‘Integrated Care in England – what can we Learn from a Decade of National Pilot Programmes?’

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Roger Steer says; *‘The policy has no clothes…'*

What can we learn from a decade of national pilot programmes whose aim was to confirm the promises of integrated care is a good question. Unfortunately the question is asked of those who may be perceived as having a vested interest in stringing out the story rather than in delivering a “coup de grace”. At least the vested interests are clear.

The article appears in the International Journal of Integrated Care, which is unlikely, we may presume to publish something that undermines its raison d’etre.

Details of the authors’ competing interests tell us that they have succeeded in extending the brief for more than a decade.

All seem to have worked on projects funded by various parts of government to evaluate the projects about which they are now writing.

These studies are therefore, to my mind, belated and muted attempts to keep sufficient faith in this direction by generating hope that the policy is justified

While this gives them better access to materials than a non-aligned researcher may attain, it does raise the question of how independent their analysis can be.

It is a little late for them to be totally frank[1]. As it is, there should be enough here to stop the Government’s policy of promoting the implementations of integrated care systems due to start in Spring 2022, in its tracks.

I have been active as a management consultant and adviser to local authorities leading up to this policy of promoting integration initiatives and during their implementation and denouement.

Naively I had assumed there would be a market in the truth and the avoidance of waste. How wrong can you be! Never mind, the experience has been character building.

My colleagues and I have advised In SW London, NW London, West Sussex, Hertfordshire, Kent, Gloucestershire, West Yorkshire and South Tyneside over this period. We reviewed the Sustainability and Transformation Plans when they were first published.

We helped undermine the explicit policy at that time to create accountable care systems, but they were simply renamed ‘Integrated Care Systems’ perhaps to avoid seeming copies of the US model of accountable care.

Our constant point of criticism, of NHS plans, presented over this period is that they didn’t add up. The context in which they were

[1] “Pilots in all three national programmes made some headway against their objectives but were limited in their impact on unplanned hospital admissions” doesn’t quite sum up the failure and wasted effort involved.

presented was misplaced and the claims for their success were either unsubstantiated, lacking in credible evidence, or plausibility; and that pilots and experiments to justify the policy were doomed from the outset.

So I cannot be accused of not having nailed my colours to the mast before.

Nor can I be accused of being a lone voice. Local people affected by NHS proposals, campaigners, professional bodies, trade unions, the National Audit Office and other policy experts have either professed scepticism or outright opposition to the NHS plans embodied in what is now termed integrated care.

What's the problem?

As Lewis *et al.*'s article suggests, part of the problem lies in the vagueness of the definitions used and the precision of the point that these pilots have tried to prove over the last ten years or more. But for some, that is the benefit of the term, integrated care.

It is simply not good enough to characterise the Integrated Care programme as achieving only 'mixed results'.

Those that believe in a comprehensive and universal system of health and social care have seized on Integrated care as a lifeline thinking it describes their model; but those of us longer in the tooth can see there is another interpretation of integrated care as the culmination of a long remorseless path heralded by health maintenance organisations in the USA, the managed care movement in the USA, and the burgeoning interests of their accountable care organisations, as a strategy for putting the private sector at the heart of strategic management of healthcare systems, whether in the USA or elsewhere.

Whatever works was the New Labour slogan masking this strategy. Some may feel this is a remote and unrealistic worry akin to conspiratorial thinking. But I'm not so reassured.

Some may ask "*what's this got to do with integrated care in the UK*" and efforts to reclaim territory lost by developments in the UK internal market, which was criticised for its excessive transaction costs and failures to deliver its promises of better quality and cheaper healthcare?

Well that is my first criticism of the article: Its context within the UK policy setting has not been clearly spelt out.

The UK policy setting

Studies like Lewis *et al.*'s are not just disinterested academic studies that seem to be attempting to confirm justification for the development of a UK-based policy initiative in favour of integrating care better in the UK.

No: the policy direction has been long established of copying US approaches.

It is for this reason that there are over 30 US companies listed in the Health Systems Support Framework accredited to deliver 'support' to Integrated Care Systems.

These studies are therefore to my mind belated and muted attempts to keep sufficient faith in this direction by generating hope that the policy is justified; all the while as the systems are implemented as though they were already proven as a success.

Never in the policy arena has so much rope been given to an idea that now stands hanging unsupported in the air as all attempts to justify it come to nothing.

