A key strategic direction of The Change Foundation is to support the implementation of an integrated health system in Ontario through evidence-based policy and research.

As part of gaining this expertise and to inform health system transformation in Ontario, the Foundation wants to learn from jurisdictions that have undertaken reforms to achieve integrated, high quality, accessible and sustainable systems for health promotion, disease prevention and management, and care. This case study is the first in a series of papers that will draw from instructive international examples of integrated health systems.

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www.changefoundation.com
The Change Foundation
The Change Foundation is an independent health policy think tank that generates research, analysis and informed discussion on health system integration and quality improvement in home and community care in Ontario.

Located in Toronto, The Change Foundation is governed by a 12-member board of directors, led by President and CEO Cathy Fooks and supported by a small professional staff.

Established in 1996 through an endowment by The Ontario Hospital Association, The Change Foundation is an independent charitable foundation with a mandate to promote, support and improve health and the delivery of health care in Ontario.

Our Strategic Plan
The Change Foundation’s strategic plan, Contemplating the way we change/Changing the way we think, has three objectives:

1. Support the implementation of an integrated health system in Ontario through evidence-based policy and research;
2. Improve patient outcomes through integration-related quality improvement projects, starting with a focus on home and community care services and informal caregiving;
3. Drive informed public debate through active engagement with decision-makers.

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

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Health Policy and Management
Health Services Management Centre
University of Birmingham
Birmingham, UK

Professor David Knowles
Senior Associate
Kings Fund
London, UK

Jamie Burn
Research Fellow, Health and Social Care Unit
Policy Exchange
London, UK

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Foreword
This is the first of several case studies on integrated health-care systems produced by The Change Foundation. Why should you care? Because Ontario has created Local Health Integration Networks or LHINs with an explicit mandate to plan integrated health care.

Why start with the English National Health Service? Because it is intentional. It takes risks. It makes mistakes and learns from them. It keeps the patient at the centre of its efforts. And, it publishes everything.

What have we learned from undertaking this work? Transformation is messy even with intent and certain things are required to support integrated care. Without the following, health care remains disjointed. Ask yourself the following questions when thinking about integrating care in your community:

Who Does What? Integration needs well-defined governance structures with clear roles, responsibilities and accountabilities.

What Services are Needed? Integration needs a strong and sophisticated purchasing framework with sufficient support, expertise and information to carry out the role effectively.

Are Patients and Their Families Involved in Planning? Integration needs support for community engagement in local health system planning, and clear definition of areas requiring community engagement in the decision-making process.

How are Services Funded? Integration needs sophisticated and aligned funding models and incentive payments in the primary, secondary and tertiary sectors to support clinical integration and collaboration between hospital and community providers.

Who Can Best Deliver Care? Integration needs multidisciplinary teams who take on a key role in coordinating care through self care support and training, disease management, and case management.

Who Decides What Should be Funded? Integration needs an independent, expert organization to evaluate the effectiveness of emerging health technologies, drugs, devices and procedures and to establish the scope of services and interventions that will be funded.

How is Quality Determined? Integration needs evidence-based service frameworks as a strategy to raise quality of care, decrease variations in service delivery and ensure accountability of providers.

What Gets Reported? Integration needs a performance monitoring and reporting system which defines evidence-based, outcome-oriented provincial standards, supports the development of locally determined health targets, and aligns performance measures, quality improvement and public reporting activities.

What Infrastructure is Required? Integration needs IT initiatives that engage clinicians and professional bodies in the planning, implementation, management and governance structures. Investments and timelines to establish and implement electronic health records are also required.

How Does Health Care Integrate with Other Determinants of Health? Integration needs a commitment to integrated public policies for public health, health promotion and population health, including a framework for health and social care, inter-sectoral partnerships, and agreements with municipal authorities.

We have tried to answer these questions as we tease out lessons from this case study for Ontario—we hope you find this useful and thought-provoking.

CATHY FOOKS
PRESIDENT AND CEO
May 2009
Introduction
The purpose of presenting international case studies is to summarize health system reform initiatives and extract lessons for Ontario. We want to tell the story behind the reforms—what made them possible? What policy and funding levers were effective integrating mechanisms? What cultural and contextual factors underlie, enable or hinder change? The case studies will review the following elements of health system integration:2

Patient Perspective
Integrated health systems are patient focused. Organizational processes consider the needs of patients and their families, are easily navigated especially across care transitions, and provide patient choice.

Provision of Care
Care is provided by multidisciplinary teams with members having clear understanding of their roles and decision authority for patient care. Standardized care models with evidence-based clinical care guidelines and protocols, umbrella organizational structures, and provider networks with standardized referral procedures, service agreements, joint training and shared information systems support successful health system integration.

Governance Structure and Authority
A strong governance model— with decision-making authority, clear accountabilities, shared risk, real opportunities for patient/community involvement in decision-making, rostering within a geographic governance area— impacts health system integration.

Funding Mechanisms and Incentives
A population-based funding formula, applied equitably, with programmatic funding dedicated to specific, priority services contributes to successful health system integration. Comprehensive funding—coverage for services across the primary, secondary, tertiary, health promotion and population health continuum—and alignment of financial incentives have been identified as critical components of successfully integrated health systems.

Performance Management
Integrated health systems aspire to continuous quality improvement—performance goals are explicitly defined, and there is a coordinated and aligned approach to setting, delivering and monitoring standards. The public should have access to information on the performance of the health system—health outcomes, patient and caregiver experience, provider performance, organizational performance, and inter-organizational performance.

Information Management
Investments in information technology, information management systems and communication mechanisms facilitate integrated service delivery along the continuum of care. The patient experience in navigating a health system can be vastly improved through electronic health records, and other electronic systems. Integrated information and communication systems are especially critical when providers are not co-located.
A Focus on England
Health system reforms are influenced by a jurisdiction’s traditions, politics, cultures and beliefs. The United Kingdom’s National Health Service (NHS) was established in 1948 as a universal service with equal access to all, free at the point of use, provided on the basis of clinical need, and funded mainly by taxation. Health care is regarded to a large extent as an entitlement and as the responsibility of the state.

The NHS has iconic status in the U.K., as does Medicare in Canada. Health care responsibilities have been devolved to constituent countries – England, Scotland, Wales and Northern Ireland. Reform of the English NHS was initiated by the Conservative Government in the 1990s and has continued under the Labour Government guided by “the interplay between patient choice, mandatory national targets, economic incentives, competition, and an extended network of independent providers in both the public and private sectors”.

(Edwards, 2007, p. 27)

England is a jurisdiction of interest for the following reasons:

→ Like Ontario, England has a publicly funded health-care system providing universal coverage. For a sense of scale – England’s population is 50.4 million (83 per cent of the U.K. population); Ontario’s population is 12.1 million (2006 Census).

→ England has a long history and tradition of regionalization – there have been different regional structures since the inception of the NHS in 1948 and regionalization has been imbedded in the culture of the NHS.3

→ England has made real progress in improving its performance in the last decade – independent research has shown the NHS has made progress in improving quality of care for patients (as cited in Darzi; 2008; Leatherman and Sutherland, 2008).

→ Reform policy in England has generally distinguished between those who commission services and those who deliver care – the purchaser/provider split.4 Ontario has pursued the purchaser/provider split with the establishment of Local Health Integration Networks following the earlier adoption of this approach with the Community Care Access Centres.

→ Goals of reform have included reducing wait times, improving service quality, reducing hospitalization through coordinated care outside hospitals, and decentralizing decision-making – goals consistent with reform objectives in Ontario.
A. Description of England’s Health System

The NHS is administered by the Department of Health which has a mandate to fund, direct and support the NHS (Department of Health, 2007a). The Department sets the strategic direction of the NHS, public health and social care (Department of Health, 2006a), develops policies in collaboration with stakeholders, and monitors the financial and clinical management of the overall system.


- **Strategic Health Authorities (SHAs):** In 2002, 28 health authorities were established to manage the local NHS on behalf of the Department of Health. In 2006, boundaries were changed resulting in ten SHAs – essentially regional organizations of the Department of Health – responsible for populations ranging from 2.6 million to 7.5 million. The SHAs have a system management role with a mandate to develop plans for improved health services, monitor performance of the Primary Care Trusts and NHS Trusts, and ensure national priorities are integrated into local health service plans.

- **Primary Care Trusts (PCTs):** are responsible for assessing local needs; developing a local health system strategy (e.g., appropriate providers, level of competition and cooperation between providers, capital spending, etc.); commissioning services from providers of preventive, primary, secondary and specialist care; monitoring service delivery; integrating health and social services; and, in most cases, directly providing services (e.g., district nursing, community services). PCTs are accountable via the SHAs to the Department of Health/Secretary of State for Health. They are assessed annually by the Healthcare Commission against standards and targets for quality of care, and the Audit Commission for financial management and accounts. There are currently 152 PCTs.

