Former LHIN CEO/NHS executive comments on *Integrated Health Care in England: Lessons for Ontario* (The Change Foundation, May 2009)

TONY WOOLGAR SPENT the past 35 years in senior health care management and national and provincial policy development in England and Canada. He served for a decade as a hospital CEO in England's National Health Service (NHS) and was the founding CEO of the South West Local Health Integration Network (LHIN) in Ontario. Given his unique experience and breadth of knowledge, Tony is well suited to comment on *Integrated Health Care in England: Lessons for Ontario,* The Change Foundation's first in a series of international case studies to highlight health system reforms and extract lessons for Ontario decision makers.

Commentary by Tony Woolgar

Introduction

COMPARATIVE STUDIES ARE IMPORTANT for health care systems to undertake and should inform policy development, structural change and investment priorities. Drawing on the experience of other systems, harvesting the best learning, while seeking to avoid the pitfalls and 'wrong turns' that have impeded progress elsewhere, makes good sense.

This case study by The Change Foundation appropriately considers how Ontario can learn from the extensive and continuous health care reforms in England. It highlights the similarities between England and Ontario — two jurisdictions with a proud history of a publically-funded health care system providing:
universal coverage and services free at the point of delivery;

- a strong political will to formulate health policy based on equity of access, targeted investment in reduced wait times and better health outcomes;
- an acknowledgement of the need for a decentralized model for the planning and commissioning of services; and
- a recognition that, despite significant increases in health care spending year after year, and continuous structural and system reform, the achievement of an integrated health care system is not yet a reality.

Integrated health care is the 'holy grail' that has eluded most jurisdictions thus far, but is increasingly a priority for politicians, policy makers and health care leaders alike, and an expectation of patients and clients and their families.

Leveraging Change

IN ENGLAND THERE HAS BEEN a continuous cycle of reorganization, restructuring and reform, often resulting in major organizational change, increasing layers of bureaucracy and the establishment, adjustment and dismantling of regulatory bodies. Ontario has the opportunity, with a shorter history of restructuring and reform, to take the best of England's experience of integrating health care: a comprehensive localized commissioning framework, patient and public involvement in planning and decision making, investment in eHealth and information technology and the creation of strong regulatory and accountability frameworks and apply this to the decentralized provincial structure recently introduced.

The new health care structure in Ontario, with the Ministry of Health and Long-Term Care moving to a stewardship role and the creation of fourteen Local Health Integration Networks (LHINs) with Community Care Access Centres (CCACs) having the same boundaries, provides the best opportunity thus far to accelerate the integration agenda.

The LHINs are still early in their development, but their responsibility for funding and allocation, planning and integration and performance management at the local level provides a framework for change and innovation. So where should Ontario focus its efforts to create a more integrated health care system, recognizing that there is little appetite for further structural reform at this time.

Patient Focus

FOCUSING ON THE PATIENT, client and family should be at the forefront. The case study highlights the significant progress made in England, at both the national and local levels in the areas of patient advocacy, patient information and patient choice. England has a strong history of patient and public representation through national consumer surveys, regulatory frameworks for clinical excellence and statutory frameworks for public consultation.

Accountability structures for Primary Care Trusts, Hospital Trusts and Foundation Trusts include a requirement to involve patients in all aspects of health service planning, performance measurement and quality improvement. In most aspects of patient and public involvement, funding has been made available to set up and maintain consultative infrastructure, introduce collaborative structures and implement change.

In Ontario, patient surveys are routinely undertaken by hospitals and CCACs, but currently there is nothing formally in place for primary care, or on a system-wide basis. LHINs undertook extensive community engagement to inform the first three-year Integrated Health Service Plans. Although there is also a statutory requirement for LHINs to engage in community consultation on an ongoing basis, the scope of community engagement is not defined and there is no requirement to have in place formal consultative machinery. It would be possible for LHINs to set up Local Involvement Networks, as has happened in England, to consult local communities about configuration and reconfiguration of services, development projects and investment priorities. There would also be value in LHINs establishing a Patient or Consumer Panel which would focus on service quality, equitable access and patient choice. A commitment to survey the wider health community on a periodic basis should be introduced.

Responsibility for maintaining service quality and excellence should include a role for health care professionals. LHINs could use the new Health Professionals Advisory Committees (HPACs) to oversee clinical standards and quality, develop protocols and guidelines for treatment and care and advise on integrated care pathways. Closer links should also be established with municipalities to promote the concepts of healthy communities and whole system planning.

The Commissioning Role

The commissioning of health care services based on the separation of purchaser and provider functions has long been an important part of building an integrated health care delivery model in England. The commissioning model has been defined, redefined and developed

over many years. The role of General Practitioners (GPs) as gatekeepers to the secondary and tertiary care system has been a feature of the commissioning model since the early 1990's. In as early as 1991 GPs were given budgets to buy services directly from hospitals including out-patient, ambulatory care and elective surgical services. More recently Primary Care Trusts (PCTs) have been at the forefront of the commissioning model, negotiating contracts with acute and community hospitals, independent treatment centres and other non-NHS providers. Although PCTs vary in the size of population they serve, the latest evaluation, as the study indicates, suggests that a larger population of between 750,000 — 1 million is considered to be the optimum size for effective commissioning.