Yet, at this stage the policy is so far down the road that the legislation that seeks to embed it, is before Parliament now.

What is wrong with learning from leading companies in the US?

Nothing in principle; but in practice the US problems of a fragmented delivery system, underdeveloped primary and community care and excessive unit costs, absence of effective cost controls, effective regulation and social iniquity are neither being solved in the USA nor are the measures being attempted appropriate to a UK system renowned for its existing centralised structure, significant existent investment in primary and community care and under-investment in facilities, staffing and activity.

This policy is like a headless chicken, it has been decapitated but it's still running in the corridors of power.

Why are intelligent people going along with it then?

Never underestimate the capacity for groupthink and dare I suggest, the possibility of even latent corruption[2] of professionals, politicians, and policy advisers who know better than the public what direction the wind (with a little help) could take them.

The fact that so many members of both houses of Parliament have direct links with healthcare companies, many international, gives the game away.

When successive health ministers from both main parties can position themselves to take advantage of this policy drift.

The current Health Secretary, formerly an advisor to the multinational investment bank JP Morgan, a bank which is also a major player on the private healthcare scene[3], then it is easy to understand why the appeal of the promise of integrated care to deliver more for less is given house room.

It seems that nothing will shake the confidence of those that are convinced the solution to the NHS is to shrink further the most centralised system in Europe; to exert even tighter cost control and to squeeze every ounce of slack out.

Whatever the question, the only answer we hear is that the NHS is too big and expensive, and that the private sector will do it better.

The pandemic has already proven the UK lacked preparation, resilience, capacity and investment.

There is an acute staff shortage made possible by decades of underinvestment in staff training, retention and recruitment policies, and made worse by Brexit and the 'hostile environment' created by successive Home Secretaries.

The pandemic has also shown how dangerous it is to rely on the private sector, to deliver anything other than profits for shareholders.

The private sector can have a place in return for genuine innovation and investment: but not in return for buying ministers, buying think tanks and journalists and spreading lies.

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[2] In the latest Transparency International Annual assessment they said this of the UK and the NHS, "Our study of public procurement in the UK during the pandemic, Track and Trace, revealed that more than 20 percent of money spent by the government on purchases in response to COVID-19, raised red flags for corruption, and appeared biased in favour of those with political access. We reviewed nearly 1,000 Personal Protective Equipment (PPE) and COVID response contracts worth a total of £18 billion; seventy-three contracts, worth more than £3.7 billion, raised one or more red flags for possible corruption, including contracts awarded to those with political connections to the Conservative Party, and others to companies with no track record of supplying goods or Services".

[3] https://tribunemag.co.uk/2021/06/why-sajid-javid-will-be-a-disaster-for-the-nhs

Surely Integration is not a bad policy? Working together can never be a bad thing right?

For a start this will not be integration. There will still be separate NHS Trusts, GP practices, purchasers, providers, regulators, professional bodies, local government social services departments, private and third sector bodies searching for a role and seeking to maximise the benefit to their organisation.

Conflict does not disappear by the mere injunction of being prepared to work in partnership for the general good.

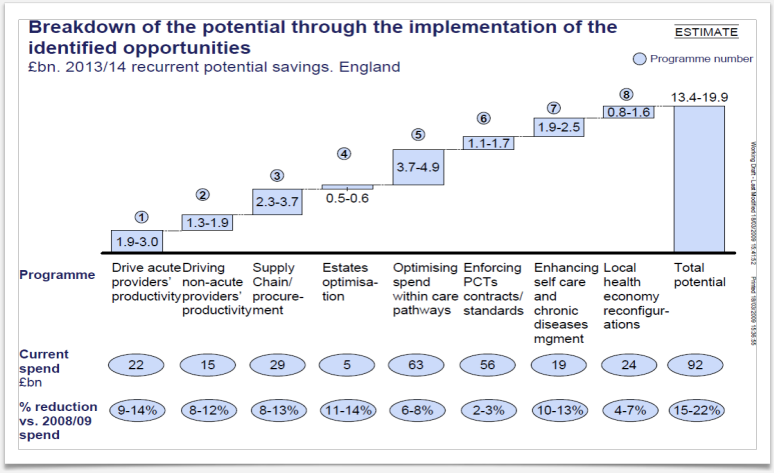
In fact as resources shrink the conflict gets worse not better.

