

# Creating an integrated public sector? Labour's plans for the modernisation of the English health care system

Nick Goodwin, Health Services Management Centre, University of Birmingham

Correspondence to: Nick Goodwin, E-mail: [N.Goodwin@bham.ac.uk](mailto:N.Goodwin@bham.ac.uk)

---

## Abstract

The current Labour Government has embarked on radical public sector reform in England. A so-called 'Modernisation Agenda' has been developed that is encapsulated in the *NHS Plan*—a document that details a long-term vision for health care. This plan involves a five-fold strategy: investment through greater public funding; quality assurance; improving access; service integration and inter-professional working; and providing a public health focus.

The principles of Labour's vision have been broadly supported. However, achieving its aims appears reliant on two key factors. First, appropriate resources are required to create capacity, particularly management capacity, to enable new functions to develop. Second, promoting access and service integration requires the development of significant co-ordination, collaboration and networking between agencies and individuals. This is particularly important for health and social care professionals. Their historically separate professions suggest that a significant period of change management is required to allow new roles and partnerships to evolve.

In an attempt to secure delivery of its goals, however, the Government has placed the emphasis on further organisational restructuring. In doing so, the Government may have missed the key challenges faced in delivering its NHS Plan. As this paper argues, cultural and behavioural change is probably a far more appropriate and important requirement for success than a centrally directed approach that emphasises the rearrangement of structural furniture.

## Keywords

England, integrated care, inter-professional working, policy, modernization, quality, standards, investment, access

---

## Creating an integrated public sector?

### Labour's plans for the modernisation of the English health care system

In England, the principles of a tax-based service, free at the point of delivery and universally accessible to all, have remained largely unchallenged since the National Health Service was founded in 1948. Nevertheless, health care policy in England has been characterised by successive packages of 'reform'. These reform packages have attempted to deal with the growing stresses faced by most health care systems in Western countries including the rising demand for, and costs of, health care services [1].

During the 1990s, the UK embraced 'managed competition' as a way to control the costs of health care services [2]. Hospitals and community services became self-governing 'trusts' in competition for contracts from local health authorities who had previously managed hospital care directly. Moreover, the system

was extended to allow groups of primary care physicians to hold funds to purchase mainly elective care [3]. The purpose was to engender quality, efficiency, innovation and better productivity to the delivery of care and the approach became a popular model for other nations to adapt. For example, a Conservative Government in New Zealand reacted to its fiscal crisis by introducing similar market principles into health care in the early 1990s including the transformation of public hospitals into Crown Health Enterprises to compete for contracts [4].

Whilst other countries continue to grapple with the demands of 'managed competition', England's dalliance with the process appears to have been short-lived, as the expected efficiency savings from competition have failed to materialise. Indeed, the management costs of creating and maintaining a health care market increased the NHS administrative budget sharply [3]. Moreover, the market approach fuelled organisational protectionism and precluded the provision of comprehensive care at low cost [5]. In essence, the collective ethos of the NHS was seriously undermined and, as a result, a health service devel-

oped that was increasingly inequitable in terms of access to care whilst health inequalities between high and low social classes widened [6]. Indeed, the Governments of most other nations that implemented competition policies in health care during the 1990s have been pulling back from managed competition [7].

As an alternative to ‘managed competition’, the current Labour Government has embarked on another period of public sector reform in what it euphemistically calls its ‘Modernisation Agenda’ [8]. A new collective vision for health care delivery in England was encapsulated in The NHS Plan of July 2000 [9]. The key elements of the agenda appear to be based on a five-fold proposal:

1. Investment through greater public funding;
2. Ensuring quality standards;
3. Improving access to care services;
4. Promoting inter-professional working and integrating service provision; and
5. Providing a more public health or ‘whole-systems’ approach.

## Investment through greater public funding

For many years, the historically low level of GDP spent on health care in England was regarded as a sign of efficiency in delivering a high quality and universal health care system [10]. Rising demand for care and increasing costs of care were approached without fundamentally increasing this share of investment. The NHS Plan, however, argued that the NHS had failed to deliver because of ‘decades of under investment’ leading to insufficient capacity (lack of doctors, nurses and other care staff) to provide the services required to respond to the individual needs of patients. The Government has since pledged to raise funding levels for health care to the European average within five years [11].

The investment strategy to be employed is based on providing increased capacity both in health care facilities and in numbers of staff. The Plan pledges an additional 7000 hospital and intermediate care beds and 100 new hospitals by the year 2010. Moreover, the Plan envisages the creation of 500 new one-stop primary care centres, 3000 modernised general practitioner premises, 250 new scanners, cleaner hospital wards, and a ‘modern’ information technology system in every hospital and family doctor’s surgery. In terms of investment in staff, the Plan suggests that the Health Service requires 7500 more hospital consultants, 2000 more general practitioners, 6500 extra

therapists and in excess of 20,000 nurses. These major investments in the capacity of the NHS in England, if followed, equate to an increase in investment of at least one third in real terms. The need to increase the burden of tax to cater for the financial needs of the NHS appears to be widely supported by both public and opposition parties [12].

## Ensuring quality standards

The investment strategy in the NHS is to be accompanied by a far more managed and centrally controlled approach to providing health care services. The strategy builds on work the Department of Health had begun to put in place soon after Labour’s election victory in 1997 [13]. A range of national standards on care provision are being pursued in order to improve quality and reduce unacceptable variations in standards of care. These include National Service Frameworks; a National Institute for Clinical Effectiveness; and a Commission for Health Improvement to monitor the delivery of care under a new national performance framework [14].

## National service frameworks

National Service Frameworks aim to set national standards of care provision by defining service models, underpinning and supporting programmes of local delivery, and developing high-level performance indicators against which progress within agreed time scales can be measured. Five National Service Frameworks have so far been produced, three in the disease areas of cancer, coronary heart disease, and diabetes [15–17] and a further two for mental health and older people’s care [18,19]. Frameworks for children’s health and renal services will be published in 2002.