- **NHS Foundation Trusts (FTs):** are community or specialized hospitals, including mental health Foundation Trusts that provide hospital and community-based services; or Foundation Trusts that provide other health services. FTs are self-governing public benefit corporations free from central government control and SHA performance management. They are accountable to a board of governors made up of members elected from their local community (patients, staff and residents) and people appointed to represent local PCTs, authorities, universities, and other organizations. NHS FTs were created under the Health and Social Care Act 2003; Foundation Trust status is earned through an assessment by Monitor, an independent regulator. The first NHS FTs were established in 2004; as of November 2008, there were 109 FTs, of which 31 were mental health Foundation Trusts and one was a Care FT (providing both health and social care). NHS FTs must provide health care according to NHS principles of universal coverage and care based on need, and meet standards set by the Healthcare Commission. They can retain financial surpluses, borrow money from public and private sources for new investments, and commit to capital investments to improve services or increase capacity.

- **NHS Trusts:** include community hospitals providing acute services, mental health Trusts that provide hospital and community-based services, Ambulance Trusts, and Care Trusts that provide health and social care. These NHS Trusts are accountable via the SHAs to the Department of Health. As of November 2008, there were 94 Acute Trusts, 43 Mental Health Trusts, 12 Ambulance Trusts, and 9 Care Trusts in England – 158 Trusts in total. They are responsible for providing high-quality services, ensuring financial accountability, and developing a strategic service plan. NHS Trusts must provide...
health care according to NHS principles and meet standards set by the Healthcare Commission. The majority of the remaining NHS Trusts are attempting to secure self-governing Foundation Trust status. However, it is increasingly being accepted that not all the existing Trusts will become Foundation Trusts.

Independent Sector Treatment Centres (ISTCs) are private and third (voluntary, not for profit) sector providers of elective treatment. The Department of Health contracted with the first and second waves of ISTCs, but future commissioning will be negotiated by the PCTs (Department of Health, 2007). The principal expansion points for the private sector have been non-emergency surgery and diagnostics; there is growing (but so far extremely limited) private sector involvement in primary care.

Regulatory Bodies: Monitor was established in 2004 as an independent regulator of the FTs (see: www.monitor-nhsft.gov.uk/). Monitor has been rigorous in applying consistent and challenging criteria before authorizing FT status. The Healthcare Commission was established in 2004 as an independent watchdog for healthcare in England with a mandate to monitor clinical performance of the NHS and independent healthcare organizations (see www.healthcarecommission.org.uk/). The Healthcare Commission will become the Care Quality Commission in April 2009 in an effort to rationalize and make adjustments to the regulatory process (see www.cqc.org.uk interim website).
B. Impact of Integration

1. Patient Perspective
Well integrated health systems are patient focused. A patient-oriented system is characterized by internal organizational processes that consider the needs of patients and their families, easy navigation for patients and families across transition points, integrated processes, and patient choice. There is a strong commitment to public health and health promotion, and the broader population health sectors.

The policy aim of reform in NHS England has been to provide patients with a stronger voice and more choice – the branding on the NHS is “Choices: your health, your choices”. NHS reform has attempted to change the culture to one where providers listen to patients and engage them in choices about how and where they receive treatment. In primary care, patients can choose to register with any GP. In secondary care, patients can choose where to have specialist treatment from a growing list of hospitals and clinics that meet standards set by the NHS, including local hospitals (NHS Trusts, NHS FTs) and ISTCs. Patients can choose to go to any provider in the country but the overwhelming majority selects providers within their PCT area.

Information on provider performance (e.g., waiting lists, MRSA infection rates, etc.) is being posted on the NHS website as a resource to patients in making informed choices. The NHS Choices information pages show which hospitals – NHS providers as well as private providers – carry out different treatments and provide other details (e.g., parking facilities, access to public transit, patient ratings, etc.) to help patients make choices. Patients receive a “Choosing your hospital” booklet from their GP which lists a ‘local menu’ of hospitals and clinics commissioned by their PCT. A ‘national menu’ of hospitals and clinics is also available for those patients considering specialist treatment outside of their local area.

A recent Department of Health survey (November 2007) provides some indications of the achievements and limitations of the ‘choice’ policy:
→ 44 per cent of patients recalled being offered a choice of hospital for their first outpatient appointment (compared to 45 per cent in September and 48 per cent in March 2007);
→ 41 per cent were aware before they visited their GP that they had a choice of hospitals for their first appointment (up from 39 per cent in September 2007 and 29 per cent in 2006);
→ 65 per cent of patients were able to go to the hospital they wanted, with a further 25 per cent having no preference and 7 per cent unable to go where they wanted; and
→ hospital cleanliness and low infection rates were selected more often (by 76 per cent of patients) than location or transport considerations as an important factor when choosing a hospital (Department of Health, 2008).

In reality, patient choice has remained limited. Most health care interventions are in primary and community-care settings and while people have the right to choose their GP (subject to the GP having capacity), that does not necessarily constitute choice at the time that a person needs intervention. Outside of non-urgent services, there is a very limited supply of accessible providers, and outside of main urban centres, the supply of accessible providers even for acute services is also limited, although the development of ISTCs has had some impact in some parts of the country (Hofmarcher, et al, 2007).

To date, it would appear that the patient choice policy has not had the intended impact given that patients, when they make a conscious choice, tend to choose on the basis of convenience and to some extent access, rather than on the basis of quality (although this may be changing).

The General Medical Council (GMC) is the regulator of the medical profession in the UK. The GMC’s “Good Medical Practice” outlines the standard of professional conduct that the public can expect from physicians. It was originally written in 1995, with a revised edition released in 2006 following a two-year consultation process. A new major focus in the revised standards is a duty of physicians to work in partnership with patients.
Wanless (2007) concludes that evidence from patient surveys suggests that the quality of NHS care has been improving over time, particularly in priority areas (e.g., waiting times, cancer care). The Picker Institute – which runs the national patient survey program for the NHS England – concurred from their surveys involving more than a million NHS patients there are areas that have improved (waiting times, cancer care and coronary heart disease) but added that patient-centred care is still not routine and that many aspects of the patients’ experience still needs urgent attention. The King’s Fund, in its report based on interviews with staff and patients as well as a review of surveys and literature, concluded that “the defining feature of patients’ experience of care in all kinds of settings was that it was unpredictable and unreliable…where almost everything depended on who was on duty and who was in charge.”

Although there is a corporate NHS promotion of a patient-oriented system, and professional associations are falling in line with re-orientations to their standards of practice, the actual implementation of patient-focused organizational and inter-organizational processes vary across individual health service organizations and local delivery systems.

PCTs are required to promote the health of their populations. While there is some cynicism, particularly and predictably from acute providers about the public health/health promotion mandate of PCTs and whether there will be a quantifiable health gain, the commitment at all levels of the NHS, including the political leadership, to this agenda is strong. However, the continued political focus on wait time reduction has put pressure on PCTs to respond to these priorities perhaps at the expense of attention to wider preventive, population health issues (Green et al, 2007). Whether political commitment to public health and health promotion will survive a period of financial austerity remains to be seen.

The patient experience of continuity of care for their health and social needs is challenged by the historical administrative, budgetary and territorial separation between health and social care – with social care being the responsibility of local authorities (i.e., municipalities). This separation has contributed to difficulties in coordination and transitions to the social sector, and concerns over cost-shifting (Godfrey, et al., 2003). The boundaries of PCTs largely coincide with the boundaries of local authorities, but joint commissioning is variable and dual managerial structures mean communication can be lacking, causing problems for the interface along the patient pathway.

There have been a series of local projects demonstrating well-integrated public policies that improve service delivery for patients and support population health. These projects have been facilitated by flexibilities introduced in the Health Act 1999 (Section 31) and repeated in the NHS Act of 2006 (Section 75), namely:

- lead commissioning: one authority transfers resources to the other which then leads the commissioning of both health and social care;
- integrated provision: one authority takes responsibility for the provision of both health and social care; and
- pooled budgets: authorities transfer resources into a single budget which is managed by one of the authorities on behalf of both (Ham, 2008c).

As well, Care Trusts – which were first announced in the NHS Plan 2000 and were included in the Health and Social Care Act 2001 – integrate NHS and local authority responsibilities in areas such as the care of older people and mental health under a single statutory body; they are NHS bodies but include local authority councillors on their boards (Ham, 2008c). However, there are currently only ten Care Trusts in England, suggesting a limited uptake on this model. Ham (2008c) recognizes the value of Care Trusts in some contexts but cautioned that the model is not likely to become a common route to integrated service delivery.

PCTs are expected to work in collaboration with local authorities and social care organizations to establish policies and care networks to support people with complex needs and to meet...
the needs of the populations they serve. *Local Area Agreements* between PCTs and local authorities are expected to increase collaboration between these sectors – i.e., to align planning and support services, and establish financing arrangements (Department of Health, 2006a, 2006b). PCTs will be required to provide *Local Development Plans* to describe how they intend to shift funding to community settings. *Local Strategic Partnerships* between the NHS, local authorities and other agencies have been promoted to coordinate planning and leadership in the integration of health and social care funding and delivery, public health issues and population health improvement.

PCTs have a statutory duty to involve local residents in health system planning, and the NHS Foundation Trusts provide for greater local ownership and involvement in developing hospital services within a broader health system plan (see discussion under “Governance Structure and Authority”). These developments, in theory, support a population health approach which stresses the need to engage local communities in health system planning. In practice, the effectiveness and genuine representativeness of these forms of public involvement have yet to be evaluated.