And the more tiers of integrated care systems, providers and partnership bodies are created the more muddied and unpredictable the system becomes.

Neither is it clear what precisely would be done to square the circle of excessive demand and inadequate resources.

The promise for senior NHS managers and politicians was that a mixture of reconfiguration and cost-shifting into the social care and community care sectors would enable a fortune to be saved from closing beds, hospitals and shedding staff.

That promise was classically laid out in the notorious McKinsey set of slides[4] prepared for the last Labour government by the Department of Health in 2009[5].



Well, many said it would not, and they were right. That is now been shown in the article by Lewis *et al.*. But that fact has not yet sunk in or been acted upon. This policy is like a headless chicken, it has been decapitated but it's still running in the corridors of power.

Are you sure? Aren't the findings more nuanced than that?

A legitimate criticism of the article by Lewis *et al.* after more than ten years of study and hundreds of millions of pounds of wasted resources is that lack of evidence justifying the policy is still not seen in their eyes as a sufficient condition for a policy reversal.

The article cites the 'integration paradox' – the puzzle that the constrained funding that inhibits attempts to deliver integrated care was precisely the stimulus that drove policy makers to adopt the policies in the first place.

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[4] Achieving world class productivity in the NHS 2008/9-2013/14 DOH March 2009 (available online at https://healthemergency.org.uk/pdf/McKinsey%20report%20on%20efficiency%20in%20NHS.pdf)

[5] Although cost cutting involving closing capacity, cutting staffing and cost shifting to social care and back to the community has been in vogue since the early 1980s.

It cites 'uncomfortable truths': that integration has been seen as a policy to enable bed closures by reducing massively the numbers of unplanned admissions by up to 50%.

In fact unplanned admissions rose remorselessly as the resources to primary care and social care declined over the period.

This in turn cut the legs from under expensive reconfiguration business cases which relied on unsustainable cuts in capacity to justify the high costs involved.

Thus NHS funders withdrew funding for integrated care initiatives which improved care but which didn't represent good investments or value for money i.e. they cost more than they saved.

Therefore it is ridiculous for Lewis *et al.* to clutch at straws by citing staff 'positivity' about changes; 'difficulties' with sharing data, 'a changing national policy context', 'the high level of national expectations about (the Vanguards) performance being burdensome', 'cultural obstacles', ' a sense of "professional" loss', 'a lack of funding or available workforce to free local leaders to develop their programmes', and even 'From 2010 austerity …creating a more inhospitable environment for innovation and service change'.

It is simply not good enough to characterise the Integrated Care programme as achieving only 'mixed results'. The claim was that these programmes would cut unplanned admissions. They did not; instead there was a remorseless rise over the last ten years. Claims that more time and resources may be required echo claims for other systems ditched by history.

Isn't it too late as the legislation to embed integrated care systems in the NHS is before Parliament, and the Government is distracted by other things right now?

It's right that the Government is in disarray but mostly of its own making. Brexit and Covid are own goals and both set to escalate as problems.

Already health and social care makes up more than a third of public spending and may rise to 40% in the next few years[6]. The Government is in the weak position of facing criticism from its own right wing for spending too much and from the increasingly large older population for not spending enough.

There will be no immediate benefit from the legislation and instead the prospect is of further impetus being given to managers and/or ministers to indulge in unpopular reconfigurations and closures as financial pressures increase. A sensible government and new leadership in the NHS should be taking stock , clarifying plans and the evidence for their likely success before making further legislative changes and letting loose gung-ho managers on an unpopular and controversial path prior to the next election. Any increase in political uncertainty may well cause even American investors to hesitate before sinking significant funds to support the policy drive.

Conclusion

The policy of pursuing integrated care seems to have a life of its own, unsustained by clarity of thought, evidence of success in the UK, or rationale beyond delivering itself. In retrospect NHS senior managers and policy experts have been reluctant to revisit their assumptions and the evidence that has been all too clear for some time now. In the parlance of the NW London 'U' turn they have been pursuing a 'counter factual' policy and it takes outsiders to bring them up short. What is disappointingly revealed is how easily academic insiders can be co-opted by the NHS to delay and dilute the message that their policy has no clothes.

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[6] https://www.telegraph.co.uk/politics/2021/09/08/health-social-care-will-account-40-per-cent-public-spending/