Key objectives set by National Service Frameworks reflect priorities in the National Health Service [20]. For example, reducing mortality rates by 40 per cent for coronary heart disease and 20 per cent for cancer amongst the under 75s by 2010. For older people, the emphasis has been placed on the delivery of high quality pre-admission and rehabilitation care in order to promote independence and reduce hospitalisation rates (see Box 1). The Framework stresses the need for health and social care agencies to integrate service provision to achieve this. Milestones include the creation of a single assessment process; investing in intermediate care facilities to reduce the delay in transfer out of hospital care; and reducing the annual rate of increase in elderly emergency admissions to less than 2 per cent [21].

**Box 1.** Summary of the National Service Framework Approach: Older People's Care

Objective:	To provide high quality pre-admission and rehabilitation care to older people. To help older people live as independently as possible by reducing preventable hospitalisation and ensuring year-on-year reductions in delays in moving over 75s on from hospital.
Targets:	By April 2002: <ul style="list-style-type: none"> <li>• a single assessment process between health and social care including a proactive process of identifying and inviting more vulnerable people for assessment</li> <li>• to lower the average rate of delayed transfer of care for people over 75 to 10% of the 2000/01 level;</li> <li>• to ensure that the average per capita rate of emergency admissions for people aged 75 or over is less than 2% and that the rate of readmissions within 28 days of discharge does not increase</li> <li>• create 1500 more intermediate care beds and undertake 60,000 more treatments</li> <li>• increase the number of people who live at home by 2%</li> </ul>
Mechanisms:	<ul style="list-style-type: none"> <li>• Promote flu vaccinations</li> <li>• Develop joint assessment procedures between health and social care</li> <li>• Develop joint working between health and social care</li> <li>• Needs assessment for nursing and residential beds</li> </ul>

**The national institute for clinical effectiveness**

The creation of the National Institute for Clinical Effectiveness in April 1999 has been a further key element

of the Government's approach to integrate quality standards. The aim of the National Institute for Clinical Effectiveness is to ensure that drugs are prescribed in an appropriate and cost effective manner and to standardise drug use across the NHS [22]. For exam-

**Box 2.** The National Institute for Clinical Effectiveness [22]

Objective:	To provide patients and health professionals with robust and reliable guidance on 'best practice' covering both individual health technologies (e.g. medicines) and the clinical management of such conditions.
Targets:	Recent technologies appraised include hip prostheses, taxanes for ovarian cancer and breast cancer, coronary stents, proton pump inhibitors for dyspepsia, hearing aids, Zanamivir (Relenza) flu, and Rosiglitazone for type 2 diabetes
Mechanisms:	<ul style="list-style-type: none"> <li>– Independent assessment of published evidence;</li> <li>– Verbal and written submissions from public/carer organisations, professional organisations and manufacturers;</li> <li>– Evaluation report with consultation and appeals period;</li> <li>– Guidance issued on level of use in NHS</li> </ul>
Examples:	<p>Taxanes for ovarian cancer</p> <ul style="list-style-type: none"> <li>– access to the product has varied considerably across NHS</li> <li>– NICE concluded that when a woman reaches an 'appropriate stage' in her ovarian cancer she should be offered Taxane. The guidance would allow 1000 additional women to benefit at a cost of around £7 m</li> </ul> <p>Zanamivir (Relenza) flu</p> <ul style="list-style-type: none"> <li>– should not be used by an otherwise healthy individual</li> </ul> <p>can be used for those at risk when flu is present in the community and patients can start medication within 48 hours of their symptoms starting</p>

ple, it dictated which drug treatments should be universally prescribed across the country for cancer care (see [Box 2](#)). This process has helped put an end to the perceived 'postcode lottery' in prescriptions of cancer drugs.

The National Institute for Clinical Effectiveness has, however, courted controversy since it is regarded by many as a political body set up to ration drug use and costs. Important decisions on what is, and what is not, nationally available on the NHS have added to this debate. For example, it was ruled that interferon beta should not be prescribed to alleviate the suffering of multiple sclerosis. The decision was made on the basis that the long-term clinical benefits were outweighed by a high cost [\[23\]](#). However, opponents to the decision argued that interferon beta was the only available drug to *delay the progression* of the disease [\[23\]](#) and that the ruling had been based on its effectiveness in treating *secondary progressive* multiple sclerosis that had already been proven to have modest clinical benefit [\[24\]](#). The case is particularly important since the National Institute for Clinical Effectiveness was effectively able to defeat a high court ruling from 1997 in which a health authority was found to have 'acted unlawfully' in denying interferon beta to a patient with multiple sclerosis [\[25\]](#).

If the National Institute for Clinical Effectiveness has provided the political backing for drug rationing across the National Health Service, there is no doubt that its work is based on well-researched and considered investigations of the cost and clinical effectiveness implications of each drug. Indeed, on balance, its impact has been to raise the overall drug cost burden to the NHS rather than reduce it.

## The Commission for Health Improvement

A further tool for ensuring quality standards in the National Health Service has come in the form of the Commission for Health Improvement, an independent inspectorate set up to improve the quality of patient

care. The Commission was set the task of assessing every NHS organisation, investigating service failures, monitoring whether national guidelines were being fulfilled, and advising the NHS on good practice [\[14\]](#).

The Commission has proved itself robust in its criticisms of poor service. For example, when asked to investigate a hospital that had higher than average death rates following heart and lung transplants, the Commission concluded that many patients had died who may not have done if treated in another transplant unit elsewhere in the country [\[26\]](#). The work of the Commission is related to that of another new body, the Modernisation Agency, which was set up to promote best practice [\[9\]](#). This agency has been instrumental in identifying 'beacons' of good practice from whom others can learn and its role is to help distribute those lessons to the rest of the NHS.