Recent Department of Health documents present policy support for greater integration of health and social care (2006a, 2006b, 2007a). An early objective is to develop a social care strategy, in consultation with other government departments, local government and social care delivery agents. Consistent with better integrated health and social care, the Department of Health announced that the *Care Quality Commission* will be established in April 2009, taking over the functions of the *Healthcare Commission*, the Commission for Social Care Inspection, and the Mental Health Act Commission.

A shift in focus from hospital care to primary and community care, and cooperation between the health and social sectors will require a change in culture. As Ham (2008c) notes, the challenge requires more than just overcoming organizational/structural barriers and funding/payment disincentives; the challenge is to build trust and cooperation between staff from different professional backgrounds.

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**PATIENT PERSPECTIVE**

**WHAT WE LEARNED FROM ENGLAND:**
1. They are continuously expanding the monitoring and reporting system on organizational and provider level performance; this performance reporting system is available to the public.
2. They have a national patient survey and they regularly use feedback on the patient experience to inform health-care planning.
3. They have experimented with a number of projects, facilitated by legislation, to successfully integrate NHS and local authority responsibilities and the historical divide between health and social care.

**WHERE ONTARIO SHOULD FOCUS:**
1. Hospital-based performance reporting has been available for some time*; reporting systems on community-based provider performance need to be developed, refined with the benefit of experience, and made available to the public.
2. Patient surveys are routinely undertaken in Ontario’s hospitals. Mechanisms for getting feedback from the public on their experience in primary care need to be developed and this feedback needs to be used to improve service planning.
3. Some LHINs are in discussions with CCACs and municipal authorities regarding health and social care planning and partnerships. Pooling of budgets should be explored as a possible financial arrangement to support health and social care integration.

*A new website – myhospitalcare.ca – has been developed by the Ontario Hospital Association to present and explain individual hospital performance information to the public.*
2. Provision of Care

The development of multidisciplinary teams with team members having clear understanding of their respective roles and decision authority for patient care, and a point of contact are key components of well integrated health systems. Standardized care models with provider-developed, evidence-based clinical care guidelines and protocols, umbrella organizational structures to guide strategic, managerial and service delivery integration, and organized provider networks with standardized referral procedures, service agreements, joint training and shared information systems support integrated care.

There is wide variability of primary care practice ranging from solo GP practices (less than ten per cent of all practices) to large practices with a full spectrum of allied health professions. Teams of nurses and physicians have historically been the norm in the NHS England. The model of care is increasingly reflecting a more multidisciplinary model as other health professionals are being incorporated into practice teams. In a Commonwealth Fund (2006) international survey, 81 per cent of primary care physicians in the U.K. reported that their practice routinely uses multidisciplinary teams.

Significant responsibilities have been provided to nurses in recent years. A number of factors have contributed to this development—pressures to reduce waiting lists and control costs; introduction of the EU working time directive which limits the excessive hours that Junior Doctors have historically worked; and the GP contract negotiation which resulted in GPs no longer having responsibility for out-of-hours care (see discussion under “Funding and Incentives”).

The NHS Plan 2000 sought to respond to throughput and cost pressures by refining the responsibilities of the nursing profession. A Leadership Centre was established to improve the managerial and clinical leadership skills of nurses, including the creation of modern “matrons” who have authority over the running of wards. Another key reform was to allow nurses to prescribe medicines—the NHS Plan stated that over half of nurses in the NHS would be given the power to prescribe medicines. The justification was that the creation of National Service Frameworks and the National Institute for Health and Clinical Excellence (NICE) ensured the availability of clear medical guidance—i.e., decision-making is rule-based and less dependent on expert interpretation—so that far more could be undertaken by non-physician staff. Extensive consultations with professional bodies, the infusion of a much needed influx of resources, and the social and economic context meant that there was no significant unrest associated with this policy direction.

Physician practice and primary care practitioner practice more generally has become more standardized with a number of factors contributing to this standardization:

- The introduction of the National Institute for Health and Clinical Excellence (NICE) clinical practice guidelines (CPGs) has introduced clinical standards that physicians are expected to adhere to unless an individual case merits alternative treatment. NICE was created in 1999 as an independent, expert organization to evaluate emerging health technologies, drugs, devices and procedures. Evaluations are based on independent data analysis, research and assessments of fiscal resources.

- The Department of Health has used National Service Frameworks (NSFs) as a strategy to raise quality of care, decrease variations in service delivery and ensure accountability of providers. Common features of the NSFs are the promotion of multidisciplinary teams, standardized care and comprehensive services along the care continuum. They describe long-term strategies for a defined service or care group setting national standards, identifying service models and key interventions, and establishing performance measures and targets, and implementation timelines. However, the Wanless review (2007) concludes that the government has not yet committed itself to a continuing program of NSF development, even though NSFs have been a very important development for the NHS in the last decade.
The Department of Health, following publication of the NHS Plan 2000, worked with the Royal College of General Practitioners to develop GPwSI – General Practitioners with Special Interests—a series of detailed frameworks which set out the need for appropriate clinical audit and governance for those GPs intending to carry out particular clinical procedures. It became clear that many other clinicians could also benefit from what are now known as PwSIs – Practitioners with Special Interests. Additional frameworks have been produced for nurses (NwSI), dentists (DwSI), pharmacists (PwSI), allied health professionals (AHPwSI), and practice managers (PMwSI) to provide clinical guidance to those professional groups who are individually accredited at the local level to provide a specific specialist service.

There has been increasing expectation for GPs and their practice teams to take on a key role in coordinating care through:

- self care – support and training for patients who can manage their own care, including health promotion, counseling, and help with prescription drug use to improve compliance;
- disease management – people with single or multiple conditions requiring specialist services via multidisciplinary teams and networks following clinical standards and protocols; and
- case management – people with complex conditions are followed by “community matrons” who have clinical expertise and training in care coordination, patient support and advocacy.

GPs play a gatekeeper role as patients need a referral to access secondary and specialist care—a typical model in tax-based health-care systems. Hofmarcher et al. (2007) refer to the “uneasy relationship” between GPs and hospital specialists (referred to as Consultants). Some commentators warn that the current NHS reforms—i.e., the establishment of PCTs and NHS FTs—will further entrench the separation between primary and secondary care (Light and Dixon, 2004). Some PCTs are making real progress in bridging this divide with care pathways, specialty and provider networks, and umbrella organizational structures. The jury is still out on whether there is evidence supporting a shift away from in-patient care towards more outpatient and community treatment (e.g., antenatal care, home treatment teams, community-based services to manage acute episodes of mental illness, etc.)—Wanless (2007) argues that there is some evidence while others contest that the evidence is still lacking.

NHS Foundation Trusts are issued authorizations by Monitor which set out the framework within which they agree to operate (see discussion under “Performance Management”). This includes the mandatory goods and services that they will be required to provide, which differ depending on the service configuration and service needs. Foundation Trusts are, however, free to develop new services or to change the way services are provided.

Although clinical integration has yet to be achieved across the English system, there are examples of successful efforts to achieve clinical integration and collaborative practice. Ham (2008a) describes common features of these initiatives—a commitment of local GP and Consultant leaders and local senior (particularly chief) executives; a compelling vision; and resilience and persistence in the face of barriers and setbacks. He also describes a number of different routes:

- using community-based specialists (e.g., diabetes teams, integrated urgent care services); and
- partnerships between primary and secondary care (e.g., PCTs and the NHS FTs);
building practice networks and expanding scope of practice to include services historically provided by local hospitals (e.g., practice networks providing outpatient services at 65 per cent of the cost at the local NHS Trust).

The Darzi review\textsuperscript{12} emphasized integrated care pathways (essentially rational distribution of tertiary and specialized services based on clinical evidence) and polyclinics. The polyclinic model is very diverse but common features include co-location or hub and spoke models of primary, community and secondary care services; care pathways and technologies to support care coordination of 50,000 or more clients; and a significant shift of some specialist services from hospital to community settings. The polyclinic model is based on the principle of bringing together GPs into a coherent organizational entity, usually a building, with access to the same diagnostic and treatment facilities. Integrated care pathways and polyclinics are both significant drivers for the improvement of multidisciplinary care. Darzi’s various reviews are proving to be immensely significant. For example, every PCT in London has to demonstrate progress towards establishing at least two polyclinics by April 2009.

eliminated strong central leadership in the development of clinical standards and have mandated their use – i.e., NICE clinical standards.

2. They commission services on the basis of standards. England’s PCTs are rigorously regulated to ensure that their commissioning decisions and contracting arrangements comply with NICE clinical standards.

3. They have successfully experimented with a variety of models to integrate primary and secondary care – e.g., the use of care pathways, specialty and provider networks, umbrella organizational structures and partnerships, and polyclinics.

WHERE ONTARIO SHOULD FOCUS:

1. Significant work has been done in the province to establish evidence-based service frameworks and standards, and professional protocols. The challenge remains on how to mandate implementation of clinical standards given current payment structures. Strong central leadership will be required.

2. Commissioning of services needs to be more aligned with the achievement of standards and targets. In the primary care sector, the majority of Ontario’s GPs are funded on a fee-for-service basis. Other primary care models include Community Health Centres (53 throughout the province) and Family Health Teams (150 in the province which when fully operational are expected to serve 2.8 million patients or 23 per cent of the provincial population; plans for 50 more FHTs have been put on hold as part of the government’s cost-cutting measures). The government is promoting FHTs and providing incentives for enrollment targets and for achieving specific service targets. However, it is up to individual providers to choose the primary care model they want to be funded through. Moreover, LHINs – the commissioners of health services – are only responsible for negotiating service accountability agreements with Community Health Centres; they have no jurisdiction over fee-for-service physicians or FHTs.

