

In Conversation with

Nick Goodwin

Co-Founder and CEO, International Foundation for Integrated Care

Renee Lyons



The Dutch-based International Foundation for Integrated Care (IFIC) is a not-for-profit membership-based network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care in policy and practice (<http://integratedcarefoundation.org/about-ific>). Guest editor, Renee Lyons, recently spoke with IFIC's co-founder and CEO, Nick Goodwin, about examples of excellence in the adoption of integrated care around the world, as well as the challenges that lie ahead in realizing its full potential across health and social care systems.

Renee: How did you get interested in integrated care?

Nick: I'm a social scientist and have worked in academia and the third sector all my life. I started off at The King's Fund – the health charity in London – as a researcher and then moved to the Health Services Management Centre at the University of Birmingham. In each of those roles, I focused on issues related to the service delivery and organisation of primary and community care and specifically the role of primary care organizations in commissioning. Integrated care became part of my

portfolio in the late 1990s and in 1999 I met up with a group of academics from different disciplines in Almere, Netherlands where we founded the *International Journal of Integrated Care* (www.ijic.org) and from which IFIC was later to emerge (Nick is currently the Editor-in-Chief of IJIC).

It has been 16 years since that original meeting. Over time, we recognised that there was a case to be made to support a ‘movement’ towards integrated care. Other than the original fascination as a social scientist in observing the complexities of integrated care, my own motivation comes from seeing first hand how the lack of care coordination has such a terrible impact on older people with multiple needs. It is a fact that people who would most benefit from care coordination – for example, older adults, those living in poverty, those from ethnic minorities, people living in rural communities and children and adults with chronic conditions who will require health and social services over their lifetime – are the ones who are least likely to receive it (Øvretveit 2011). So, despite integrated care being pro-equity in its philosophy, there’s currently an “inverse care law” in how care is designed and delivered that needs to be addressed. I became very motivated about that, and it was in 2011 – when we officially founded IFIC – that we began to tease out what the Foundation might do.

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Renee: You’ve interacted with so many people who are testing out innovations in integrated care. If you were to pick three or four places that you think are leaders in this area, what would they be?

Nick: That’s a really interesting question. In my view, integrated care should be a program for people with complex needs that improves health and reduces costs. However, because we typically assess short-term pilot projects, we see a lot of failure to achieve these aims.

My vision of what a system should attempt to do is very much population health focused to improve health outcomes for communities and involving communities in their own care. It’s really through an inclusive and collective vision, and the ability to engage effectively with people and professionals through empowerment and engagement strategies, that you begin to really see transformational change in care.

When you look around the world, there is a definite trend towards population-based and more integrated delivery systems that bring together a capitated budget for that population and seek ways to make the best use of that money through multi-agency partnerships, networks and alliances.

A good example of this is in Counties Manukau, New Zealand. This area, to the south of Auckland, has a high percentage of Pacific Highlanders and Maori, many of whom have lifestyle factors that mean they have a greater susceptibility to chronic illness. A key philosophy in Counties Manukau has been the need to invest in communities and families to be able to improve health as a whole. Projects include the development of four local community partnerships (LCPs) that use a global budget to shift care into the community to focus more on prevention and early intervention whilst improving processes through investing in multi-disciplinary teams and redesigning care pathways (Counties Manukau Health n.d.)

Another excellent example is the NUKA health system in Alaska where healthcare to the 60,000 people in the Alaskan Native Community has been significantly improved through developing community-owned and integrated healthcare solutions around people’s needs. In 1997, the Alaskan Congress passed a law that allowed Alaska Native people to obtain the ownership and management of their health system. As a result, the Southcentral Foundation established a range of primary care centres that offer an interdisciplinary set of services including home health, health education and specific programs to support the elderly and children. Active ownership of the Foundation by the local community (so called ‘consumer-owners’) and ‘walking with communities’ to achieve change has been central to its success. Key results since 1997 include:

- increased enrolment in primary care from 35% to 95% of the population;
- same day access for routine appointments, down from 4 weeks;
- waiting lists for behavioural health consultations eliminated through having integrated physical and mental healthcare services;
- increased patient and staff satisfaction with a greater respect to culture and traditions, with reduction in staff turnover of 75%;
- a 36% reduction in hospital bed days; 42% reduction in visits to the emergency department; and a 58% reduction in treatment at specialist clinics;
- reduced disparities and improved care outcomes for people with cancer, obesity, diabetes, and dental caries; plus
- reduced levels of child abuse, child neglect, domestic violence, substance abuse and suicide (Gottlieb 2013; Kyle 2016).

The key to NUKA’s success lies in relationship-building. By engaging with the local population around their healthcare needs they have enabled a culturally sensitive way of working to get the best outcomes.