## 'Earned' autonomy

In contrast to these imposed measures of quality assurance, the NHS Plan supports the idea of allowing greater freedom from the centre for local innovation and self-determination. The Plan talks specifically about creating a 'new system of earned autonomy' in which the Government devolves power 'as modernisation takes hold'. In reality, earning this autonomy is linked directly to achieving Government-led quality and access targets [\[27\]](#).

To ascertain the performance of hospitals, the Government has instituted a star rating system based on a number of key components (see [Box 3](#)). Those with three stars, the best rating, will be allowed 'earned autonomy' manifest, amongst other freedoms, in less frequent monitoring from the centre, the ability to innovate new services without receiving prior approval, and the opportunity to access additional resources without having to go through a bidding process. Indeed, the Government has established a 'performance fund', which will rise to £500 m by 2003/4, for use by good performers. Those with zero stars, the worst rating, will be subject to external intervention to improve performance.

### Box 3. The NHS Performance Rating System – key targets for acute hospitals [\[27\]](#)

- ◆ Shorter inpatient waiting lists
- ◆ No inpatients waiting more than 18 months for inpatient treatment
- ◆ Reduction in outpatient waiting
- ◆ Fewer patients waiting on trolleys for more than 12 hours
- ◆ Less than 1% of operations cancelled on the day
- ◆ No patients with suspected breast cancer waiting more than two weeks to be seen in hospital
- ◆ Commitment to improving the working lives of staff
- ◆ Hospital cleanliness
- ◆ A satisfactory financial position
- ◆ Not receiving a critical report from the Commission for Health Improvement

**Box 4.** Key access goals for the NHS [20]

Targets:	<ul style="list-style-type: none"> <li>– Maximum wait for outpatient appointments to fall to three months and for inpatient treatment to fall to six months by 2005</li> <li>– Two-thirds of all outpatient appointments and inpatient elective admissions to be pre-booked by 2003/4 aiming for 100% by 2005</li> <li>– Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004</li> </ul>
Mechanisms:	<ul style="list-style-type: none"> <li>– NHS Direct – telephone and internet health care advice</li> <li>– Booked admissions for elective care</li> <li>– Walk-in centres and one-stop health care clinics</li> <li>– New primary health care 'teams'</li> <li>– Personal Medical Services</li> </ul>

## Discussion

At the heart of the Labour Government's centralist approach to quality assurance and performance monitoring is concern over extreme variability in standards of care across the NHS. However, the determination of Government to deliver the 'modernisation agenda' in such a centrally determined way has imposed much stress, uncertainty and morale difficulties amongst staff. Moreover, the approach could be considered to be over-prescriptive in terms of binding clinical decision-making to ensure homogeneity of care. In this sense, a centralist and prescriptive approach allows less room for service innovation and appropriate local variances in care provided to certain groups.

The centrally-driven approach to quality assurance also impinges on long-held and jealously guarded professional freedoms. As a result, the medical profession has given a lukewarm reception to the imposition of national standards of care believing them to be as much a 'straightjacket' to the delivery of care as an attempt to design and deliver more effective health services [28]. Others have described national standards as a 'noose' around the head of the NHS since they promise a level of care to the public that they may not be able to provide. As a result, some have predicted a rise in litigation as a cash-strapped NHS fails to provide the standard of service prescribed centrally [29].

The negative response to top-down quality control in the NHS was perhaps to be expected given evidence from Health Maintenance Organisations in the USA. Health Maintenance Organisations have imposed on physicians the need to co-operate with utilisation management, cost containment measures and quality assurance activities. However, as a consequence of this control, a managed care backlash within Health Maintenance Organisations has developed as physicians have been angered over their loss of authority, autonomy and income [30].

There is a strong perception within the Service that its ability to deliver centrally led quality standards will remain impossible until sufficient injections of funding work their way through to develop the necessary capacity to tackle change effectively. In the absence of immediate additional resources, achieving goals such as those imposed by National Service Frameworks have been regarded as unrealistic [31]. There is no doubt that a quality-driven NHS is seen as laudable, but the method of implementation has as yet not provided the conditions or the incentives for the deliverers of care to reach these aims in a sensible timeframe.

## Improving access to care services

Improving access to care services is an important theme in the NHS Plan that appears to reflect growing impatience from the public to a system that has increasingly forced patients to long waits for aspects of care provision. To address this, the NHS Plan pledged to significantly reduce waiting times for outpatient appointments, eradicate long waiting lists in accident and emergency wards, and enable patients to see a primary care provider within 48 hours (see Box 4) [9].

Whilst NHS hospitals have been performance managed on their ability to contain costs and reduce waiting lists and times for several years, the NHS Plan introduced a range of new mechanisms to attain access goals. These mechanisms have been radical and include the redistribution of primary care professionals through new local contracts, investment and modernisation of primary care in needy areas, walk-in centres, and NHS Direct. All of these approaches suggest the willingness and potential to promote access to care for those population groups poorly served by the current system (such as the poor and homeless) [32].

## NHS Direct

NHS Direct, which is a telephone or Internet help line for health care advice, was established as way of managing demand for emergency care. In the view of its proponents, NHS Direct has the potential to act as the new 'gatekeeper' to NHS and other care services by, for example, integrating social services and primary care teams for out of hours care; enabling the process of booking appointments with general practitioners; and out-calling to at risk patients [32].

The evidence on the use of NHS Direct to date suggests that it has been used primarily for 'social' reasons. In particular, research has shown that many users wanted to gain access to primary medical advice out of hours of general practice surgery times, particularly women with young children [33]. Moreover, a high area of unmet need has been observed for advice on mental health problems and sexual health issues [33]. Currently, there appears to be no data on whether NHS Direct has had any significant impact on reducing emergency admissions [34]. There has also been concern that the system has yet to be linked to formal booking or referral mechanisms. Moreover, the system has not been used by poorer members of society, due to technology and telephone costs, and has also been under-used by the elderly who appear to prefer the continuity of face-to-face contact with a known primary care physician [34].