3. Significant effort has been undertaken to develop care pathways and there are focused efforts at developing provider networks and inter-organizational partnerships. However, a more strategic and comprehensive approach to integrating primary, community and secondary care is required.
3. Governance Structure and Authority

A strong governance model with decision-making authority has been identified as a factor that impacts successful health system integration. Successful governance models promote coordination, align financial incentives, share risk, have clear accountabilities, and involve patients/community representatives in decisions about local health system delivery. Geographic rostering – i.e., larger numbers of clients within a geographic governance area – has also been referenced as a contributor to successfully integrated systems.

The theory behind the NHS reforms in England was that the principles of state provision and equality of access were retained, but purchasing budgets and decision-making were decentralized, creating a potential market for provider competition. Four major policy themes have influenced the structure and authority in England’s reformed health system:

(i) devolution of planning and commissioning responsibilities to local bodies;
(ii) separation of commissioner and provider functions (with exceptions);
(iii) creation of independent hospitals and community-service providers; and
(iv) participation of patients and the public in local decision-making.

PCTs are the main commissioners of health care with statutory accountability to the SHAs. The performance of PCTs is closely monitored by SHAs, which are accountable to the government for meeting targets. There are strong central pressures on PCTs, and SHAs are highly motivated to influence PCT decision-making, particularly since SHAs have lost direct leverage over the NHS Foundation Trusts. SHAs will intervene if PCTs are not performing to the expected standards – SHAs appear to move more quickly than used to occur when it sees systematic failure in a PCT. Often instances of SHA intervention relate to complex and/or controversial exit or decommissioning strategies which involve significant changes to service configuration with impacts crossing PCT boundaries.

Chief Executives of PCTs (and NHS Trusts) are ‘accountable officers’ and can be summoned to appear before the Public Accounts Committee (PAC) of the House of Commons. This personal accountability of the CEO is over and above the organizational accountability to the SHA. This is a powerful accountability mechanism as being summoned to appear before the PAC is public and high profile, and it elevates the standing of the CEO within the local organization.

PCTs are responsible for local populations ranging from 90,000 to 1,253,000; with an average population of 330,000 (Department of Health, 2005). An effort was made to establish co-terminus boundaries with the Local Authorities to support the integration of health and social services. The current perceived wisdom is that effective commissioning probably requires a population of between 750,000 and one million. However, a good proportion of the PCTs are much smaller than this ideal population base.

The NHS is committed to a purchaser/provider split with PCTs contracting with providers including general physicians, hospitals (FTs, NHS Trusts), ISTCs, and the third sector. However, it is not a clean split as PCTs can also directly provide health services.

The tradition of the NHS since its inception has been that the public views the government as carrying ultimate responsibility for health care. The vast majority of the general public has little understanding of the PCTs – PCTs now appear to be putting much more effort into the process of communicating with their local communities.

NHS Foundation Trusts (FTs) are accountable to a Board of Governors which has elected and appointed members. The move to NHS FTs is expected to establish stronger connections between local hospitals and their communities. NHS FTs provide for greater local involvement as patients, local residents and staff can become members of the NHS FT and are eligible to stand for and vote in elections for Governors who set the overall direction of the organization and work with the Board of Directors who are responsible for day-to-day management of the

“NHS Foundation Trusts will herald a new form of social ownership where health services are owned by and accountable to local people rather than central Government.”

Department of Health, 2002
NHS FT. This form of public involvement and accountability is expected to ensure that the FT is an important partner and contributor to the PCT as it plans and commissions health services that accurately reflect the needs and expectations of local people.

A legal requirement to consult the public on the planning and provision of local services has existed since 1974. Recent statutory frameworks include the Health and Social Care Act of 2001 (section 11), and now Section 242 of the NHS Act of 2006.

Patient and Public Involvement Forums (PPIFs) existed for every NHS Trust, NHS FT and PCT. As of April 2008, PPIFs were replaced with 150 Local Involvement Networks (LINks) under legislation that strengthens the statutory duty of PCTs to consult local communities about changes to services. £84 million over three years will be given to local authorities to commission an organization to act as a LINks which will no longer be attached to individual NHS institutions but will operate over a geographic area, usually a PCT boundary (Thorlby et al, 2008; www.gnn.gov.uk/). They will be responsible for actively surveying public opinion and holding local services to account for perceived failings. They also have the power to request information which must be provided in a set period of time, to carry out spot checks, and produce reports and recommendations with a guaranteed response. LINks are intended to increase public involvement in PCTs and their accountability to public opinion. In the past, the only recourse had been to lobby local politicians or to pursue legal action against the PCT over funding decisions (a relatively common occurrence).

In addition, Health Scrutiny Committees, committees of the Local Authorities, have a mandate to monitor health-care provision for their local communities. These committees have the power to appeal to the Secretary of State against decisions of PCTs following a formal process of consultation.

A policy question remains as to whether local accountability needs to be further enhanced. Thorlby et al (2008) note that effective implementation of existing engagement and accountability structures (e.g., LINks, local authority joint working arrangements), clearer guidance to PCTs about minimum standards of engagement, and improved regulation supports local accountability. However, there are also musings about new governance structures such as ‘PC Foundation Trusts’. Such a development would require a greater level of autonomy from the central government than PCTs currently have, and acceptance of variation in PCT services and governance. Thorlby et al (2008) conclude that there is no compelling evidence that the public wants greater local accountability of PCTs, or would engage in any reformed local accountability structures. They recommend that the government specify which areas of a PCT’s activities are subject to genuine local autonomy, and that greater links with local authorities and elected councilors be pursued.

A long-standing debate in the governance area is related to the issue of distancing the management of the NHS away from the Department of Health and the political level. Advocates for an ‘arm’s length’ NHS claim it would reduce micromanagement by the Department of Health, imposition of centrally determined policies and targets, political interference in NHS daily management, and that an arm’s length NHS board would reduce one of the most damaging aspects of central government control – continuous structural reforms. This may be a moot point as all the main political parties have vowed not to embark on further reorganization for the foreseeable future (Dixon, Alvarez-Rosete, 2008).

“\textit{The Department of Health has been reorganised three times; the regional structure and purchasing tier in the NHS have each been reorganised four times; there have been mergers of providers of acute services and reorganisation of mental health services; and inspectorates have been created, expanded, abolished and merged (with one lasting 17 days); the policy of a market driven by provider competition...was introduced in 1991, abolished in 1997, and reintroduced from 2006...}”

GOVERNANCE STRUCTURE & AUTHORITY

WHAT WE LEARNED FROM ENGLAND:
1. They went through numerous iterations and refinements to initial reform efforts; they were willing to take risks and to learn from and finesse initial experiments.
2. They have clearly defined respective roles, responsibilities and accountabilities at the political, strategic, managerial and operational levels; they have demonstrated a commitment to earned autonomy.
3. They instituted legislation that clearly defines when PCTs need to consult with and engage the public, and respond to patient and public feedback on services.
4. They committed significant financial resources to support public engagement.

WHERE ONTARIO SHOULD FOCUS:
1. Further iterations of the governance structure can be expected in Ontario – the challenge is to base reforms on experience and evidence, and to reflect a strategic, non-political approach. The experience in England and other Canadian jurisdictions demonstrates that too many iterations of a reform agenda can foster cynicism, skepticism, de-motivation and resistance within the system.
2. The roles, responsibilities and accountabilities of the Ministry of Health and Long-Term Care and the LHINs need to be clearly defined. The principles of subsidiarity – Ministry involvement in those issues where provincial leadership and participation is beneficial – and transparency should be considered as key operating principles.
3. An evidence-based province-wide planning framework for all health services is needed.
4. LHINs and health service providers have legislative requirements to engage in community consultation in developing plans and setting priorities for health services in their region. LHIN planning and community engagement responsibilities are directly linked to their powers to integrate health services. However, the scope of community consultation and public engagement is not prescribed under the legislation. We need greater clarity on community engagement – which areas are subject to patient/public involvement in decision-making; the appropriate scope of engagement; etc.
5. There is no targeted funding support for community engagement. LHINs and health service providers must find financial resources to support public engagement in existing operational budgets. Successful community engagement requires a commitment of financial resources.

There are strong opposing arguments to an arm’s length NHS, including the view that the sheer size of the NHS demands direct political accountability and control (Wanless et al., 2007). Dixon and Alvarez-Rosete (2008) argue that recent reform in the health system – i.e., devolution of responsibility to local health-care organizations – has diminished the need for an independent board. Rather, they propose other changes to secure local autonomy and prevent excessive ministerial and central control of health services, including:

→ adopting the principle of subsidiarity – adaptation of an EU principle which essentially argues that decisions and actions should be made at the local level unless the objectives of the action can more effectively be achieved through decisions made at a national level;

→ redefining the ‘bedpan’ doctrine – the original doctrine argued that the Secretary of State for Health is accountable when there are failures in local health services; in a devolved system Ministers must resist involvement in local service issues unless they are a consequence of shortcomings of national policies; and

→ increasing transparency – the Department of Health should make information and research evidence supporting policy decisions publicly available in order to reduce perceptions that policies are politically motivated.
4. Funding Mechanisms and Incentives
Experience in other jurisdictions suggests that a population-based funding formula, applied equitably, with programmatic funding dedicated to specific, priority services contributes to successful health system integration. Comprehensive funding—coverage for services across the primary, secondary, tertiary, health promotion and population health continuum—and alignment of financial incentives are contributors to successfully integrated health systems.

