Editorial

When integration policy and implementation part ways

In an article on the do's and don'ts of evaluation, Lorelei Jones (2018) wrote that "policy is treated as a given, assumed to be fixed, stable and goal orientated. However, […] when it comes to health care policy, none of these may be safe assumptions" (p. 265).

Policy formulated at various levels, national, regional or local, is of particular importance to integrated care. As I noted previously, the impetus for integrated care rarely emerges from local concerns. Integration programmes are usually introduced top-down through national policy initiatives. The integration of services is not a preferred local response to routine service problems. To paraphrase the former editor of this journal Jon Glasby, no service director wakes up on a Monday morning and, facing a series of challenges in his organisation, decides "to integrate".

Instead, services are usually mandated to integrate. And whilst care integration has gained some prominence in policy announcements, it is less clear whether or not we know enough about how policy translates into implementation processes. This appears to be the crux of Jones' argument: policy and implementation possess their own contexts, their own dynamics and, perhaps should also be judged by their own measure of success.

We already know a lot about this disjuncture between policy and implementation. It is well known that most integrated care programmes either fail or often create new challenges without solving old ones. The issue of cost savings is a typical example. Robust evidence that integration programmes reduce care costs in the short term is difficult to come by. Like any service modification, changes produce unintended consequences, often unlocking latent demand which leads to higher care costs. Yet cost savings and improving care quality remain primary policy intentions when instructing local services to integrate. So what is going on?

The wider policy literature is teeming with vigorous debates about the fundamental changes that have taken place in governance and public policy formation over the last two decades. To simplify, where there was once a straight trajectory from central policy to the point of delivery, policy has now morphed into providing a framework of change only. Where once policy was highly prescriptive, it now permits and encourages local services to find their own solutions to problems.

In part this was a response to the growing realisation that policy cannot be imposed on service landscapes populated by largely autonomous and semi-autonomous health care organisations and professions. The new permissive thrust of policy also spoke to the wider devolution of powers that reflected a shift away from rigid mandatory policies in the public sector, based on overly simplistic cause and effect notions of policy levers and service responses.

Healthy skepticism about the direct impact of policy on frontline services is not new. Aneurin Bevan's dictum that the clang of a dropped hospital bedpan should be heard in the corridors of Whitehall was always more aspirational rhetoric than realistic. Yet, as public policy scholars pointed out, the last 20 years have brought about a shift in policy making which increasingly recognised ambiguity, fragmentation and complexity as key features of policy formulation (Matthews, 2013). Today's policy is less prescriptive than ever, setting only broad parameters of change and general directions of travel, whilst leaving it to local organisations to find solutions to their problems on the way.

The pilot programme is a perfect illustration of this transformation of policy. Routinely, policy makers now invite services to bid for funding to implement pilots, specifying only the

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broadest criteria, or, even encouraging local services to form what can only be called exploratory consortia developing solutions to problems as they go (the English NHS called this "defining new models of care"). Whilst these programmes are marked by unprecedented freedom to experiment, and factor in the possibility of failure, they also create serious tensions between what pilots are supposed to do and what they actually do. As Ettelt, Mays and Allen pointed out, pilots in large transformational health care programmes often play dual roles, testing a particular solution (integration) to a specific problem (rising health care costs), whilst also promoting a specific policy change (Ettelt *et al.*, 2014).

This fundamental move away from prescriptive policy to "permissive" policy, devolving details of implementation to local organisations, leads to the disjuncture between policy and implementation that Jones noted. Her argument on the specificity of contexts is a key observation. It points to the important dislocation between policy intentions and implementation intentions. But are not we all interested in creating better, integrated services? So, is there not sufficient common ground for policy and implementation?

As I argued before, agreement amongst policy makers and local implementers on what is being implemented and why rests on the fragile consensus to improve patient care (Kaehne, 2018). Policy documents on care integration are brimming with aspirational language about how working together will improve service quality. However, the epistemic and operational distance between these policy objectives and organisational reality is large indeed. What determines the behaviour of local staff is framed by the local organisational context, defined by daily routines and practices, rather than idealised versions of what their work should ultimately create. To mix baseball and rugby metaphors, policy is a home run, implementing integration programmes is a scrum.

The move away from policy making grounded in notions of direct control of local services towards policy steering of largely devolved, semi-autonomous organisations with significant latitude in implementing national policy has also fractured the unity of context which allowed us to conceptualise policy intent and policy implementation in one consolidated framework. Instead, we are now faced with policy making that reflects ambitions of the wider policy field, such as creating sectoral collaboration, and implementation practices which are hostage to local dynamics, dousing the singular policy narrative in the reality of local tussles.

The tenuous overarching frame lending support to these disparate endeavours is supposed to be provided by the theme of better patient care, and the fundamental values of health care work, reflecting a unity of professional virtues, something that has been questioned by Lipsky (1980) long time ago.

So what does this mean for researching integrated care programmes? Echoing Jones, integrated care researchers will need different sets of tools, different approaches and different measures of success for investigating integration policy to the implementation of this policy. In a way, the gradual divergence of both fields has spurned the emergence of implementation science, a vibrant new area for organisational and health systems researchers. But it also means that we are dealing with different social phenomena when looking at policy making and policy implementation, a point that is appreciated by Jones when she writes that "policy is [not] the only one – or even the major – influence on the behaviour of people" (Jones, 2018, p. 264) in organisations.

Last but not least, it means that we need to stop perceiving broad policy goals and intentions, such as better patient care, as sufficient conditions for the success of transformational change programmes in health services. The intention to collaborate is not enough to bring about interprofessional or interorganisational collaboration or integration. Integration, as an outcome of national policy, remains hostage to the fortunes of local actors, who interact with each other in a political and organisational arena defined by

micro-, macro- and meso-level factors. This is a key insight for policy makers whose experimental "framework" approach to health care change programmes needs to be matched by a better understanding of the diversity of outcomes it is likely to engender.

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