## Walk-in centres

Walk in centres, consisting of nurse consultation, diagnosis, triage, and minor treatment, were envisaged as a way to improve convenience of access to areas under-served by existing primary care services. They were also thought to have merit as a safety net for the disadvantaged and unregistered [32]. Such centres also have the potential to expand beyond their medical function to be community health centres providing welfare advice, information, and screening – therefore delivering a social requirement as well as to reduce inequities in access to health care services [32].

Walk-in-centres have been unpopular amongst primary care doctors in England who argue that they inflate demand, reduce continuity of care and compromise their traditional gate keeping role. Comparative evidence suggests that such fears could be well founded. The development of walk-in-centres in Canada, for example, led to more fragmented care, differential treatments, and inadequate follow-up of chronic conditions [32]. Indeed, access to walk-in-centres in

Canada was mainly promoted to the convenience of existing users with minor problems via longer opening hours rather than promoting access to disadvantaged groups. In England, early indications suggest that walk-in-centres are similarly and predominantly accessed by higher social classes though also providing an unmet need for information and advice, particularly in the areas of contraception, sexual health, and drug misuse [35].

The key problem behind the walk-in-centre approach is the potential reduction in the threshold of care that may increase demand uncontrollably, particularly if it fuels demand for the more 'social' elements of health care. The integration of walk-in-centres and NHS Direct with the role of general practitioners and 'traditional' primary care will be a key to overcoming such problems. However, such integration is also likely to be the biggest obstacle since it requires significant co-ordination, collaboration and networking between professionals and providers that have traditionally worked as autonomous and separate parts of the system. A requirement of the Government's access agenda, therefore, is the need to instil flexibility and integration as a core component to each health professionals agenda such that, for example, the use of shared protocols and regular exchange of information becomes a characteristic of the system.

## Primary health care teams

The access agenda also suggests a move away from the traditional general practitioner-centred gate-keeping role. A key Government priority has been to develop new roles for primary care professionals and encourage partnership between doctors, nurses and social workers. Indeed, the current renegotiation of the national GP contract may specify, or encourage through financial incentives, working in partnership with other primary care professionals [36]. Indeed, such arrangements have already been encouraged through the development of Personal Medical Services pilots in which general practitioners provide an agreed set of services under a salaried arrangement with local health authorities [37].

## Discussion

Access to care will remain a key theme in Labour's modernisation agenda. The strategy has encouraged the development of multiple entry points into primary care. If the approach is to succeed, the importance of co-ordination and integration for effective assessment and triage must not be underestimated [38]. This is

important since the promotion of multiple access points runs the risk of reducing the continuity of NHS service provision to patients and providing services on demand rather than according to need. Whilst one might argue that such a system would meet the unmet need of social users and those wanting to receive welfare advice, the cost is likely to be prohibitive. Moreover, the measures proposed may not necessarily provide better access to NHS services for disadvantaged groups nor necessarily reduce demand on other parts of the system. Furthermore, a system based purely on promoting access to care can cause perverse incentives for providers in justifying performance since the system would be based on levels of numbers seen rather than on treatment according to need. The information technology and wider co-ordination implications for the service is also likely to inflate costs to the system.

## **Promoting inter-professional working and integrating service provision**

Related to the Government's intention of promoting better quality and access to care is the NHS Plan's intention to bring about the redefinition of the roles of health and social care professionals [9]. Much of the emphasis is placed on primary care services, particularly general practitioners, where it is suggested that new modern contracts will be created that are quality-based. This implies far greater clinical accountability and justification within a profession and a Service that has traditionally been based on local clinical autonomy.

## **New primary care organisations**

The role of new local contracts to employ primary care professionals on a salaried basis is being encouraged. Indeed, the emphasis appears to be based on the creation of US-style managed care organisations in the guise of Primary Care Trusts [39]. These organisations, at least in theory, should enable the better integration of general practitioner, community, specialist and local authority services [38]. Moreover, these organisations have the power to question traditional professional and organisational boundaries often seen as a key barrier to effective integration [40].

Many general practitioners and hospital consultants are unhappy about the Government's modernisation proposals because they undermine their status and professional autonomy. Successive Governments

have been attempting to bring general practitioners under the aegis of mainstream NHS management, a move that hits at the very heart of their small business ethic. It is reported that general practitioners feel increasingly victimised by proposals to shift the funding of single-handed practices under new local contractual plans [41]. Indeed, so unhappy have general practitioners been with their relationship to the NHS that many are looking to resign as they struggle to cope with what they perceive as unrealistic and unmanageable demands. A 2001 survey reported that two-thirds of family doctors had lower morale than five years previously whilst 90 per cent believed that NHS Plan targets were not achievable without proper funding and increased remuneration to general practice [42].

In an attempt to improve capacity within the NHS the Government has also been examining various options of professional coercion. For example, the NHS Plan suggests that newly qualified hospital consultants should be forced to do solely NHS work for seven years after graduation. This idea in the Plan was clearly aimed at retaining consultant numbers within the NHS. However, consultants have responded to the idea that they must 'repay the State' by holding an exclusive contract with the NHS as 'insulting and contemptible'. Many trainee consultants, for example, have threatened to move abroad or set up consortiums outside of the NHS should such a system be imposed [43].

As well as promoting capacity within the Service, the NHS Plan described the need to reduce professional demarcations between staff. The idea is to develop new skill mixes amongst health care teams such that nurses and social care staff work together in teams with medical professionals within the same organisation. This would have the potential advantage of allowing nurses, for example, to attend to the minor and non-medical users of the system and help free up time for medical professionals to treat the more urgent cases and to explore careers in more specialist medical areas. It is suggested in the NHS Plan that nurses, in particular, will be provided with greater opportunities to extend their roles (for example, to prescribe medicines) [9]. The Government has set aside £280 m over three years to skill-up such staff and begin to establish a new generation of managerial and clinical leaders.