**Funding Allocations**
The government has made significant increased investment in the NHS over the last decade—in 1996/97, the budget for the NHS in England was £33 billion; in 2008/09 it is £96 billion. As a per cent of GDP, spending has risen from 7.7 per cent of GDP in 2002/03 to 9.4 per cent of GDP in 2007/08. It is uncertain whether the NHS will be able to continue with its presumed growth with the current financial crisis.

The government sets the budget for the NHS and a capped overall budget for PCTs on a three-year cycle. Therefore, in theory, PCTs get planned budgets for three years. However, in practice, this is not always the case—the PCT funding allocations for 2009/10 was not announced until December 2008.

Funding allocations to PCTs—85 per cent of NHS spending (Boyle, 2008)—are calculated using a complex formula based on population (i.e., population of people registered with the GPs who practice in the defined area), estimated health needs (related to demographics and local morbidity and mortality patterns), and adjustments for variations in cost of living.

PCTs are mandated to fund health promotion activities which contributed the largest sector of revenue growth in 2008/09. However, as noted earlier, whether political commitment to health promotion will survive a period of financial austerity remains to be seen.

PCTs have a statutory responsibility to achieve financial balance each year, as do NHS Trusts. PCTs and NHS Trusts appoint and if necessary terminate the employment of their CEOs, though the SHAs appear to retain some influence over these appointments given their accountability role on financial and quality targets.

NHS Foundation Trusts make their own decisions on senior executive appointments and terminations given their self-governing status. Monitor might play an influencing role, particularly in relation to termination of senior executives—on par with the SHAs in relation to the PCTs and NHS Trusts.

**PCT Commissioning**
PCTs have significant discretion over how they allocate resources:
- there is little earmarking of funds—the amount of earmarking has declined over the years;
- they are currently not required to justify variations in spending on different clinical areas—although as the comparative data is increasingly available, PCTs are coming under pressure to explain and justify significant variations; and
- they are free to commission services from the private and third sectors—although they do so to a limited extent.

PCTs are rigorously regulated to ensure they comply with core clinical standards. PCTs are responsible for ensuring the implementation of the NICE clinical practice guidelines, which provides the clinical basis for their decision-making and a standardizing influence on the quality of care. The Healthcare Commission (the Care Quality Commission as of April 2009) investigates whether PCTs and service providers are meeting government core standards for quality and safety (see discussion in “Performance Management”).
PCTs sign Service Level Contracts with providers that specify the range of services to be made available, referral or treatment protocols and relevant performance criteria. Contracts can contain incentives and penalties and provide an opportunity to specify evidence-based practices and efficient care pathways across different organizations. The ambition is for commissioners to develop local systems of payment by results, but at present this is rare as block contracts remain commonplace.\textsuperscript{14}

The Darzi review plans to introduce a new model of financing from 2010/11 to enable greater commissioner leverage in the distribution of funds in which bonus payments will be made available for incentivizing quality and improving outcomes in local priority areas. The current practice of paying for an activity according to a tariff system – i.e., providers receive a set payment per referred patient calculated annually as the average of a group of fifty procedures (Health Resource Groups) using the previous year's data – does not subsidize the cost of innovative and possibly more expensive procedures that improve quality. This can lead to perverse incentives – i.e., if an innovation improves efficiency a Trust may actually be penalized for doing so since innovative practices may reduce activity; if this frees up capacity, income can be recovered, but the Trust will need to invest to utilize this capacity.

This financial environment has reinforced the tendency towards a lack of disengagement from outdated practices, and has contributed to the poor uptake of medical devices and diagnostics in particular. The introduction of the Commissioning for Quality and Innovation Scheme (CQUIN) will attempt to change this situation. CQUIN will enable PCTs to incentivize the adoption of best practice by overlaying the tariff payments with bonus payments in commissioning contracts. Instead of paying a set tariff across the board, these funds will be diverted to commissioners to address local health priorities (Darzi, 2008).

Light and Dixon (2004) maintain that a core problem with PCT commissioning is that the government has locked in the hospital-centric arrangement. Within budgets devoted to PCTs, “the consultants and acute trusts remain separate and deeply protected” (p. 764). Unintended consequences have been articulated: reinforced competition and reduced willingness to collaborate between hospital and community providers; and restrictions on the potential for administrative collaboration and efficiency gains through commissioning across primary care, hospitals, and social services (Ham, 2007a; Hofmarcher et al, 2007; Light and Dixon, 2004).

As noted earlier, the majority of PCTs directly provide services. PCTs are expected to ‘externalize’ their provider services with a provisional target date of the end of 2009. The concern is that as long as PCTs are themselves provider organizations, their commissioning decisions might be distorted to ensure that their own provider arm is not put at risk. A variety of organizational models are emerging, including private sector, social enterprise that is not directly part of the NHS, and NHS Trusts. Some PCTs are seeking SHA approval to go to a formal consultation to create an NHS provider organization to assume responsibility for their community services.

PCT commissioning is recognized as the Achilles heel to achieving successful reform in the English health system. Ham (2007b) argues that there is an urgent need to strengthen the PCT commissioning function noting that many PCTs are focusing their efforts on reduction of deficits rather than development of new services, with lower levels of expenditure growth in 2008 and now expectations of squeezed budgets for 2009 and beyond.

The government has recognized this deficiency in the reform agenda and the Department of Health has established the World Class Commissioning (WCC) programme demonstrating the government’s commitment to developing decision-making capacity at a local level. Key elements of the program include a vision for world class commissioning, a set of world class commissioning competencies (i.e., knowledge, skills, behaviours and characteristics commissioners need), and a support and development framework (i.e., tools, sharing of services and good practices, development of internal resources, securing external expertise). For example, having a high quality Board has been identified as a crucial element to PCTs becoming world class commissioners and the Department of Health has developed tools and resources that all PCTs can access to
help them improve the performance of their Boards.\textsuperscript{15} The WCC competencies are the focus of huge investments of time and energy, and there is currently a nationwide review of PCTs’ capacity to meet these competency standards.

With the “world class commissioning” drive, PCTs are expected to achieve both effective commissioning and de-commissioning. However, a recent survey of PCTs found that the total value of services decommissioned across 60 PCTs that responded to the survey was £14 million, a fraction of the £70 billion PCTs spend annually (Crump, 2008). The majority – 40 of the 60 – reported that they had not de-commissioned any services. It was suggested that many of the decommissioned services reflected the additional capacity PCTs were building into the acute system to hit the 18-week treatment target and their guaranteed volume contracts with the independent sector, so the traditional provider landscape is predominantly unchanged.

One of the issues emerging in this environment of devolved decision-making and improved information about variations across local delivery systems is that the public and health-care professionals have a strong sense that variations in treatments available to residents are unacceptable. ‘Post code lottery’, a popular political catchphrase in England, refers to the occasional reality of fundamentally different services in one locality compared to a neighboring locality. Studies have indicated that this problem is marginal, but the strength is in the perception. There is a genuine tension between the delegation of commissioning decisions to PCTs and the need for equitable distribution of NHS services, and the government is strongly motivated to standardize services to some acceptable level.

**PAYMENT SYSTEMS, INCENTIVES**

The NHS Plan 2000 recognized that historically the system of payment penalized success and rewarded failure given its record of cutting the budgets of those NHS organizations that “over-performed” and had low waiting lists, and providing extra funding to those organizations with long waiting lists who were struggling to provide services within budget—a history similar to that in Ontario. As well, to bring in the controversial reform program under development in the NHS Plan 2000, the government realized that they needed to have doctors brought onside.

The British Medical Association’s (BMA) role in the GP and Consultant (hospital physician) contract negotiations to set the tariffs was significant, and it is generally accepted that these professional groups received extremely good deals and that the government did not get enough in return for the pay deals. For example:

- GPs no longer have responsibility for out-of-hours care which now relies on a multi-professional model—necessarily a bad approach but it provides more favorable working conditions for GPs and is an extraordinary concession given the increase in GP wages.
- Consultants can still perform in both public and private practice—waiting lists represent a market for their private practice where patients can jump the queue, which further distorts incentives.
- Consultant contracts included incentives to dedicate more time to NHS (public) practice—however, this was based on the mistaken assumption that consultants throughout England had the same working practices as those in London where there is a far larger market for private health care and arguably a different consultant culture; the result was that the government ended up spending more money on consultants for work they were already doing—i.e., working in the NHS.

The GP contract—the *General Medical Services (GMS)* nationally negotiated contract—is generally viewed more favorably. Implemented in 2004, it provided unprecedented new investments in primary care—a 33 per cent increase over three years (increasing from £6.1 billion per year to £8 billion by April 2006). As part of this investment, significant changes were made to the way primary care was delivered, introducing quality incentives and extending the payment of GPs to facilitate the de-hospitalization of services.