Primary care provision in Ontario is fragmented and under-resourced with many people not having access to a family physician. Although the introduction of Family Health Teams (FHTs) (presently 150 increasing to 200) should support the development of more integrated services, the lack of a consistent primary care model across the province will inhibit the development of primary care led commissioning. It is possible however, to introduce commissioning pilots in some larger FHTs using the experience of PCTs in England.

LHINs are well positioned to begin to develop an effective commissioning framework for Ontario; they are large enough in terms of population coverage and have a statutory requirement to develop an integrated health care system. The accountability agreements now in place with hospital and community providers could evolve into three-year Service Level Agreements (SLAs), with indicative cost and volume specifications and specific performance improvement targets. SLAs could initially be negotiated on a block contract, and for higher cost, lower volume services on a cost and volume or cost per case basis. There should also be targeted integration initiatives to create new models of care and incentives to move to a health and wellness model.

Developing a commissioning model that truly supports integrated care delivery, would require an expansion of the LHINs' mandate to include responsibility for primary care development, Family Health Teams, public health and ambulance services. Despite these limitations, there is still much work that LHINs can do to move the commissioning agenda forward within the existing scope of their authority.

Funding and Allocation

ALTHOUGH ENGLAND HAS DEVELOPED sophisticated funding mechanisms, many of which are designed to facilitate patient choice and ensure that 'money follows the patient', there are still separate budgetary allocation systems for hospitals, primary care, community services and social care. The added complexity of social services being provided by municipalities impedes building a truly integrated health and social care delivery system.

Although Ontario currently does not have a population-based funding model for health care, the development of the Health-Based Allocation Model (HBAM) would enable LHINs to be able to commission services based on the most effective utilization of resources and the health needs of the population. The key to HBAM being applied effectively would be evidence-based decision making by LHINs, firm targets for performance improvement and the introduction of system-wide metrics to evaluate the quality and effectiveness of health care delivery.

Information and eHealth

INFORMATION MANAGEMENT AND TECHNOLOGY and the adoption of an electronic health care record have been key policy and investment priorities for the NHS since 1991. As the study shows, the investment required to deliver the National Programme for Information Technology (NPIT) has far exceeded budget projections or funds available. While at the national level there are serious doubts about the financial viability of the programme going forward, at the local level clinical and patient information systems are in place which support integrated care pathways, inform patient choice and support performance management and clinical audit activity.

Ontario has recently made a significant commitment to invest $2 billion over the next three years in the implementation of eHealth initiatives and the creation of an electronic health record by 2015. This level of investment, along with the establishment of the new eHealth Ontario Agency, will start to address the view that Ontario is significantly behind the rest of Canada in eHealth adoption.

LHINs also need to engage clinical leadership to inform the development of the eHealth strategy within each LHIN. Currently LHINs are inadequately resourced to design and implement an eHealth strategy. This needs to be remedied quickly to ensure a return on the province's investment.

Conclusion

MUCH CAN BE LEARNED and applied from England's progress towards an integrated health care system. Regardless of the geographical and cultural differences and the growing pains of a new decentralized regional model in Ontario, there is a unique opportunity to make major strides in the areas of patient and public engagement, commissioning, governance and accountability and eHealth.

The priority afforded to accelerating the integration agenda is reflected in the provincial health budget for 2009/10 which targets investment in Emergency Room Wait Times, improved access to Family Health Care and modernizing infrastructure including eHealth initiatives.

LHINs will play a key role in moving this agenda forward, and, together with CCACs, their effectiveness will be measured by their ability to implement real change and innovation with limited resources.

Integration may still be the 'holy grail' that proves difficult for Ontario to attain, but this and future case studies will confirm that a 'made in Ontario' solution can include change that has been successful elsewhere.

The experience in England shows that significant investment in infrastructure, numerous iterations of a devolved management model and strong regulatory and governance frameworks do not in themselves deliver integration or improve the patient and client experience. It is the scope of our ability, as a system, to listen and respond to local needs that will be the lynch pin in bringing and keeping an integrated system together. By building on what works in other jurisdictions, avoiding what doesn't and applying a "local needs" lens to system design, health care transformation may not be painless, be is most certainly achievable.

Tony Woolgar *is Managing Partner with Connective Intelligence and CEO of Connective Intelligence Health Systems, and was the founding CEO of the South West Local Health*

Integration Network

Companion Pieces

TO PROVIDE FURTHER INSIGHTS and prompt additional reflection on the lessons from NHS England's health reforms, The Change Foundation offers the following companion pieces and supportive charts to accompany our case study:

- Health System Reforms in NHS England: Context, Culture, Power, a Q&A with Jamie Burn;
- A Commentary by Tony Woolgar on *Integrated Health Systems in England: Lessons for Ontario* (The Change Foundation, May 2009) and a feature video podcast interview with him and The Change Foundation;
- A summary of key components/characteristics of NHS England;
- Integrated health systems—England case study: Comparative analysis with Ontario.

All companion pieces can be found at www.changefoundation.com