

## The tacit assumptions of care integration

The field of service integration is not short on excellent conceptual or theoretical work. In a sense, conceptually framing the activity of care integration started before people starting “doing” it. This has often led to the charge that the field is overly theoretical at the expense of common-sense, practical “how to” knowledge. It has also led some to believe that, given the complexity and sheer intractability of integrating services, some hard graft, rather than more theory, is the best way to success (Dickinson, 2014).

Whilst I largely agree with this, I also sometimes feel that, despite all the theoretical and conceptual work, we do not see the forest for the trees. What do I mean by that?

Integrating services is a moral exercise, in deed and language. It is motivated by concerns for care quality and its language has deep ethical resonances. The act of “integrating” something in public services relates to partnership work, collaboration and co-operation across boundaries, all words with strong positive connotations. Working together is thought to be beneficial for everyone, not least patients who would otherwise face a fragmented and splintered landscape of professional services. The notion of patients not able to deal with fragmented care is a central pillar of the self-perception of those who want to advance care integration.

However, service planners, just like researchers, approach the activity of integrating organisations as a rational endeavour. They set up service structures, review and assess demographic trends and try to map systemic capacity against patient demand. Thus, when integrating services we are motivated by moral imperatives, improving patient care quality, but we are engaging in a rational activity, planning services. This conflict between moral intentions and rational service delivery is nothing new and is part and parcel of what Max Weber called the “disenchantment” of the modern world.

However, this tension between integration as an enterprise motivated by moral tenets and a bureaucratic, rational undertaking is, with few exceptions, rarely the explicit focus of research (Baillie, 2017). It is an under-theorised and under-conceptualised field of inquiry in integration research. Does this matter?

There are two aspects of this lacuna of research that directly impact on how we investigate and, ultimately, how we deliver integrated care. The first is a matter of critical distance, the second has implications for how we explore organisational integration. I will set out both below.

In a recent paper on “Healthcare teams as complex adaptive systems”, Pype *et al.* (2018) use complexity science to explore the perceptions of stakeholders towards team working. The teams are interprofessional, a key prerequisite for care integration. In the paper, complex adaptive system principles act as an interpretative back foil in their investigation of collaborative patterns of behaviour amongst team members.

Not surprisingly, in their study all respondents profess to want to “improve patient care”. The authors write that “participants in our study clearly stated that their mission in healthcare was to focus on the patient and the quality of care. *‘We are here for the patient’*” (italics in original) (p. 4). Consequently, the authors find that “sharing the same mission of delivering quality care – the willingness to act in the patient’s best interests” (p. 9) is a facilitating factor for team collaboration.

Shall we be surprised by this? It is what nurses and doctors are professing to do every day. It is a part of their DNA; indeed, it is a part of their training to question the merits of anything they do in the light of patient care quality and patient benefit. In a sense,



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their insistence that they “are here for the patient” and that this can sustain and support collaborative working is the outward expression of the internalised moral thrust of any healthcare. It is what they are supposed to do. But is it true?

In 1980, Michael Lipsky published a book called *Street-Level Bureaucracy: The Dilemmas of the Individual in Public Services*. It is still much discussed and cited in public administration and public governance circles. The book’s theme was the way in which public sector workers resolved situations where limited resources clash with client needs. Lipsky (1980) was sceptical of the outward manifestations and expressions of staff’s unencumbered commitment to clients. His key insight was that “clients are *not* the primary reference group of street-level bureaucrats” they do not count among the groups that primarily define street level bureaucrats roles” (italics in original) (p. 47).

Lipsky thinks that we take the moral impetus of public servants’ work (which he does not deny) as the main reference point for what they do. That, he argues, is a misunderstanding. Their role is defined by the organisation they work in and by the practices that are regulated by those very organisations or their professional associations. What matters when they face clients is that they have adhered to and complied with all relevant rules and regulations that are defined, mandated and legitimised by the service they work for. In other words, Lipsky thinks that we take the trees for the forest. We are staring at (bona fide) articulations of the moral and ethical impetus of healthcare work and forget that professionals work inside the organisations which legitimise, standardise and authorise their work. It is, what I would call a lack of criticality on our part to equate their moral intentions with their organisation’s impact.

The second aspect emerging from the tension between the moral import of healthcare work and its bureaucratic delivery structure is the way in which we investigate integrated care. There is a wealth of evidence on how organisations influence and shape collaborative ventures between services. The initial focus is invariably the service level, where two or more services come together to improve patient care. As organisations establish service level agreements or other convenient contractual arrangements, the attitudes of members of staff then come into view, trying to identify what helps or hinders the implementation of new multi-professional or cross-organisational practices. To explain the success or failure of a programme we explore facilitators and barriers to collaboration and tend to draw on poorly defined factors such as “leadership”.

The implicit hope is that whilst organisations determine the structural framework of care integration to its individual members of staff who make it work. Where organisations fall short, we shift our explanatory lens to leaders who fail to show the very attribute we expect from them, leadership (paradoxically, a moral attribute rather than a pragmatic skill). It appears to me that much of our “explanations” of success or failure of integrated care programmes is thus down to an expedient flexibility at the heart of our explanatory frameworks, the ability to shift the onus of success or failure of collaboration from individuals to organisations and back again. This flexibility is generated at the expense of a disregard of Lipsky’s central insight. As he reminds us, individuals are embedded in organisations from which they draw critical resources that allow them the effective conduct of their work, such as status, authority and legitimation. Staff thus operate within a system of rules. To stress free agency (again an attribute of decisive moral import) as a key factor in integrating services fails to take into account the role of organisations in shaping and informing work practices.

Why is this important for integrated care? Why is the tension between the moral impetus of interprofessional work and its organisational setting relevant to integrated care?

The integration of services is a policy-driven enterprise. It occurs where services are mandated to work together. As often noted, integration rarely happens bottom up (Paley, 2010; Suter *et al.*, 2009). Care integration by and large remains a top down,

policy-driven activity, imposed on stakeholders by political diktat. This should caution us to overemphasise individual agency. Organisations and the structures they establish are the main vehicles for change. It is true that institutions are little more than “habits of behavioural patterns”. But to equate individual agency with the capacity to change requires careful assessment of the organisational setting and how it curbs or permits space for autonomous action to support change. In a sense, underestimating the organisational constraints of agency is the mirror image of our wishful thinking that nurses and doctors are only motivated by their desire to do good. It is where the trees stand tall to block our view of the forest.

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### References

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