“The new proposed GMS contract is the most ambitious quality based incentive scheme for primary care in the world.”

Secretary of State for Health, Speech to the National Association of Primary Care, March 2003
The 2004 GP contract introduced substantial financial incentives tied to achievement of performance targets resulting in the only genuine payment by results system in the NHS. Ninety percent of patient contact with the NHS does not go beyond their GP, so improvements in this area have the greatest impact on patient experience. The GP contract gives greater flexibility and autonomy in the delivery of services to encourage experimentation and diversity of provision. Points related to payments are provided for how well the practice is organized, how patients view their experience, whether extra services are provided (e.g., child health, maternity), and how well chronic diseases are managed (Boyle, 2008). The Quality and Outcomes Framework directly links GP income to patient care – the more points a practice achieves, the more money it earns. A 2006 Commonwealth Fund international survey of primary care physicians reported that 92 percent of surveyed physicians in the U.K. received financial incentives for achieving clinical care targets (Schoen et al; 2006); in reality, all GPs receive financial incentives related to clinical targets under the 2004 contract.

Most GPs are independent contractors and hold GMS contracts with their PCT. Alternatively, GPs who choose to be directly employed within the NHS can negotiate a Personal Medical Services (PMS) contract with their PCTs. The National Association of Primary Care was commissioned by the Department of Health to produce the 2004 PMS framework agreement. The PCT, within the national framework, can influence the level of budget allocated to the GP (usually a group practice) as well as the performance-related incentives.

Other contracting routes for PCTs include: Alternative Provider Medical Services (APMS) contracts with individuals or organizations (often in the independent sector) that meet provider conditions; and the Primary Care Trust Medical Services (PCTMS) contracts for employing professionals and providing services directly.16

GPs do not have an automatic right to establish a practice. Physician practices must be registered by the PCT which has a statutory responsibility to try to maximize reasonable access to GP services for all residents in its community. PCTs have set up primary medical performers lists, established in 2004 to rationalize the former separate lists for medical, supplementary medical and alternative services lists, and enable the NHS to better regulate practitioners. PCTs try to attract more GPs to under-serviced localities and also to bring GPs together to practice in multidisciplinary premises. GPs must be listed on only one English PCT list – normally the PCT of their main contract or where they do most of their work – but they may work in other PCTs in England.

PCTs directly contract acute services from NHS Foundation Trusts, NHS Trusts and Independent Sector providers. There is a standard government template for these contracts which forms the basis for local negotiations on indicative volumes, processes, incentives, and monitoring arrangements.17 This negotiation process allows PCT commissioners significant leeway to specify how care should be provided. For example, they use NICE guidance to form the basis of clinical requirements, and set referral protocols to ensure minimal disruption to the patient pathway.

It is generally felt that the national contract templates and the level of commissioning expertise is still evolving away from the old practice of ‘block contracting’, with contractual arrangements seen as a key tool in generating improved health care.
However, as Ham (2008a) notes, the introduction of PbR “was reported to have set back attempts to integrate care, as hospitals focused on maximizing the benefits to them from this system of payment rather than continuing efforts to achieve closer collaboration” (p.10).

As well, the ability of patients to choose services on the basis of quality, in the hope that this would create market pressures to improve, has been compromised by the inadequacy of the available information on quality. For example:

→ ‘quality’ data is aggregated at the level of hospitals, and detailed quality measures are still being determined;
→ there are problems with the comparability of data coding submitted by ISTCs and NHS providers; and
→ some information is expressed as progress against targets for the baseline year – the information presents how an organization is currently performing against their targets using a traffic lights system; however, an organization can be labeled green for good progress and another organization can be labeled red for deterioration but the green organization is progressing from a much worse position and is a poorer performer in absolute terms.

As noted earlier, block contracts between PCTs and providers remain commonplace and the development of local systems of payment by results are rare. Also noted earlier, the 2004 GP contract is the only genuine PbR system in the NHS (with financial incentives tied to achievement of performance targets). One of the key limitations of PbR is that it fixes prices – there is no negotiation to speak of between commissioners and providers.

### Practice-Based Commissioning

Since 2005, GP practices have been allowed to, and generally expected to hold a practice-based commissioning (PBC) budget from their PCT. By early 2007, 93 per cent of patients belonged to a practice that had received the incentive payment for becoming a practice-based commissioner (Oliver, 2007).

PBC was intended to put commissioning powers in the hands of those at the frontline of primary care service delivery based on the belief that they are in the best position to make decisions about their patients’ needs. With PBC, GP practices are given ‘virtual’ budgets with which to ‘buy’ health services for their population, while PCTs continue to hold the ‘real’ money (Curry et al, 2008). PCTs must ensure that PBC plans are in line with national targets and local health plans and targets.

Practices or groups of practices must submit a PBC business case to their PCT describing plans for a new service or a clinical re-design initiative. All practice parties must sign a conflict of interest declaration as part of the submission; these are kept confidential by the PCT and used only in relation to the business case review. Where business cases are likely to cause a significant reduction in secondary care, full discussion will take place with the acute provider(s) and a formal notice of final intentions will be given. Consortium plans for new services transferred from hospitals to more appropriate settings need to demonstrate how a range of provision will be secured across a geographical area, ensuring equity of access and choice for patients. Practices with an approved PBC business case sign an Annual Accountability Agreement with their PCT confirming agreement to deliver PCT priorities and targets through demand management initiatives and service re-design.

Government support for PBC has been based on the premise that GPs will commission better quality of care and will be less likely to make unnecessary referrals to hospitals if they are responsible for their own budget. PBC was viewed as a way to counter-balance the dominant market position of hospitals. However, some argue that GP practices are too small or lack the skills to effectively commission services from large, powerful hospitals (Ham, 2007a; 2007b). Others argue, at least anecdotally, that the dominance of the hospital sector appears to be declining slowly as commissioners gain experience and confidence (Edwards, 2007).

GP practices can use their PBC budget to directly manage the delivery of care for their patients, and can keep 70 per cent of savings which they are required to invest in capital projects or to broaden the range of primary care services (Hofmarcher, et al 2007; Oliver, 2007). Oliver (2006a) reported that savings are being invested in a variety of new services, including community-based dermatology, diabetes, orthopaedics, chronic-disease management, community-based glaucoma care equipment, and telephone/email advice services.
Recent reviews of PBC have concluded that PBC has been slow to develop: very few PBC-led initiatives have been established; where initiatives are developed, they have tended to be small scale, local pilots focusing on providing hospital services in community settings; and while most practices are involved on paper, the depth of involvement is limited to a few enthusiastic GPs in each PCT (Curry et al, 2008). The Department of Health’s latest GP practice survey found that four in ten GPs are still not supporting the PBC initiative – or six in ten practices have submitted business cases for service redesign (see www.hsj.co.uk December 05, 2008 news item).

Smith et al. (2004) argue that GP commissioning should be part of a range of commissioning models – i.e., there is no ideal size for a commissioning organization, different population bases are needed for commissioning different services, and different models are required for more specialized services. They recommend a more sophisticated commissioning framework with: (i) adequate levels of management support and a degree of organizational stability; (ii) timely and accurate information, and advanced forms of support (e.g., predictive modeling, risk stratification, etc.); (iii) real and meaningful clinical engagement; and (iv) effective relationships between commissioners and providers, with ability to move services.

Similarly, Curry et al (2008) recommended a ‘matrix’ model for PBC that recognized the multi-layered nature of commissioning and the fact that certain types of commissioning are best performed at different levels. In their proposed model, PCTs would remain responsible for strategic, population-wide commissioning; and real budgets for specific service areas would be devolved to GPs and PBC clusters (which would become statutory organizations) who would have autonomy to design services within an overall vision. The model would involve a continuum of earned autonomy, in which high performers would be rewarded for increased independence, and budgets would be devolved only for tightly defined areas, reducing clinical and financial risks while increasing accountability.

Curry et al (2008), in their assessment of PBC, identified a number of reasons for the slow progress on PBC:

- Disagreement between GPs and PCTs over their respective roles and responsibilities in commissioning – both are struggling for control of the PBC agenda.
- Lack of capacity at the GP and PCT level – there is a lack of skills in data analysis, low level of support from PCTs, inexperience with commissioning, etc.
- Lack of reliable, timely data – GPs have little information with which to develop commissioning ideas, and PCTs are not willing to approve business cases developed without reliable data.
- Concerns about financial and clinical accountability – PCTs have few levers available to them for holding GPs to account, and clinical risks are inherent when moving services out of hospitals.
- Potential conflict of interest – GPs are both providers and commissioners of their own service, subverting patient choice; and PCTs may favour services they themselves provide instead of tendering competitively for services commissioned under PBC.

The government has repeatedly asserted a commitment to PBC but there is some speculation in the policy analysis field that the Department of Health is disengaging from PBC, or at least withdrawing from the original, all encompassing objectives for PBC. Given the government’s current focus on the World-class Commissioning program, and that PCTs are seen to have a big developmental path ahead of them to achieve WCC competencies and capacities, PBC is further back in the queue for benefitting from the program.