The development of new primary care organisations in England in the form of Primary Care Groups, Primary Care Trusts and Personal Medical Services pilots has helped to co-ordinate the roles of health and social care professionals [37,44]. However, a key frailty in the system has been exposed during this

process. That frailty comes from the differing training and cultures of family doctors, nurses, community staff, hospital clinicians and social care staff that mean each considers themselves as a collection of individuals rather than as a team [45]. Moreover, the development of collective or corporate ownership of problems within new primary care organisations has required a significant widening of their terms of reference outside their traditional professional boundaries. Evidence suggests that this process is possible, but requires considerable time to nurture new relationships through inclusive and local negotiation [35]. Without such space and time, primary care organisations are unlikely to develop the unity of purpose across the professions that the Government wishes to see happen.

## New health and social care partnerships

The development of new primary care organisations is but one component part of the Government's strategy to promote professional and service integration in the NHS. This theme within the NHS Plan is taken further forward through the vision that health and social care organisations should become formally integrated. This would mean, for example, social services and the NHS coming together with new agreements to pool resources to commission and provide health and social care as a single organisation [9]. The idea behind this is that integration would prevent patients, particularly older people, from 'falling in the cracks' between the two services or being left in hospital when they could be safely in their own home.

The introduction of the *Health Act 1999* provided health and social care organisations in England with new opportunities to integrate public services [46]. The Act removed the legal obstacle to pooling health and social care budgets and promoted the notion of joint commissioning and integrated health and social care provision. The NHS Plan went further by detailing a vision of Care Trusts, or new multi-purpose legal bodies to commission and be responsible for all local health and social care.

The use of flexibilities within the Health Act 1999 to develop new joint services, and the development of Care Trusts, has not proven popular [47]. For example, there were only thirty cases of the use of health act flexibilities following the 'launch' in November 2000. Of these, most were used to co-ordinate existing services better (for example, by integrating community health and social service teams or developing joint health and social care beds). The emphasis has also been on the process of organisational integration rather than achieving better service delivery. Success

amongst the first cohort was expressed in terms of developing good relations between partners and resolving staff issues as opposed to achieving better user/carer services. Indeed, new partnerships had yet to overcome demarcations between existing professional groups. Less than 20 per cent of cases reported any staff relocation (for example, from secondary to primary care) or the development of new integrated teams that might reduce fragmentation of delivery and improve continuity of care delivery to users [47].

In March 2001, the Department of Health detailed its emerging framework for Care Trusts [48]. The document reneged on the original and radical proposal in the NHS Plan that Care Trusts should be a completely new statutory organisation to be responsible for all health and social care. Instead, existing statutory agencies would remain sacrosanct whilst the notion of a Care Trust became not much more than a symbolic name for a 'virtual' partnership. Once it was learned that the Department of Health had scaled back on its original proposals, the number of organisations interested in becoming 'demonstrator' Care Trusts in 2002 reduced dramatically [49]. Many Primary Care Trusts at the forefront of change reported that 'no genuine benefits' were to be had from Care Trust status following the backtracking in its scope [50].

## Discussion

A number of key issues emerge from the methods employed to promote service integration. One is the apparent dominance within new partnerships of health professionals and the medical model of care and the marginalisation of social services and other professional groups [47]. The integration agenda appears dominated by the NHS leading to distrust and defensive behaviours from potential partners, especially local authorities. Another issue is related to the observation that the geographical boundaries of new health and social care partnerships appear often to be different to existing organisational boundaries of primary care groups or trusts and of local authorities [47]. Such geographical and administrative discontinuities are surprisingly commonplace and, ironically, have the potential to create the same kinds of barriers to cross-agency working that the agenda they are following seeks to avoid. This is the 'disintegrated integration syndrome' and can be destructive if not contained [40].



## Providing a more public health or 'whole-systems' approach

A final key element of the NHS Plan is to develop a care service that is aimed at improving health in its broadest sense. As the NHS Plan concedes, 'good health depends upon social, environmental and economic factors such as deprivation, housing, education and nutrition' [9]. As well as this understanding on the need for a more public health approach to care, there is an associated commitment to reducing health inequalities. The NHS Plan envisages the creation of a task force on inequalities and integrated public health groups across the NHS and local government. Such sentiments are reaffirmations of the need for NHS services to not work in isolation.

Since the production of *Saving Lives: Our Healthier Nation* [51], a range of initiatives to promote health in the NHS have been advanced. These include Sure Start, an initiative targeted to support the development of young children in deprived communities, and other policies that have promoted reductions in smoking, better diet and nutrition, and to tackle drugs and alcohol misuse.

The need for organisational and service integration is inherent in the Government's agenda on promoting health and reducing health inequalities. However, the reform process appears to have focused overmuch on structural change in organisations. Such changes, it has been argued, target the delivery of care rather than the root causes of ill health [52]. Indeed, at a national level, strategies that directly link attaining health improvement to economic regeneration or education have yet to develop.

At a more local level, public services in England have embraced many strategies to integrate services for specific local issues yet, as a whole, these strategies remain poorly co-ordinated. For example, whilst Primary Care Trusts are required to develop Health Improvement Programmes that provide the basis for prioritising services needed by their population, local authorities in the same localities work to a separate set of priorities based on Community Plans [53]. Moreover, the priorities identified by Primary Care Trusts through Health Improvement Programmes are rarely, if ever, linked to the distribution of resources since these are determined through other mechanisms. Hence, priorities for health improvement are not always reflected in investment.