Population health approaches are happening in many other places. There's a unique initiative called *Gesundes Kinzigtal* (meaning "Healthy Kinzigtal") that is the only population-based integrated care approach in Germany. The system is run by a regional health management company in cooperation with a physicians' network. A key feature in *Gesundes Kinzigtal* has been the development of a 'shared health gain' approach by means of a shared savings contract, and the model has attracted non-health partners (e.g. leisure centres and other community groups) to become stakeholders (Lupianez-Villanueva and Theben 2013). Having started in 2006, continued investment in preventive and health promotion programs have led to a reduction in morbidity and mortality compared to comparator regions, and reduced overall costs to the insurer (Barnes et al. 2014).

Renee: So what is it about the context that contributes to such changes?

Nick: There is something important about the capacity of the community to respond and engage in their own health and welfare. So if you go to somewhere like Kazakhstan, for example, there is no recognition that part of the social compact between care providers and patients is that patients should be empowered and take responsibility for managing their own health. In any country where there is an entitlement-based or demand-led culture it can be much more difficult to engage people in their health behaviours. Unless you can have that two-way conversation with the local population to make things better, so that people feel a responsibility to their own care and that of the community, then you're not going to get far in dealing with today's challenges.

Integrated care at its most ambitious aims to bring together all of your community assets, along with your healthcare providers, with a remit to improve health. When that happens, there is the greatest potential for truly transformational effect in terms of health and well-being within those communities. There are enough examples now across the world to demonstrate this to be true, but of course they're isolated examples, highly context-specific, and so difficult to replicate.

Renee: What can we take away from these examples?

Nick: One cannot simply adopt or transfer a specific model of care. One has to take the lessons from how change has been implemented and start, probably from scratch, in working with the local community and the various health and care stakeholders to devise your own solution. Hence, the process needs a guiding coalition, a common purpose, and a shared vision. Underpinning these must be

a compelling narrative on what partners must do together to influence and change the way care is organised and delivered. All should be convinced that it is likely to lead to better health outcomes, improve care experiences, and more affordable and sustainable services. It's about creating a business model that people can understand and from which all will ultimately benefit.

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Renee: It's very much a community development model that you're talking about. I want to ask you about government's role in scaling up and sustaining effective practices. What does government need to consider to support this kind of work and sustain it over time?

Nick: There are two streams of thought here. On one level, you need governments to be able to provide the vision for the system to move forward and so take steps to create an enabling platform for change. For example, in The Basque Country, Spain, they basically set out a mission to become the "best chronic care system in the world" and set out policies, targets and a range of support mechanisms (such as electronic health records and new payment models) to encourage change from the top. However, they also recognised that change would only be delivered by care professionals with the drive and commitment from the "bottom-up," so within that national directive was a significant degree of support for local innovation (Bengoia 2013).

Today, the Basque system has progressed to create Integrated Healthcare Organizations (IHOs) with a single governance structure to oversee care in primary, community and hospital settings whilst promoting less formal care co-ordination approaches with social care (Toro Polanco et al. 2015). The speed of innovation in the Basque country is impressive, and in part this is because they have adopted integrated chronic care as a consistent national strategy.

However, the problem in most countries is that there is not the same political stability to stick with coherent integrated care policies into the long-term. Moreover, since public finances are increasingly tight, you see the strains of that – particularly in Europe in the current economic crisis. Too often integrated care is used as a policy to cut or contain costs, rather than a force for quality improvement, and this leads to short-term thinking as the primary focus is managing austerity rather than the fundamental transformation that is required of care systems that focus on people-centred integrated care and have a chance to change the cost curve.

In my own country, England, this is absolutely the case. At a local level, there is great innovation but also tight control over what can and cannot be expended, meaning that it's almost impossible to properly invest in that innovation. Whereas in the Basque Country, they do not have the same financial problems as they have a political pact with the people to more generously fund health and social care. They have let innovation bloom because they have the political mandate to do so and feel it will lead to better outcomes.

The role of government is to provide the policy and have the enabling architecture in place – finance, accountability, and information technology. But it shouldn't micro-manage the process. It's much better to set the vision for a local community, give them a capitated budget and say, "These are the outcomes we're looking for. You've got the experience; you know all of the providers – off you go." Government can also help with information exchange and knowledge transfer, so that people don't replicate practices, and they bring in good practices. There are lots of things government can do, but micro-management kills it. Although that, of course, is very common.

Renee: Do you see tensions between physicians and the other parts of the healthcare system, in terms of moving change forward?

Nick: Absolutely. Even where you manage to create recognition that by working together they can achieve better outcomes, it's very easy for it to fall apart for two main reasons: first, the win-win situation isn't there, so one organization is benefiting when another one is not; or second, there's the perception that someone within a partnership is not doing a job that others are professionally happy about.

