Editorial

Why is integrated care not a "policy"?

Health researchers may think of health policy as something that emanates from central and local authorities or commissioners, guiding local implementation efforts. In the last decade, policymakers have increasingly become wary of formulating prescriptive policies for areas with large constituencies of autonomous professionals. Instead, policies often define broader aims and objectives whilst communities of practice are advised to design local solutions to problems.

This leaves integration of services as one option amongst many. Given the complexity of integrating organisations, it rarely is the preferred choice for managers. In addition, integrated care lacks the clear epistemic and practice link with a specific problem, or as Jon Glasby put it: "If integrated care is the solution, what is the problem?"

This appears to suit those of us as practitioners and researchers who subscribe to the view that integration is not an intervention but a transformation of services, fitting the characteristics of a service innovation rather than the model of a singular, discrete change of practice. This does, however, make integrated care somewhat of a political orphan. Integration as a policy mandate is subject to the vagaries of policy swings and roundabouts, at times riding the waves of high hopes whilst at others, being dismissed as impossible to deliver.

Despite the remarkable progress in the integrated care field over the last two decades, what integrated care is *not* is a clearly defined policy arena. This has implications for the (at times lacklustre) political support it receives and the waxing and waning of funding it receives. In other words, integrated care lacks stable political support. It remains at the mercy of sympathetic policymakers and the feeling that the historical fragmentation of health and social care in the UK in 1974 was a policy blunder and ought to be reversed.

A quick search on prominent search engines reveals how tenuous the link is between policymaking and integration in health and social care. Google Scholar produces four entries in total for the search terms "integrated care" and "policy", comprising one book, and two papers by one author team led by Mur-Veeman on health policy (Mur-Veeman *et al.*, 1999, 2008). In their most recent publication, the authors conclude that a clear proactive policy is important to implement integrated care in health systems and stress the role policymakers play in bringing about receptive practice and management. Their methodological approach is firmly rooted in policy studies, utilising a neo-institutionalist conceptual framework for their analysis, a point I will return to later.

The same search on PubMed (admittedly not exactly a data base specialising in policy studies) produces only three entries, including one relating to the EU funded project INTEGRATE, analysing high level policies in European countries, and a paper on iCOACH focussing on key issues of local policy implementation such as assessments of organisational readiness for integrated care and knowledge transfer (Evison *et al.*, 2018).

These meagre search returns demonstrate the almost complete absence of policy research on integrated care. Yet, hold on, are not there countless studies investigating how integration policy affects local services? And what about the burgeoning literature on knowledge transfer, innovation and pilots as policy instruments?

This takes us back to the approach Mur-Veeman and her team used in their recent paper. Neo-institutionalism is a framework borrowed from policy studies, investigating the role of institutions in society. But this policy angle is rarely used in health policy research as we see it

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in integrated care studies. So why do we seldom look over the fence? And, more importantly, should we look at all? What is in it for us?

I would argue that the reason why there is little engagement by integrated care researchers with policy studies proper is because of the way in which integration has been conceptualised. It grew out of concerns about organisational fragmentation, a local issue with (nationwide) policy implications of costs. Integrating services appeared to be a possible solution to rising costs and fragmented care delivery. The amorphous moral underpinnings of integration terminology may be added here, a case of proselytising by postulating better patient care outcomes (Kaehne, 2018).

Conventional policy studies operate from a different perspective. They look at policymaking and what determines policies as outcomes of the interaction between various constituencies in a wider policy arena. Policy networks and network governance are prominent frameworks to understand this interaction. The notion of policymaking as a process of stages goes back to the 1970s and has by now proliferated into sophisticated models of policy streams, critical junctures and multiple network alignment.

Whilst this encapsulates the intricate policy formation process, researchers on this side of the fence have mainly operated with simplistic assumptions about research as an evidence production facility and policymakers as rational respondents to problems of fragmentation. We now know that both have produced at best shaky foundations for integrated care. Evidence is hard to come by and policymakers have also been reticent to respond to the little evidence we have by committing funding and political capital to integrated care. Consequently, integration remains hostage to sporadically commissioned pilot programmes and wishful thinking based on nebulous aspirations, such as "improving patient care".

So what can policy studies tell us that integration studies have not told us yet? For a start, the notions of critical junctures and policy agendas may help us understand why integrated care has remained tenuously supported by the policy community. Developing a unitary model of the policy process, Howlett *et al.* speak of the critical juncture in the policy stream which complete the phase of formulating alternative policies and pre-configure decision-making (Howlett, 2018). They argue that this stage captures the moment when policymakers review options for policy. This angle reveals the fundamental weakness of integrated care in the policymaking process: integration is not an "option" amongst others. Integrating services is not conceptualised as a clear and unambiguous policy option in the first place, competing with other policy choices. It highlights the obstructed policy pathway for integrated care in policy making. Integration rarely gets beyond the agenda setting stage as a coherent, discrete policy alternative. Integrated care as a "course of action" remains too fluid, too uncertain and unpredictable to offer clear advantages to policymakers over other courses of action.

The approach championed by policy studies can therefore reveal the impediments to developing integrated care as a clear policy choice. Conceptualising and, ultimately, overcoming this deficiency would represent a major contribution to the maturity of integration studies as a field of practice and research. Charting the path from developing the policy agenda of care integration to the moment of policy choices being made would help us identify the barriers to developing integration as a coherent policy alternative for policymakers. It would also assist us in pulling together the various dots of policy research that some integrated care researchers have tentatively began to map out: the role of pilot programmes as experimental vanguards of integration programmes to come, the policy levers that are available to underpin integration as mechanisms and tools to bring it about (such as pooled budgets) and the role of legislation within the wider policy field to mandate integration efforts.

It should be worthwhile to look over the fence from time to time if we want to establish integration as a clear and coherent policy option.

Axel Kaehne

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