Whilst most localities in England have developed a range of partnerships between health and social care, these are often poorly co-ordinated. For example, in

Newcastle-under-Lyme, a locality in Staffordshire with an urban and rural mix, a dizzying array of locality partnerships developed in the 1990s. These partnerships included schemes for urban regeneration, the redevelopment of coalfields, a health action zone, and partnership to tackle crime and disorder, the creation of a 'healthy living centre', and Sure Start amongst at least 20 others. As a result, silos upon silos have been created that has led to the development of new organisational bureaucracies [54]. In other words, the eagerness of different partners to tackle certain issues has led to a 'compartmentalisation' of approaches. This process is common across England in which layers upon layers of partnership innovations are being created that, ironically, have the potential to create the same kinds of barriers to 'whole system' integration that many were designed to overcome. This is yet another example of the 'disintegrated integration syndrome' that is so endemic in the English public sector.

A recent Government examination of partnership working between health and social care concluded that there are 'profound systematic and structural problems which relate to the lack of co-ordination between different government departments, statutory agencies, elected authorities and the voluntary sector' [55]. It recommended that Health Improvement Programmes and Community Plans should be integrated as a matter of urgency. Moreover, better policy co-ordination at local level has been proposed through the development of Local Strategic Partnerships [56,57]. The purpose of these is to provide a vehicle for the rationalisation of multiple local plans and partnerships into a single co-ordinated initiative. However, in the NHS Plan, the original idea for Local Strategic Partnerships as the key to integrating planning processes was rejected. The NHS Plan regards their development as simply an umbrella for linking health education and other causes of social exclusion [53].

## Implementing the NHS Plan – barriers from further organisational restructuring

The NHS Plan is broadly supported across the NHS. Indeed, some observers have suggested that the Plan is 'as good as it gets' since it sets out enduring principles on which change should be based and promises a significant injection of money sustained over five years [10,58].

From the discussion of the various aspects of the Plan given above, it would appear that the nature and speed of the Plan's implementation would be reliant

on two key factors. First, appropriate resources are required to create capacity within the NHS to enable new functions to develop. There was a fear expressed by many that the Government was looking for results without first investing in people to enable this to happen. For example, there have been real concerns about the lack of management capacity and resources in Primary Care Trusts and their ability to cope with taking forward greater commissioning responsibilities [45]. Second, the promotion of access and service integration requires the development of significant co-ordination, collaboration and networking between agencies and individuals. This is particularly important for health and social care professionals within the system since their historically separate professions mean that a significant period of change management is required to allow new roles and partnerships to evolve.

However, the ability of the Service to deliver the NHS Plan has come under increasing stress following the Department of Health's July 2001 publication *Shifting the Balance of Power in the NHS: securing delivery* [59]. The document was meant to be the framework through which the goals of the NHS Plan could be delivered. However, the document set out radical proposals for further organisational restructuring including:

- The replacement of the current 95 health authorities with 28 larger 'strategic' health authorities; and
- The transfer to Primary Care Trusts of most health authority responsibilities.

The outcome from this structural reorganisation is likely to be a system in which care will be commissioned by Primary Care Trusts holding a budget for populations of about 250,000 people. The commissioning approach of Primary Care Trusts will be influenced heavily by strategic guidance from national government guidelines and strategies developed by their host Strategic Health Authorities. Acute hospitals will remain independently 'governed', whilst community and primary care services will be integrated and more directly managed through a system of local contracts.

The assumption that is implicit is that such structural change will help improve the performance of the NHS in delivering the NHS Plan. However, the scale and pace of the new structural changes (meant to be completed by April 2002) seem at odds with the need to deliver demanding NHS Plan targets. Indeed, a recent survey of 304 chief executives found that three-quarters felt the *Shifting the Balance* reorganisation

would severely delay the delivery of the NHS Plan and create a major disincentive for organisations and individuals who would now focus on survival rather than on delivering the future [60]. Others have shown how gains in ownership and involvement that resulted from the creation of new primary care organisations have lost momentum. In this sense, the Government's rhetoric of empowerment and devolution has been tempered by an approach that has centrally determined their size, shape and function [44].

Through its emphasis on structural reorganisation the Government may have missed the key challenges faced in delivering its NHS Plan. As this article has shown, the need to address cultural and behavioural change is probably far more important and appropriate than an approach that just rearranges structural furniture. A less directive set of implementation plans were required that performance managed the Service on results rather than on process. The lack of space and time to build on and encourage delivery and partnership has led to increasing disengagement from general practitioners and hospital clinicians who feel pressured, overworked and undervalued. Moreover, managers within the system find their jobs increasingly at risk if targets are not met. Such a scenario paints an increasingly unhealthy picture of those within the Service struggling to cope with excessive levels of top-down Government initiatives.

## Conclusion – towards an integrated public sector?

A number of conflicting messages appear to emerge from Labour's modernisation agenda in relation to the better integration of public services in England. On the one hand, the tone of the 'modernisation agenda' suggests that professional, organisational and service integration are key tasks. For example, the Labour Government can be credited with the creation of mechanisms that removed legal obstacles to such joint working [40,47]. This has allowed health and social care agencies the potential to pool budgets and integrate service provision. Furthermore, the development of new local contracts and organisations for the delivery of primary care, such as Personal Medical Services pilots, gives rise to a vision of a 'managed' service that integrates the accountability and performance management of professionals and the delivery of services they provide. The NHS Plan envisages the creation of a 'single care network' in which family doctors, other primary care and social care staff

work in teams providing a range of care services for patients. The National Service Frameworks also promote the need for integration. For example, the National Service Framework for older people encourages the development of intermediate care services at the interface between hospital inpatient care and nursing home or care at home services [19].

However, other policies suggest that the integration of public services may be somewhat limited. For example, the NHS Plan's emphasis on promoting access to care is suggestive that care delivery is more important than tackling poverty and the causes of ill health at source. Moreover, recent structural reorganisation has not overcome the different alignments of geographical boundaries and constituencies that inhibit the ability of health and social care agencies to integrate. Evidence suggests that Primary Care Trusts have not been organised to promote geographical alignment with local authorities (except in London), but have instead been based on creating associations with, as far as possible, like-minded health professionals [47]. This process reveals a disturbing lack of policy direction to aid organisational integration as well as the lack of weight given by health professionals to the integrated care agenda.

