Legislating for integrated care in the UK

Lessons from abroad

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Go directly to sections of this document using the buttons below:

The time for legislative change in England

Is legislation really a mechanism for change?

Looking to Finland's experience

The importance of Aligned Payment Systems

Learnings from Oregon's CCO model

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The time for legislative change in England

At the International Foundation for Integrated Care, we have many years of experience sharing and generating knowledge on integrated person-centred care: why it's important, what it can achieve and what it needs to be successful.

The UK Government's recently published White Paper **Integration and innovation: working together to improve health and social care for all** which applies to England, prompted us to think about what lessons we could share from other systems legislative change initiatives as the government develops the detail of the Bill and local health and care systems prepare for the changes to come.

As the White Paper rightly acknowledges, "the legal framework for the health and care system should be like any operating system – the sort of thing you tend not to notice when it is working well" (Section 2.2). Equally "legislative change can bring real benefits when it helps to remove barriers, provide flexibility and clarify roles".

WE ASK: What can be learnt from other countries legislative changes about creating an enabling environment for integration to happen where it needs to – at the front-line of person-centred care?

The NHS (National Health Service) Long Term Plan, originally launched in 2014, set out an ambitious but reassuringly light touch vision for integrated, person-centred care in the context of population health and well-being. Since then, a series of programmes and national level initiatives have embedded care integration into the everyday language of the NHS. This policy mechanism has been remarkably effective despite the absence of a legislative backdrop. That is a testament to the shared values and vision set out the Long Term Plan and reinforced repeatedly by senior leaders within NHS England.

It is clear that there now needs to be some legislative change to remove barriers and clarify roles while providing flexibility, so that the reforms to the health and care system are codified. Getting a balance between 'clarity' and 'flexibility' is a significant challenge, and possibly not one best addressed through legislation.

Is legislation really a mechanism for change?

The primary focus of the proposed legislation is largely on system wide governance and leadership with the creation of 'place-based' Integrated Care System (ICS) bodies to govern care.

The alignment of payment systems is also covered although in less detail at this stage. The White Paper also refers to changes that will allow greater data sharing, a key enabler to integrated care. However, little mention is made of the workforce outside of proposed changes to professional regulation.

Looking to Finland's experience

Looking specifically at the proposals around system wide governance and leadership, it is worth reflecting on the experiences of Finland.

Successive governments have attempted to reform the health and social welfare system and its underpinning structures since 2005. In Finland, there are 309 municipalities for a population of 5.5 million people. This has historically been the level at which primary health care services have been organized. The last attempt in legislative reforms in 2015-2019 failed after several revision rounds and led to the collapse of the government in 2019. Some elements of the reform legislation were seen as conflicting with Constitutional Law.

This law provides municipalities with a strong constitutional position in organising local services. The proposed reform legislation aimed to address problems of health and care inequalities and access to care that the government put down to the fragmented model of organizing health and social services at municipality level. The reform legislation aimed to create new structures to consolidate the administrative units that organize health and social services to 18 larger counties, whilst introducing extensive customer choice with provider competition to drive improvements in local service delivery.

Although the recent reform efforts were not successful in terms of legislative passage, they have driven a slow reduction in the overall number of municipalities in Finland by signaling an intent to change. Currently only a quarter of the municipalities organize services themselves the rest have transferred the responsibility to a joint municipality authority. However, the model remains highly localized. While responsive to local needs, it has meant that commissioning capabilities have been spread thinly, contributing towards inequalities in provision and access to care across municipalities. This incremental locally driven change has provided the current government with a foundation for their more limited and focused approach to legislating for change.

The current Government in Finland, in power since 2019, has proposed new legislation to reform health and social care organisation. Like the previous legislation, it proposes organizing health and social services more centrally. The plan is to introduce 21 new wellbeing service counties. The City of Helsinki will organize its own health, social and rescue services. Much like ICSs in England, counties would be created as entirely new regional entities. Compared with the previous reform legislation proposal in 2015-2019, the new legislative framework is not as complex.

