention the social and political spheres (United Nations 2001). In 2015, over 16% of the population was 65 years or older in developed countries, a proportion which will exceed 22% by 2030 and approach 26% by 2050 (World Bank 2016). Ageing is closely linked to the prevalence of chronic conditions, which account for an overwhelming share of the total burden of diseases (WHO 2008). This epidemiologic trend is associated with emerging clusters of patients characterized by complex needs that cut across disease categories and medical specialties. Addressing such needs – belonging not only to a disease, but also to associated conditions, complications, and circumstances – calls for organizing care around the patient. This requires coordinated processes that might involve professionals from different disciplines, organizations and sectors to integrate all the resources (from simple information to concrete services) necessary for a single patient (Goodwin et al 2014; Porter & Lee 2013).

3. Is more business the appropriate cure?

On the one hand, technologic advances and medical knowledge expansion tend to orient health professionals toward pigeonholing and care fragmentation; on the other hand, patients need more and more cooperation among health providers and institutions.

In this situation, increasing competition between players does not help healthcare to accommodate the present growing needs. One might use the classic argument that competition contains costs. However, competition does not address the challenges of population aging and its associated argument is questionable.

Actually, in 2007 Bernasek (2007) pointed at the higher share of U.S. health costs dedicated to administration compared with the Canadian single-payer (i.e., much less business-like) health system; in 2015 the first evaluation of the introduction of a prospective payment system to finance Swiss hospitals – a competition-oriented reform with cost containment as one of its main goals (Consiglio Federale Svizzero, 2004) – did not show evidence of improved efficiency after three years of implementation (OFSP, 2015).

If we consider the previously depicted healthcare scenario, providing appropriate care (in terms of quality, patient satisfaction, effectiveness and cost-effectiveness) is a matter of collaboration between healthcare professionals and organizations. The cooperation between healthcare professionals takes different paths: multidisciplinary teamwork and collaboration between specialists of same discipline and/or different professions (e.g., between doctors and nurses).

As far as multidisciplinary teamwork is concerned, scientific literature shows important advantages associated with multidisciplinary cooperation in oncology. The systematic review made by Prades et al. (2015) found that teamwork communication and cooperation improve patient outcomes in terms of diagnosis and/or treatment planning, survival, patient satisfaction, and clinicians' satisfaction. This because team members work together toward a common goal: obtaining the patient's best outcomes as efficiently as possible (Porter and Lee 2013). They have specialized expertise, trust one another, and meet or communicate frequently to review data on their own performance. Based on those data, they work to improve care quality and outcomes, by establishing new protocols, devising better ways to empower patients (e.g., change behaviors, improve medication adherence) and their caregivers, change practices, reach out to other professionals, etc.

The cooperation between specialists of the same discipline and/or different professions can modify clinical practices and procedures, raise clinical standards and improve performance in terms of quality for patients. For instance, in 2001 two Italian healthcare organizations in the Emilia Romagna region (Santa Maria Nuova Hospital Trust and Local Health Authority of Reggio Emilia) observed a variability in the way that endoscopies were performed and in terms of completeness, accuracy, sedation, and comfort for patients. In 2004, the top managers of the two organizations asked their clinicians to collaborate together to develop an integrated and standardized approach to perform colonoscopies (Formisano et al. 2007). Moreover, a mass screening for colorectal cancer was to commence. A working group including 16 physicians, 8 nurses and one biostatistician (who were working in the two healthcare organizations and in 5 different hospitals) was trained in clinical audit. Both physicians and nurses actively participated to the pre-audit (run-in period), as well as in the audit, with the aim to establish common clinical standards and a single procedure for colonoscopies. After the implementation of the new procedure, important clinical targets were achieved by the professionals of each hospital (Formisano et al. 2007): for example, the crude rate of completeness moved from 87.7% (appraisal in 2003) to 95.7% (appraisal in 2006); adequate sedation was also more frequently used, from 51.1% (2003) to 94%

(2006). The experience is a good example of how cooperation between healthcare professionals can deeply modify practice and improve performances. Nowadays the cooperation between the two healthcare organizations has extended to other specialties, involving many different professionals. Similar approaches are applied in many cases of conversion of small hospitals, located in rural and/or remote areas, into health centers (Calciolari et al. 2015), where efficiency and effectiveness of care are of paramount importance. Here the cooperation involves the personnel of the new center, the primary care local actors, and the closest hospitals.

A more extensive form of collaboration consists of the development of networks involving health professionals, healthcare organizations, national and regional health departments. An interesting example is represented by the cancer networks created in several countries. These collaborative structures improve patterns of cancer care and outcomes for patients by: (a) the promotion of efficient and effective data collection; (b) the creation of common wide cancer repositories; (c) the implementation of supporting clinical audit (i.e., techniques of retrieval and appraisal of the evidence, identification of indicators and standards, etc.); and (d) the development of complex research programs.

Important conditions of the benefits associated with the described forms of collaboration are professional education, training toward cultural change, and investment in technological solutions enabling effective communication (especially when co-location of professionals is not possible or too expensive).

In general, providing appropriate care by reorienting services toward coordination and cooperation (or "integration") calls less for structural solutions and more for "soft" aspects. In the past years, different business-like approaches were used to direct professional behavior towards better quality and appropriateness of care (Adler and Kwon, 2009): ranging from hierarchical control, to economic incentives for achieving defined targets, to public disclosure of information on the quality of services provided by healthcare organizations and/or professionals, etc. However, managing such aspects through hierarchical control or performance-based accountability systems proved to be complex and not completely solve problems, due to the pervasiveness of care quality and appropriateness issues (Marshall and Davies, 2000). Clinical behavior can be changed and oriented toward desired goals by means of working on clinicians' attitudes, cultures, and the way they perceive their position and responsibility in their organizations.

As a consequence, academics and decision-makers have increasingly focused on clinical engagement: a change management approach leveraging on health professionals' willingness to actively participate and take direct responsibility in the decision-making processes of their organizations. Such an approach allows for working on aligning clinicians' interests with those of the organization to foster performance and quality of care (Spurgeon et al. 2011; Grilli et al. 2016; Gutrie et al, 2005; Lega et al. 2013).

Secondly, organizational culture – the apparatus of symbols, values, attitudes, and beliefs shared by the members of an organization (Davies et al. 2007) – is one

of the most important factors that promotes clinical practices fostering quality and contrasting issues of under- or over-supply, turf wars, and errors plaguing modern medicine (Roehr, 2011; Prenestini et al. 2015). As a consequence, healthcare organizations should focus on appointing top managers with the leadership style most apt to facilitate the growth of collaborative cultures and include cooperation among the learning objectives of their training programs.

4. Conclusions

Sometimes doctors may not have a clear diagnosis for their patients. In such circumstances, one may argue that integrating knowledge with experience and intuition – always keeping in mind the best interest of the patient – is reasonable and can help. Likewise, in the policy or management field, a rational approach to change consists of assessing the diagnoses, experience, intuitions (and interests) of reform champions. In particular, comparing and challenging the different diagnoses – and the evidence on which they are based – and distinguishing them from intuitions is a good premise to avoid reforms built on myths and mystifications.

In healthcare, the mere presence of (more) business-like models/practices is no guarantee to foster better performances. Further, if they are not coupled with change management approaches enhancing clinical engagement, multidisciplinary and multiprofessional cooperation, and integrated service delivery, any reform runs the risk of dismantling the good of health systems and hampering the best developments.

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