Perhaps the key failure of the Labour Government's modernisation agenda to date is its predisposition to curing Service ills through structural change when much of the available evidence suggests that the key and persisting barrier to service integration is the values and cultures held by professionals [1,40,45,47].

Emerging lessons from the development of Personal Medical Service pilots in England suggest that service integration and professional team working has, as yet, failed to materialise despite the incentives for team working under new local contracts [61]. Such findings suggest that if the Government really wants to move towards a more integrated public sector then the focus needs to shift to a process of cultural and behavioural change amongst health and social care professionals. Deeming the solution to be structural is likely to be doomed to failure. Whilst structural solutions might remove organisational barriers to help parties engage, they do not address the fact that professionals with fundamentally different attitudes to service delivery are unlikely to use them.

## **Lessons for other countries**

The English experience of 'modernisation' has a number of implications for other countries. In particular,

the motivation for further reform of the English health care system was the inability of its 'internal market' to provide effective, comprehensive, and accessible care services. Given that the Governments of many other countries have similarly had to intervene due to the failure of 'managed competition' in their health care systems [7], developing countries such as those in Eastern Europe or Latin America currently seeking market solutions to the provision of public health care should be aware that the approach is likely to promote inequity whilst not necessarily promoting cost-efficiency.

Another key lesson surrounds the ability of Governments to gain the allegiance of health care professionals to work in a collective manner. In most countries, except through heavily socially engineered systems such as Cuba, authorities or central insurance organisations are administrative rather than managerial since their decision-making power over professionals remains very limited. Despite the rhetoric of devolving power to frontline professionals, the imposition of a range of national frameworks, clinical governance arrangements, and quality-based local contracts in England appear to be shifting the balance in favour of the manager and making the health care professional far more accountable. The approach appears similar to those quality assurance mechanisms employed by US Health Maintenance Organisations. In both cases health care professionals have balked at the level of managerial control.

A final important observation of the English experience is that professional and managerial allegiance to existing health and social care institutions remains a significant and enduring barrier to integration. One might suggest, therefore, that to develop integrated care systems better one should move away from institutionally based care that fragments service delivery. Indeed, the English Department of Health has recognised the need to develop 'networks' of care, already developing for cancer care [62], basing its ideas on innovations from countries such as Australia and Scotland where clinical networks have developed amongst providers of care that are unconstrained by existing professional and organisational boundaries [63].

## **Vitae**

**Dr. Nick Goodwin** is lecturer at the Health Services Management Centre, University of Birmingham, UK. His main teaching and research interests are in the fields of health policy, integrated care and the development of primary care organisations.

## References

1. Mays N, Wyke S, Malbon G, Goodwin N. The purchasing of health care by primary care organisations. An evaluation and guide to future policy. Open University Press, Buckingham; 2001.
2. Mays N, Mulligan J-A, Goodwin N. The British quasi-market in health care: a balance sheet of the evidence. *Journal of Health Services Research and Policy* 2000;5(1):49–58.
3. Le Grand J, Mays N, Mulligan J, editors. Learning from the NHS Internal Market – a review of the evidence. King's Fund Publishing, London; 1998.
4. Fougere G. Transforming health sectors: new logics of organizing in the New Zealand health system. *Social Science & Medicine* 2001;52(8):1233–42.
5. Hardy B, Mur-Veeman I, Steenbergen M, Wistow G. Inter-agency services in England and The Netherlands: a comparative study of integrated care development and delivery. *Health Policy* 1999;48:87–105.
6. Benzeval M, Judge K, Whitehead M, editors. Tackling inequalities in health: an agenda for action. London: King's Fund; 1995.
7. Light DW. Cost containment and the backdraft of competition policies. *International Journal of Health Services* 2001;31(4):681–708.
8. Department of Health. Modernising health and social services. National priorities guidance 2000/2001–2002/2003. London: Department of Health; 2000.
9. Secretary of State for Health. The NHS Plan. A plan for investment, a plan for reform. London: The Stationery Office; 2000.
10. Dixon J, Dewar S. The NHS plan. As good as it gets – make the most of it. *British Medical Journal* 2001;321:315–6. Available from: URL:<http://www.bmj.com>
11. Beecham L. Tony Blair launches radical NHS Plan for England. *British Medical Journal* 2001;321:317. Available from: URL:<http://www.bmj.com>
12. Serjeant G. More tax is unhealthy choice. *The Times*; 2002 February 22. Available from: URL:<http://www.thetimes.co.uk>
13. Department of Health. The New NHS, Modern, Dependable. London: The Stationery Office; 1997.
14. Department of Health. A first class service. London: Department of Health; 1998.
15. Department of Health. The NHS Cancer Plan. A plan for investment. A plan for reform. London: Department of Health; 2000.
16. Department of Health. National service framework for coronary heart disease. London: Department of Health; 2000.
17. Department of Health. National service framework for diabetes: standards. London: Department of Health; 2002.
18. Department of Health. Mental health: a national service framework. Modern standards and service models. London: Department of Health; 1999.
19. Department of Health. National service framework for older people. London: Department of Health; 2001.
20. Department of Health. Modernising health and social services. National priorities guidance. London: Department of Health; 2000.
21. Department of Health. Implementation programme for the NHS Plan. Department of Health; 2001. Available from: URL:<http://www.doh.gov.uk/nhsplanimpprogramme/priorguid.htm>
22. NHS Executive. Faster access to modern treatment: how NICE appraisal will work. Leeds: NHS Executive; 2000. Available from: URL:<http://www.nice.org.uk>
23. Dobson R. NICE to reconsider evidence on interferon beta. *British Medical Journal* 2000;321:1244.
24. Forbes RB, Lees A, Waugh N, Swinger RJ. Population-based cost utility study of interferon beta-1b in secondary progressive multiple sclerosis. *British Medical Journal* 1999;319:1529–33.
25. Dyer C. Ruling on interferon beta will hit health authorities. *British Medical Journal* 1997;315:143–8.
26. Commission for Health Improvement. St George's Healthcare and NHS Trust Report Published. London: CHI; 2001 September 12. Available from: URL:<http://www.chi.nhs.uk>
27. Department of Health. NHS Performance Ratings. Acute trusts 2000/01. London: Department of Health; 2001.
28. Harrison A. National Service Frameworks – an overview. London: King's Fund; 2000.
29. Shellens T, Dimond B. Strapped for cash. *Health Service Journal* 2000;110(5711):7–8.
30. Enthoven A. America's experience with managed health care and managed competition. In: Goodwin N, editor. The new NHS: what can we learn from managed care in New Zealand and the US? Seminar briefing paper no.1, Office of Health Economics, July 1999.
31. Taylor A. National service framework goals branded unrealistic. *Health Service Journal* 2001 August 3.
32. Coffey T, Boersma W, Smith L, Wallace P, editors. Visions of Primary Care. London: King's Fund; 1999.
33. Munro J, Nicholl J, O'Caithain A, Knowles E. Evaluation of NHS Direct First Wave Sites. Second interim report to the Department of Health, University of Sheffield, Medical Care Research Unit; 2000.
34. Florin D, Rosen R. Evaluating NHS Direct. *British Medical Journal* 1999;319:5–6.
35. Chapple A, Halliwell S, Sibbald B, Roland M, Rogers A. A walk-in? Now you're talkin! *Health Service Journal* 2000;4:28–9.