A study from the Netherlands, led by Pim Valentijn, found this situation when looking at the more successful Dutch Care Groups that were utilising bundled payments to manage people with chronic disease (Valentijn 2016). The Care Groups that were less successful were more likely to report dissonance between partners in care through a lack of mutual gain and poor process management. There is a need to build collaborative capacity, but there also has to be something concrete underpinning integrated care that demonstrates its benefits to different professional groups and organizations (for example, financially, through higher quality of care, or a better work-life balance). Otherwise, no matter how motivated people are, they're not going to get engaged.

Hospitals, for example, are often perceived negatively when it comes to integrated care, yet have the resources and knowledge to play a huge and positive role in integrated care. For

example, in the case of the Hospital Clinic Barcelona, where they have evolved a program of chronic care management from the late 1990s to create a project called *Barcelona Esquerra* that helps to provide community-based and integrated chronic care through a population health-based approach to the 'left' side of Barcelona (Font et al. 2016). This has included investing and building primary care facilities, which they own and operate, and enabling a close relationship between GPs and specialists. The outcomes for people with chronic illness, such as the numbers of people coming into the hospital with exacerbations that need an emergency or acute response, have been reduced.

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Renee: The process of making things work in a specific context may misalign with budgets and indicators. There's this sort of tension, isn't there?

Nick: Time is a big factor. It takes a long time to invest in public health and engage with the community. If you're running one-year budget cycles where you have a specific budgetary target to meet within a year, then long-term thinking to invest in integrated care becomes impossible, which destroys such initiatives quite quickly. Most of the time, complex service innovations like integrated care are being evaluated within such a short time frame that it is impossible to see any financial benefit from it. It may take seven or eight years of hard work and effort for integrated care systems to mature.

Renee: Any thoughts on the current "evidence" in complex care?

Nick: There is a lot of evidence to demonstrate how integrated care, and the components that make up an integrated care strategy, can improve care experiences and outcomes for people. There is less convincing evidence when it comes to costs and, in particular, of evaluations of strategic initiatives to adopt integrated care in different countries – such as the Integrated Care Pioneers in the UK (Erens et al. 2016).

For me, as an advocate for integrated care, this negative evidence provides difficulties. It is clearly a problem when I've stood up in front of an audience and somebody very clever has said, "Well, we tried this in Australia three years ago and it didn't work then. Why should it work now?" You have to take them through a process, describing to them why it didn't work three years ago.


In most cases, these failures result because these initiatives did not – fundamentally – implement integrated care in the sense of promoting better coordinated and people-centred care. They might, perhaps, have implemented a merger of two organizations or created some common governance and financial arrangements, but the implementation aspect – the essential integration of care at a clinical and service level around people’s needs – may have been underdeveloped and so represent just a partial response of what the capability should be. The evidence on case management is very clear in this respect where you often see the creation of excellent multi-disciplinary teams, but which sit within an uncoordinated system. This means you might find it impossible to draw upon the other essential services needed to support care to people with complex needs regardless of the commitment and quality of the professionals coordinating the care.

One has to be very careful, therefore, about interpreting the evidence. We know that if the components of integrated care programs are broken down – supported self-care, medications management, care pathways – there’s a huge amount of evidence for positive benefits. Yet somehow we’ve layered it all together and called it *integrated care*, and what we actually end up looking at is a merger between the health and the social care department or something at a very abstract level. That’s not what integrated care is. The good things about integrated care happen at a personal and clinical level. That’s where you’re going to have all of your influence. So until you get a real understanding of what is actually happening at the business end, with patients managing their lives better and coordinating their services more appropriately, they’re not going to get the answer to the question they’re looking for.

Moreover, integrated care is a complex service innovation and you can’t expect any level of certainty through an evaluation within a typical 12- or 18-month period. Also, evaluations do not tend to know enough about the actual interventions undertaken because they are not written up that way. It’s a black box exercise. Unless you go into the black box and see what they actually did, you’re just ticking off a marker at an abstract level.

That’s not how these complex service innovations need to be evaluated and researched, and it’s why our Foundation’s mission to advance the science behind integrated care is very important. We’ve got to try to find a way to create more appropriate evaluation methods for these types of investigations, for example on health economics where the existing hierarchy of evidence will need to be challenged given the inappropriateness of RCTs in this area. If you look at the studies of chronic illness, frail older people and people with multiple co-morbidities are almost always screened out from the beginning.

So the evidence we have is thin and we need to find new evaluation methodologies. Fundamentally, current research methods examining integrated care schemes are often not properly formulated or implemented.

Renee: Thanks so much for this interview, Nick. You have provided important, practical insights that will resonate with health providers and researchers alike. 

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