The proposed counties would have fewer responsibilities outside health and social care services and there is no mention of patient choice and introducing competition to the public services. These elements were subject to much debate under the previous government and in practice were highly complex. The compound effect of introducing choice legislation with other legislation, such as those governing social care, were so significant and complex that attempts to address these increased the scale and scope of the legislation. It was this scale, scope and the pace of change proposed that ultimately mobilized interested parties against the legislation. Culturally, since the 1990s the Finnish healthcare system has been locally driven at municipality level without a strong national vision or steering for health and care. The government tried to address this through consolidation at county level but without setting out a clear vision that would have been widely accepted.

While all of this has been going on, local initiatives have been getting on with the practice of integrated person-centred care. There is nothing in the current legislation that stops local areas from acting collectively in this way. But as the progress has been slow and incremental, policy makers recognize the important role that legislating can play in signaling to the entire system the urgency and need for change.

The importance of Aligned Payment Systems

Aligned Payment Systems are an important part of any integrated care system as they can drive behaviours towards integration or fragmentation depending on their design.

Payment systems also underline most of the decisions that system-wide decision-makers have to make. The White Paper sets out the UK government's intent to enshrine in law some of the payment systems that have been developed in England over the last decade including the Better Care Fund. Otherwise, there are relatively few changes to the national tariff and other payment arrangements.

Social care is outside of this legislation and there is no timetable for promised reform of the sector. Targeted proposals for public health are mentioned to reinforce the role of public health in integrated care systems but with little detail on how this will happen at a time when public health grants have been cut in real terms over the last 6 years.

Learnings from Oregon's CCO model

The State of Oregon in the Pacific Northwest of the US has a long and distinguished history of being in the vanguard of health system reform for 30 years.

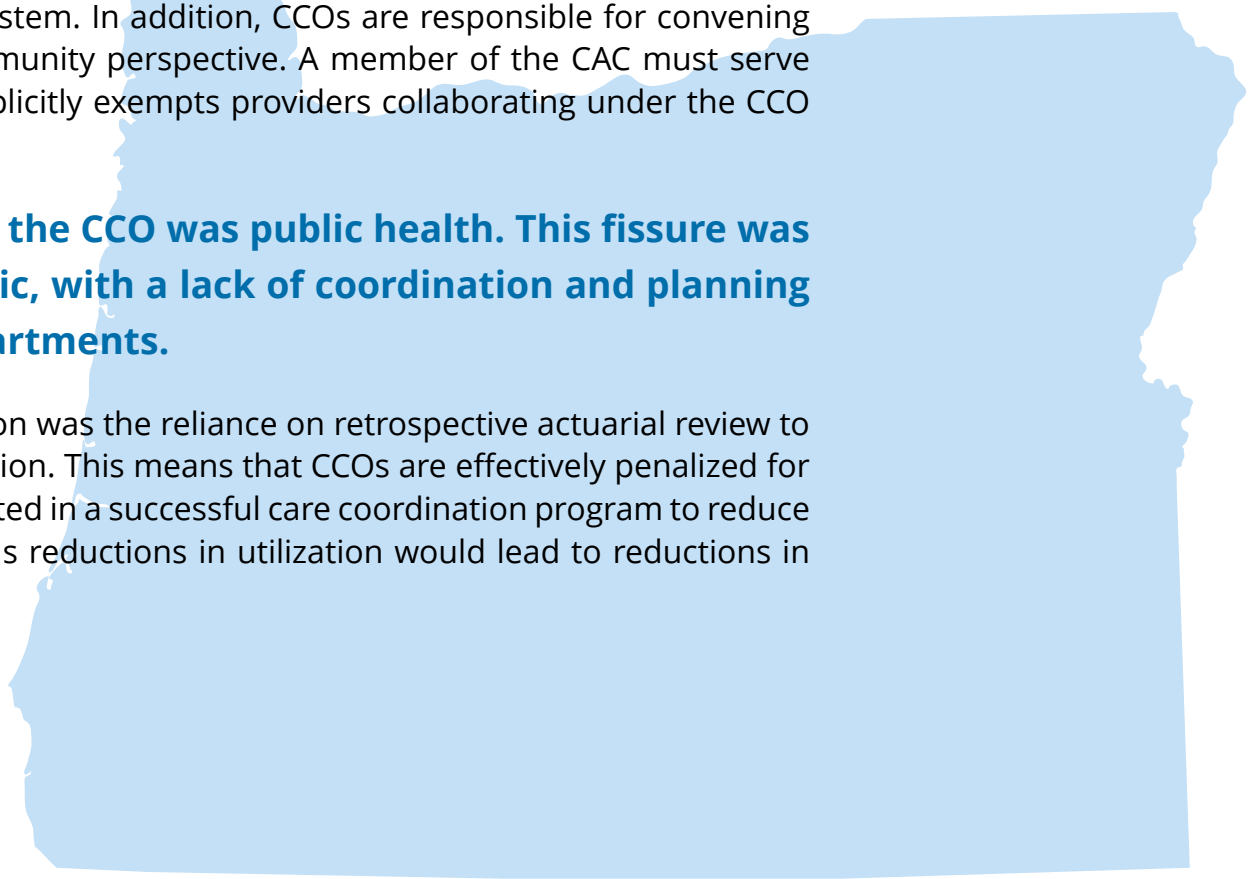
It has a population of 4.2m people at a similar population density to Finland. In 2011, after the passing of the Affordable Care Act (2010), the state legislated to integrate and coordinate health care systems including social care. The legislation created Coordinated Care Organisations (CCO) of which there are currently 15.