Ham (2007a) suggests that the combination of PbR and PBC creates incentives for avoiding hospital admissions and for providing community care but “the levers and incentives to promote networks and integrated care – collaboration between clinicians in primary care and secondary care – are underdeveloped” (p. 6-7). Ham (2008) concludes that PBC...
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has failed to offer a significant stimulus to clinical integration, while recognizing the potential of PBC as a vehicle for achieving closer integration of health and social care (Ham, 2008c).

The government is aware of the shortcomings of PbR and PBC, and recognizes the need for more sophisticated incentive systems and commissioning frameworks. The Department’s White Paper (2006a) recognizes the need to: refine the current tariffs (e.g., incorporate the ability to apply tariffs to activities in community settings, “unbundle” tariffs so aspects such as diagnostics and rehabilitation can be provided out of hospital); explore a “year of care” approach to a broader range of chronic conditions; and provide stronger incentives for effective management of people with long-term conditions (Ham, 2007a; Department of Health, 2006c). More recently, the Darzi review (2008) recommended better incentives to GPs for maintaining good health as well as good care (i.e., new funds that the SHAs would make available to the local NHS to promote innovation), and greater freedoms and support to high-performing GP practices to develop new services for their patients.

WHAT WE LEARNED FROM ENGLAND:
1. They have developed sophisticated funding models and incentive programs to support clinical integration and population health. It appears that unintended consequences of funding formulae have required ever-more sophisticated and continuously improved funding arrangements.
2. They are committed to developing the commissioning capacity and have provided significant resources so that commissioners can commission effectively. They have recognized the importance of ensuring that commissioners are large enough, sufficiently resourced with appropriate skills (e.g., negotiation, contract management, etc.) and adequately supported (e.g., timely data, predictive modeling, etc.) to effectively commission services.

WHERE ONTARIO SHOULD FOCUS:
1. Historically Ontario has used a variety of funding allocation models to fund health-care providers. A Health-Based Allocation Model (HBAM) is under development and may be used by the Ministry to determine LHIN budgets and potentially for the LHINs to use to determine local provider budgets. One of the guiding principles of HBAM is to facilitate health sector integration. It is a utilization-based funding model as it is based on the previous three years of utilization by individual LHIN residents. It is generally accepted that utilization models like HBAM do not capture unmet service needs or improvements to service delivery models (e.g., from institutional to community-based). The ongoing refinement and improvement of HBAM or any other funding model must be sufficiently sophisticated to support evidence-based delivery models and population health promotion, and to ensure equitable access to high quality care.
2. LHINs are not yet true commissioners of health services in Ontario. They are planning bodies and they are flowing funds to health service providers but they are not yet commissioning or purchasing services in a competitive environment as is the case in England where PCTs are in a position to actually choose between provider A and provider B. The exception is in the area of home care where CCACs are actually choosing between providers. LHINs need to be supported as they evolve into true commissioning bodies – supported in the development of commissioning skills, in having timely access to data and modeling, in the development of their leadership.
5. Performance Management
An important component of integrated health systems is accountability and performance monitoring and reporting systems. Integrated health systems are continuously improved when performance goals are explicitly defined, and there is a coordinated approach to setting, delivering and monitoring standards. The public should have access to information on the performance of the health system – health outcomes, patient and caregiver experience, provider performance, organizational performance, and inter-organizational performance.

England’s NHS has a national performance framework which outlines common indicators and explicit targets and standards for performance – i.e., decentralization of health-care planning has been accompanied by more centrally driven national target setting (Oliver, 2005; Edwards, 2007). The Labour Government adopted and extended the previous Government’s use of national targets as a means of raising standards of care, improving efficiency, and focusing on key priorities. Some targets are monitored by the regulatory bodies and others by the SHAs. FTs and NHS Trusts are benchmarked against the performance of peers on a number of activity measures (e.g., length of stay, readmission rates, cost of standard procedures, etc.).

There are divergent views on the impact of national targets. Some reviews criticize the selection and implementation of targets for creating unintended behaviours (Bevan and Hood, 2006). Others conclude that targets and top-down performance management were crucial to achieving reductions in waiting times (Dixon and Alvarez-Rosete, 2008). There have also been complaints about the extensive number of national targets and the type of targets – most of which are process rather than outcome measures (Dixon and Alvarez-Rosete, 2008). The Department of Health (2007a) has committed to reducing the number of national standards, making them more evidence-based, and including more outcome-oriented measures. The most recent Darzi review (2008) committed to no new national targets.

A recent Department of Health (2006c) report notes that at this stage in the reform process, there needs to be a shift from top-down national target-setting and performance management, to bottom-up change driven by patients, commissioners and clinicians. Attention is shifting to the development of locally determined health targets – i.e., PCTs are expected to identify locally relevant measures and targets. However, as Green et al (2007) note, achievement of national targets consumes resources available leaving little room for local priority setting.

“Quality can be at the heart of everything we do in the NHS. It means moving from high quality care in some aspects to high quality care in all.”
Lord Darzi, 2008.

A key component of the performance management system has been the establishment of a strengthened regulatory framework.

Monitor is responsible for assessing new applications for FT status, and ongoing monitoring to ensure compliance with authorization terms (e.g., services provided, amount of income earned from private charges, amount of money borrowed, and financial and statistical information to be provided). As mentioned earlier, Monitor has been rigorous in applying consistent and challenging criteria before authorizing FT status. Monitor has established a risk-based approach to regulation. If an NHS FT is performing poorly and breaches authorization terms, Monitor can and does intervene, requiring a remedial action plan, regular progress reports, or more extensive action.

The Healthcare Commission’s statutory duties include: assessing the management, provision and quality of health care and public health services; reviewing performance and awarding an annual performance rating; and regulating the independent health sector through registration, inspection, monitoring, and enforcement. The Commission reports to the public on health system performance – i.e., annual ratings in different domains for individual health care organizations (e.g. PCTs, hospitals, etc.). Measures used for public reporting are consistent with the national performance framework. As noted earlier, the Healthcare Commission (along with the Commission for Social Care Inspection and the Mental Health Act Commission) will become the Care Quality Commission in April 2009. It will have new enforcement powers, an expanded mandate to include social and mental health care registration, and requirements for essential levels of safety and quality.

The Healthcare/Care Quality Commission, Monitor and the Audit Commission work closely together to ensure that standards for clinical care, financial accountability, and corporate governance are met.

Dixon and Alvarez-Rosete (2008) note that there is confusion about the performance management and assessment system for PCTs: the Healthcare Commission collects information on performance against standards established by the Department
WHAT WE LEARNED FROM ENGLAND:
1. They established national targets in a national performance framework which was key to monitoring local health planning and was linked to quality improvement efforts and public reporting activities. PCTs are monitored closely by SHAs on key targets and overall policy direction but they also have substantial authority to respond to local priorities and re-allocate resources.

WHERE ONTARIO SHOULD FOCUS:
1. Performance reporting is currently primarily through the existing or developing Service Accountability Agreements between the LHINs and individual organizations (e.g., hospitals, CCACs, CHCs, mental health/addiction services, community support service agencies, long term care homes). As well, there are key components of the health service delivery system that are not under the jurisdiction of the LHINs. For example, LHINs have no authority to report on the performance of health service providers in the primary care sector – e.g., fee for service physicians, Family Health Teams – and public health initiatives. A system-wide performance framework is required where LHINs report to the public on region wide achievements in relation to provincial level targets and regionally defined targets.

PERFORMANCE MANAGEMENT

of Health; the Department has asked the Commission to develop more comprehensive performance criteria for PCTs; the Department for Communities and Local Government will soon be assessing PCTs, local authorities and stakeholders as part of a comprehensive area assessment; the Audit Commission is responsible for holding PCTs accountable for financial management; and PCTs are subject to local authority Health Scrutiny Committees.

In relation to quality improvement, the Institute for Innovation and Improvement was established in 2005 to support the NHS by rapidly developing and spreading new ways of working, new technology and world class leadership. The Darzi review (2008) committed to:
- an expanded NICE to set and approve more independent quality standards;
- a new National Quality Board to offer transparent advice to Ministers on what the priorities should be for clinical standard setting by NICE;
- a statutory requirement that all registered health-care providers working for, or on behalf of, the NHS publish ‘Quality Accounts’ to mirror their published financial accounts; and
- a new ‘Quality Observatory’ in every NHS region to inform local quality improvement efforts.

As mentioned previously, the Commissioning for Quality and Innovation Scheme (CQUIN) is being introduced to enable PCTs to incentivize the adoption of best practice. Commissioners will be required to collect and monitor provider data to determine who is achieving the best outcomes in priority areas. They can then research the processes that are yielding these outcomes, how these differ from practice in poor performers, and use this knowledge of best practice to set process measures that indicate the required standard of care. The objective will be to clearly disseminate the best practices that come out of this process, and to reward providers financially with bonus payments above the tariff price for implementing improvements.

PCTs are taking a much more proactive approach to performance management of GPs. As more data becomes available providing analysis of performance related to targets and standards of clinical care, PCTs can initiate an external peer review of a GP practice. The PCT can establish initial objectives engaging with the GP pending the outcome of a more formal review. If unacceptable levels of performance are confirmed, the GP is suspended, usually pending referral to the General Medical Council. This can be an arduous process but PCTs are increasingly taking this route to seriously challenge poor primary care provision.
6. Information Management
Investments in information technology, information management systems and communication mechanisms facilitate integrated service delivery along the continuum of care. The patient experience in navigating a health system can be vastly improved through electronic health records, and other electronic systems. Integrated information and communication systems are especially critical when providers are not co-located.

