

Editorial

Does scarcity lead to better integrated care?

This is an attractive idea. The argument is that shortage of resources should motivate professionals to share these effectively, and this inevitably means integration. Examples include war leading to social cohesion in uniting against a common enemy. In World War II efficient use of scarce food resources through rationing led to improvement in health of the majority of lower-class people in the UK and an overall improvement for the whole population, although the rich may have missed their luxuries.

But scarcity leads to fear and may encourage individuals in small groups to be more inward looking, to 'look after number one'. Here, scarcity risks disintegration of care.

Whether the first or second of these points applies will depend on the context of trust. If members of a complex system or society trust each other then they will

- (a) wish to cooperate well with colleagues, leading to better co-ordination and integration, and
- (b) be unselfish and prepared to share scarce resources perhaps with other colleagues who seem better able to use them or who have greater need of them.

On the other hand, if trust is lacking, the professionals may adopt a 'bunker mentality' where individual units or groups keep resources for themselves, even when they may not be able to use them effectively. They will prioritise internal performance goals more highly than the performance of the system as a whole. They may blame the system for perceived failures of delivery or deterioration of outcomes, rather than ask whether they themselves could make a better contribution towards co-operation and integration.

The British experience of the 'internal market' for health care is instructive. The laudable aim of the scheme was to cost competing health care resources accurately and to allow the purchaser, typically a health authority or a fund-holding primary care unit for example a general practice, to bargain and choose which resources to use based on price and value for money. This would encourage better use of resources as care providers would be motivated to work more efficiently. More efficiency should include better integration.

This system was abandoned after six years at a time of change of political leadership. It was deemed to have failed for two main reasons.

1. It was not possible for prices to accurately match costs.
2. A two-tier system was developing. The system lacked equity for patients because those registered with 'fundholding' (financially independent) general practitioners had quicker access to specialists.

Critics could argue firstly that it was not allowed enough time or space to succeed and, in association with this, a genuine market was not allowed to develop as no one was allowed to fail (for example, go bankrupt or shut) [1].

A more measured assessment was that integration did not result in an internal market because the market did not encourage the trust necessary for good integration. The independent provider units, or 'trusts',¹ behaved secretly and concealed their processes and costs. Thus, the previous culture of shared values and resources was seriously undermined and integrated care was handicapped. Boundaries between primary, secondary and tertiary care systems and between health and social care systems became entrenched and true integration became more difficult.

Ironically, after a period of talking up sharing and co-operation, the incoming Blair government has espoused a commissioning process, which is strikingly similar to the former purchaser-provider split that they so vocally ended when they first came to power in 1997. There has been micro-management and target setting leading to 'cooking the books' and falsified statistics in order to reach the targets. This breaks down trust again and may at best lead to the appearance of integration without genuine co-operation (pseudo-integration).

Scarcity implies hard times and I have mentioned the stimulus of war towards social cohesion. But the advance of biomedicine since the end of World War II has led us to a permanent state of scarcity where resources can never meet perceived needs or opportunities to deliver care. It may be no accident, then, that integrated care is riding on to the battlefield like

¹ The pun on 'trust' may be enjoyed or ignored!

the proverbial 'knight in shining armour' to rescue cash-strapped health services. As academics interested in the development and application of integrated care systems, we are interested in mechanisms. How do systems and people work? Which systems use resources best? How can care be delivered so that patients perceive continuity and co-ordination rather than disjunction, interruption and disintegration?

My message is that good mechanisms are interesting and important, but they are not sufficient to deliver truly integrated care. Policy makers, including managers and professional leaders, must have another priority if

they wish to appear as success stories in tomorrow's history books. They must deliver the right context, that is a context of trust. This will enable professionals and managers to trust each other and the political framework. They need to trust that their best efforts to work together for the good of patients will be recognised appropriately. They need to feel so rewarded as to redouble their efforts!

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References

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