

Integrated health and social care: can England's NHS learn from Canterbury New Zealand?

Nicholas Mays, LSHTM

Judith Smith, Nuffield Trust

A recent King's Fund report describes impressive progress made by Canterbury New Zealand¹ in moving from a situation in the mid-2000s when the main acute hospital was regularly 'gridlocked' with no possibility of affording additional capacity, to one where there is an extensive system of care coordination across hospital, community, social and primary care. As a result, emergency medical admissions, lengths of stay and readmissions have fallen appreciably. This raises two important questions: how was this achieved; and what can the English NHS learn from Canterbury, given the strong similarities between the two countries' systems?

What did Canterbury do?

From the mid-2000s, Canterbury District Health Board (which is the statutory local funder of health and social care, and also the manager of hospital and some community health services) began a process to persuade local health professionals and public that provision in the district was financially and clinically unsustainable. The DHB argued that it needed to plan for the coming 20 years on the basis of 'one system and one budget', transcending the usual organisational and financial divisions. New strategic goals and principles were agreed locally, in particular, to deliver 'the right care, in the right place, at the right time by the right person'.

Over 2000 staff and contractors were trained to identify and bring about service change, enabling design and implementation of new 'health pathways' across general practice, social care and hospitals. Activity-based payments for hospitals were replaced with bottom-up budgeting for each specialty, and contracts for externally provided services were moved from a competitive, often fee-for-service basis, to a form of 'alliance' contracting derived from the construction industry. This entails organisations agreeing contracts where maximum collective gain can only be realised if all parties support one another and agree to share any losses².

What enabled this to happen?

In 2008, an incoming right of centre coalition government pledged that it would not impose reorganisation on the system, and has kept its word through two parliaments. This wider stability of the health system, along with sustained policy goals focused on clinical leadership, service integration and delivering locally to a set of national outcome measures³, appears to have given local health managers (most of whom have been long in post by English standards), clinicians and board members space to implement plans that make sense in meeting local needs and national outcomes. Critical to this has been a longstanding, highly developed general practice network established in the

early 1990s², which had steadily built a culture of collective peer review, service development and practice support across Canterbury. This network, Pegasus, has enabled Canterbury to involve primary care in new ways of developing and using clinical guidelines and pathways, sharing data, and working with the wider health care community.

Canterbury has largely removed two factors frequently cited as obstacles to service integration in England⁴: the goal of competition between providers; and a payment system that tends to incentivise hospital activity. In New Zealand, the bruising experience of aggressive pursuit of quasi-market reforms in the 1990s seems to have ruled out any return to the use of market forces between hospitals⁵.

Unlike the current context in England, Canterbury's budget grew reasonably in real terms at between 3% and 6% per year throughout the process. This allowed it to invest the increases outside the hospital while restraining the rate of growth in hospital spending. Efficiency improvements in hospitals did not lead to the removal of funds from hospitals - rather they allowed more elective work to be done.

Alliance contracting is widely regarded as important for service integration. How far it represents true sharing of financial risk and reward, and can withstand the future challenge of reducing hospital capacity to extend primary care provision further, is yet to be proven. The contracts have not been through the stress of renewal, but they have enabled a more collective approach to local health funding that seems to encourage service integration.

A final factor impossible to quantify, is the impact of the 2011 Christchurch earthquake in reducing hospital capacity in the city by over 100 beds, bringing health and social care staff together to develop innovative solutions to deliver safe services for the population, and enabling the more rapid pursuit of plans for service integration that had been long in discussion.

Learning points for the English NHS

The Canterbury experience offers a number of insights for the NHS in England. First, there is the uncomfortable message that frequent reorganisation of the system, and particularly of the commissioning function, undermines local attempts to make significant and sustained changes to services⁶. The New Zealand government has upheld its promise not to reorganise the system. Likewise, at a local level, continuity of clinical and managerial leadership is an important enabler of changes to services⁷,

Second, organised general practice is a vital prerequisite to developing new forms of coordinated care. This is something that English GPs have sought at various times over the past two decades, and with the current interest in GP federations and networks, seems closer than ever before⁸.

Third, as noted in analyses of evidence on integrated care, district-wide coordination of care benefits from careful crafting of governance, contracting, funding and information sharing that support the overall approach⁹; in particular, a focus on sharing risk and responsibility across health

organisations as a way of driving out care fragmentation, rather than encouraging competition between organisations.

Finally, it seems that having a local statutory funder with responsibility for both health and social care helps integration of care for frail older people in particular.

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References

1. Timmins N, Ham C. *The quest for integrated health and social care: a case study in Canterbury, New Zealand*. London: King's Fund, 2013
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf Accessed 27 October 2013
2. Stephenson A. Alliance contracting, partnering, co-operative contracting: risk avoidance of risk creation. Paper presented to the Clayton Utz Major Projects Seminar, October 2000 cited in Thorlby R, Smith J, Barnett P, Mays N. *Primary care for the 21st century: learning from New Zealand's independent practitioner associations*. Research report. London: Nuffield Trust, 2011
3. Ministry of Health (2011) *Better, Sooner, More Convenient Health Care in the Community*. Wellington, New Zealand: Ministry of Health.
<http://www.health.govt.nz/publication/better-sooner-more-convenient-health-carecommunity>. Accessed 25 July 2012.
4. Ham C, Smith J. *Removing the policy barriers to integrated care*. London: Nuffield Trust, 2010
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/Removing_the_Policy_Barriers_Integrated_Care.pdf Accessed 27 October 2013
5. Gauld R. *Revolving doors: New Zealand's health reforms*. 2nd edition. Wellington: Victoria University of Wellington, 2009
6. Smith J, Walshe K, Hunter DJ. The "redisorganisation" of the NHS. *BMJ* 2001; 323: 1262-3
7. Baker GR, MacIntosh-Murray A, Porcellato C, Dionne L, Stelmacovich K, Born K. *High performing healthcare systems: delivering quality by design*. Toronto: Longwoods, 2008
8. Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R, Walsh N. *Securing the future of general practice: new models of primary care*. London: Nuffield Trust, 2013
<http://www.nuffieldtrust.org.uk/publications/securing-future-general-practice> Accessed 27 October 2013
9. Rosen R, Mountford J, Lewis G, Lewis R, Shand J, Shaw S. *Integration in action: four international case studies*. London: Nuffield Trust, 2011
<http://www.nuffieldtrust.org.uk/sites/files/nuffield/integration-in-action-research-report-jul11.pdf> Accessed 27 October 2013