36. Lipman T. Shifting professional roles in the primary health care team. In: Coffey T, Boersma W, Smith L, Wallace P, editors. *Visions of Primary Care*. London: King's Fund; 1999.
37. Goodwin N. The long term importance of English primary care groups for integration in primary health care and deinstitutionalisation of hospital care. *International Journal of Integrated Care* [serial online] 2001 Mar 1; 1. Available from: URL:<http://www.ijic.org/>
38. Salisbury C, Boersma W. Balancing demand and supply in out of hours care. In: Salisbury C, Dale J, Hallum L, editors. *24 Hour Primary Care*. Oxford: Radcliffe Medical Press; 1999.
39. Weiner J, Lewis R, Gillam S. *US managed care and PCTs*. London: King's Fund; 2001.
40. Goodwin N, Shapiro J. *The road to integrated care working*. Health Services Management Centre, University of Birmingham; 2001.
41. Beecham L. GPs are disappointed at gaps in NHS Plan. *British Medical Journal* 2000;321:470.
42. British Medical Association. *Radical action required to keep family doctors in the NHS*. BMA Press Centre; 2001 October 17. Available from: URL:<http://www.bma.org.uk>
43. Beecham L. Government plans for private practice are 'insulting'. *British Medical Journal* 2000;321:470.
44. Shapiro J. Will devolution of power lead to a final revolution? *Primary Care Report* 2001 October, p. 21.
45. Regen E, Smith J, Goodwin N, McLeod H, Shapiro J. *Passing on the baton: final report of a national evaluation of primary care groups and trusts*. Health Services Management Centre, University of Birmingham; 2001.
46. Department of Health. *Health Act 1999*. London: The Stationery Office; 1999.
47. Glendinning C. *Implementing Care Trusts: some lessons from research*, paper presented to Care Trusts: Shotgun Marriage or Coming of Age? HSMC seminar, Botanical Gardens, Edgbaston, Birmingham, 3 October 2001.
48. Department of Health. *Care Trusts. Emerging framework*. London: Department of Health; 2001 March.
49. Giles S. *Care Trusts: the future*, paper presented to Care Trusts: Shotgun Marriage or Coming of Age? HSMC seminar, Botanical Gardens, Edgbaston, Birmingham, 3 October 2001.
50. Stephenson P, Crail M. DoH names nine care trusts to pilot reforms. *Health Service Journal* 2001 July 26.
51. Department of Health. *Saving Lives – Our Healthier Nation*. London: Department of Health; 1999.
52. UK Public Health Association. *Prospectus for Public Health*. UK Public Health Association; 2001 March.
53. Knight TM. The NHS Plan: improving health and reducing inequality? *HSMC Newsletter* 2000, 6;3.
54. Warnes M. *Integrated planning processes: joining it up in Newcastle-under-Lyme*, paper presented to HSMC seminar, Climb Every Mountain ....? Reaching the dream of integrated planning for health improvement, Botanical Gardens, Birmingham, 12 June 2001.
55. Department of Health. *Government response to the House of Commons Select Committee on Health's Second Report on Public Health, CmP 5242*. London: The Stationery Office; 2001.
56. Department of the Environment, Transport and the Regions. *Local Strategic Partnerships: Government guidance*. London: DETR; 2001.
57. Social Exclusion Unit. *A new commitment to neighbourhood renewal. National Strategy Action Plan*. London: Social Exclusion Unit, Cabinet Office; 2001 January.
58. *Health Service Journal*. Yet more change is still not the answer. *Health Service Journal* 2001 October 11;15.
59. Department of Health. *Shifting the Balance of Power in the NHS: securing delivery*. London: Department of Health; 2001.
60. Walshe K, Smith J. Cause and effect. How do chief executives feel about the latest NHS reorganisation? *Health Service Journal* 2001 October 11:20–3.
61. Walsh N, et al. *PMS pilots: final report of a national evaluation*. Health Services Management Centre, University of Birmingham; 2002.
62. Department of Health. *Shifting the balance of power – the next steps*. London: Department of Health; 2002. Available from: URL:<http://www.doh.gov.uk/shiftingthebalance/index.htm>
63. Clark J. From hospitals to networks? *Health Services Management Centre Newsletter* 2002;8(1):1.