The essential elements of the CCO model included:

- integration and coordination of benefits and services;
- local accountability for health and resource allocation;
- standards for safe and effective care; and
- a global budget tied to a sustainable rate of growth.

CCOs are accountable for the provision and management of physical, behavioral and oral health for their populations within a fixed global budget. They are held to account for delivering improved health outcomes as well as staying in budget. The reforms were aimed at reducing the fragmentation of care that led to higher costs without commensurate improvements in wellbeing outcomes.

In 2011, Oregon was facing a financial cliff in health care spending and this was the most important driver of change. The legislative change focused on integrating payment systems and incentivizing coordinated person-centred care through per capita global budgets with a strong emphasis on innovating within the global budget. CCOs were a completely new system structure developed to integrate providers including traditionally non-health services, such as housing, food insecurity and employment support. The legislation mandates who needs to be included in the CCO governing body. A majority on the CCO governing board must be comprised of representatives from entities that share financial risk. Also included are representatives from the major components of the health care delivery system. In addition, CCOs are responsible for convening community advisory councils (CAC) to assure a community perspective. A member of the CAC must serve on the CCO governing board. The legislation also explicitly exempts providers collaborating under the CCO umbrella from anti-trust laws.



The one part of the system not included in the CCO was public health. This fissure was badly exposed during the Covid-19 epidemic, with a lack of coordination and planning between CCOs and local public health departments.

A further limiting factor on the impact of the legislation was the reliance on retrospective actuarial review to set future funding that is governed by Federal legislation. This means that CCOs are effectively penalized for savings that they make. For example, a CCO that invested in a successful care coordination program to reduce hospital readmissions would actually be penalized, as reductions in utilization would lead to reductions in per-member payment rates the following year.

A blunt instrument

The experiences of both of Finland and Oregon show that legislation has an important place in creating the conditions for integrated care, but on its own is blunt, and sometimes misdirected instrument.

The key difference between the two examples was that Oregon had a clear vision for change and a history of radical healthcare reform. Finland did not. Oregon recognized the importance of linking system wide governance and leadership to aligned payment systems and other aspects of care integration such as workforce development and community involvement.

Significant progress has been made in England to deliver integrated care at clinical and professional levels with some progress at organizational level and now the focus has rightly shifted to the system level.

The White Paper is missing detail and there are areas important to the delivery of integrated care that are absent from legislation and policy in England at the moment, most notably workforce capacity and capability and people as partners in care. In the context of the White Paper noting "Legislation can help to create the right conditions, but it will be the hard work of the workforce and partners in local places and systems up and down the country that will make the real difference." (section 2.5), these are significant gaps.

Legislation is a powerful tool as signal of intent to underline an inclusive vision for integrated person-centered care. Any gaps in this inclusiveness will be taken as a sign that care integration is limited in scope and ambition and may not have the needs of the person at its centre.

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IFIC Knowledge Tree

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