The National Programme for Information Technology (NPfIT) – the world’s largest civil information technology project – was established in 2002 with a mandate to introduce technology systems into the NHS to improve service delivery, patient care and research opportunities. The objective was to create a single electronic care record for over 50 million patients and to connect 30,000 General Practices to 300 hospitals by providing secure access to patient records by authorized professionals. NHS Connecting for Health (CfH) was established in 2005 as an agency to deliver the program. As of early 2007, responsibility was moved to the SHAs, with CfH retaining responsibility for local service provider contracts.

Roll-out is underway of the NHS Care Records Service, the patient electronic care record. Full patient records will be created for every patient and held at their local GP or hospital. Summary records will be held on the “spine”, a national, central database enabling immediate data availability. When fully implemented, local records will automatically upload important information to the summary patient record on the spine, including demographic information and summarized clinical information.

Current components of the program include:
- an electronic transmission of prescriptions and logging the information on the patient record when the prescription is dispensed;
- an appointment booking system – enabling primary care staff to make appointments for secondary care and providing patients a choice of provider;
- a digital imaging storage system – Picture Archiving and Communications System (PACS) to review images on screens in different locations, and access old x-rays/scans;
- Secondary Uses Service – protects patient confidentiality and enables secondary usage of anonymised data to analyse health trends, outcomes and NHS capacity – this component is intended to support the future system of Payment by Results where payments will be linked to outcomes; and
- a central email and NHS-wide directory service.

Previous investments in primary care has allowed for investments in IT infrastructure. A Commonwealth Fund (2006) international survey of primary care physicians reported the impact of these investments: 89 per cent of physicians use electronic patient medical records; 84 per cent (the highest score) reported electronic access to patients’ test results; 91 per cent were routinely alerted about potential problems with pharmaceutical prescriptions; and 92 per cent (the highest score) reported the ability to easily generate lists of patients by diagnosis. The shortcoming appears to be the absence of linkage between primary care IT and secondary care.

A 2005 survey of physicians indicates that support for the NPfIT as an “important NHS priority” dropped to 41 per cent from 70 per cent the previous year, although reasons for this shift were not explored. As well, components of the program have not experienced reasonable take-up – e.g., the booking system is used for only 12 per cent of bookings (Coiera, 2007). Also, there continues to be difficulties and delays especially in the implementation of the spine. Some NHS organizations are frustrated and have gone ahead with their own local investments in IT systems given long waits for inclusion in the national initiative.

The NHS chose to procure systems centrally and implement them locally with the requirement that systems conform to national standards. NPfIT divides England into five clusters which contract with a local service provider – as of January 2007, three separate consortia were LSPs for the five clusters. Benefits to this approach were identified: central procurement resulted in competition saving about £4.5bn; the government avoided risks associated with dependence on one supplier; and local implementation of similar systems introduced tendering competition. On the downside: the speed of procurement precluded preparation of key policy documents (e.g., information governance), standards (e.g., clinical coding), and system architecture; and vague contract language resulted in significant legal fees (Coiera, 2007).
LESSONS FOR ONTARIO INTEGRATED HEALTH CARE IN ENGLAND

NPfIT was originally expected to cost £2.3 billion over three years, but by 2006 the total cost was estimated by the National Audit Office (NAO) to be £12.4 billion over ten years. The Public Accounts Committee issued a critical report in 2007 warning of probable expenditures of £20 billion and expressing concerns of the clinical benefits to be achieved. Coiera (2007) notes that once all implementation and training costs are accounted for, the final budget could total £30 billion. However, the cost overruns will not entirely be held by the government given the contracting terms which required IT contractors to prove their systems worked before they were paid. Two of the four original contractors have now withdrawn due to serious financial difficulties.

The NAO audit registered other criticisms:

WHAT WE LEARNED FROM ENGLAND:
1. There was strong political leadership and financial support for the National Programme for Information Technology. Specific investments in primary care infrastructure contributed to high adoption of electronic patient records and information systems.
2. Effective engagement of clinicians in the design and implementation phases is a critical success factor.

WHERE ONTARIO SHOULD FOCUS:
2. The government is headed in the right direction with the establishment of eHealth Ontario under strong leadership and with its continued financial commitment to an eHealth strategy.
3. Ontario’s eHealth strategy is focused on three clinical priorities with the ultimate goal of creating an EHR for all Ontarians by 2015. The eHealth Strategy has identified the engagement of clinicians as a guiding principle in moving forward. This principle of clinician engagement in the design and implementation of components of the eHealth strategy will be critical to the success of the eHealth strategy.

The latest commentary on the NPfIT and CfH²⁰ suggests a loss of confidence, perhaps rooted in the undeniable and damaging inflation of costs but reflecting also a mood that the program is not going to achieve its goals and possibly also that with evolving technology it’s now an out-of-time project.
C. Concluding Comments

The NHS is now in better shape… to deliver improved quality and increased productivity, although huge challenges remain around commissioning and choice, competition between providers, the balance between targets, standards and incentives and between central direction and local discretion in the shift towards local provision of care.

(Wanless et al, 2007)

There are clearly things that Ontario can learn from the experiences with health system reform in England. Namely, integrated health systems are facilitated by a number of key components:

1 / Well-defined governance structures with clear roles, responsibilities and accountabilities, agreed-upon operating principles (such as transparency and subsidiarity) as well as the use of evidence-based frameworks.

2 / A strong and sophisticated commissioning framework – including a number of commissioning models if necessary – with sufficient support, expertise and information to effectively carry out the commissioning role.

3 / Real support for community engagement in local health system planning, and clear definition of areas requiring community engagement in the decision-making process.

4 / Sophisticated and aligned funding models and incentive payments in the primary, secondary and tertiary sectors to support clinical integration and collaboration between hospital and community providers.

5 / Multidisciplinary teams who take on a key role in coordinating care through self care support and training, disease management, and case management.

6 / An independent, expert organization to evaluate the effectiveness of emerging health technologies, drugs, devices and procedures and to establish the scope of services and interventions that will be funded.

7 / Evidence-based service frameworks as a strategy to raise quality of care, decrease variations in service delivery and ensure accountability of providers.

8 / A performance monitoring and reporting system which defines evidence-based, outcome-oriented provincial standards, supports the development of locally determined health targets, and aligns performance measures, quality improvement and public reporting activities.

9 / IT initiatives that engage clinicians and professional bodies in the planning, implementation, management and governance structures.

10 / Commitment to integrated public policies for public health, health promotion and population health, including a framework for health and social care, inter-sectoral partnerships, and agreements with municipal authorities.

Health policies in Ontario will be influenced by provincial history, politics, and culture. However, we can also benefit from the experience of others who have undertaken reforms to achieve integrated, high quality, accessible and sustainable health systems. There are lessons that we can extract from the experience in England and solutions that we can adapt and build on as we continue to transform health care in Ontario.

Note: For additional commentaries and charts related to this case study, go to www.changefoundation.com
End Notes

1. See: www.changefoundation.ca

2. This framework evolved from Suter et al (2007), and a presentation by Cathy Fooks, CEO of The Change Foundation, on January 25, 2008 available at www.changefoundation.ca/presentations.html

3. This case study will focus on more recent reform initiatives and regionalization developments.

4. However, this is not a complete split as England’s Primary Care Trusts are both purchaser and provider of many community health services.


6. The Healthcare Commission will become the Care Quality Commission in April 2009.

7. The government expects that up to 157 ISTCs will be included as patient choice options in the near future. As of April 2008, commissioners are expected to reimburse ISTC providers at the national tariff when patients choose them under the “free choice” option (Dixon and Alvarez-Rosete, 2008).

8. There are two areas of healthcare where the location for treatment is not subject to free choice – mental health and maternity care.

9. See: www.pickereurope.org

10. See: www.hsj.co.uk/news/2008/12/kings_fund_report_points_to_patchy_patient_experience

11. The nursing profession has historically experienced a relatively powerful and influential role – prior to 1974, ‘Matron’ was a hugely significant leadership focus in all hospitals; from 1974 to 1984 the NHS had consensus management teams which gave nursing a prominent leadership role; and since 1984, NHS chief executives were given guidance or instruction to ensure a nursing representative was included on the executive team.

12. Dr. Darzi, a London surgeon, was given a mandate in 2006 to advise the London SHA on the planning and development of health services. Before his report was published he was appointed as a Minister in the Health Department by Prime Minister Brown, putting Lord Darzi in the House of Lords and transferring him into a de facto leader for the NHS.

13. Local Government and Public Involvement in Health received Royal Assent in October 2007.


17. The template is available in Annex E to the NHS operating framework for 2008/09.

18. This policy is similar to the GP fund-holding policies taken by the Conservative Government in the 1990s where real budgets were devolved to GPs (Dusheiko et al, 2007; Oliver, 2006a, 2007; Curry et al, 2008).

19. See www.conectingforhealth.nhs.uk/

20. See the Health Services Journal (http://www.hsj.co.uk/), a weekly on-line report widely read by politicians and NHS leaders/managers.
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