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Can we mandate partnership working? Top down meets bottom up in structural reforms in Scotland and Norway

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Abstract

Purpose – Partnership working across health and social care is considered key to manage rising service demand whilst ensuring flexible and high-quality services. Evidence suggests that partnership working is a local concern and that wider structural context is important to sustain and direct local collaboration. "Top down" needs to create space for "bottom up" management of local contingency. Scotland and Norway have recently introduced "top down" structural reforms for mandatory partnerships. The purpose of this paper is to describe and compare these policies to consider the extent to which top-down approaches can facilitate effective partnerships that deliver on key goals.

Design/methodology/approach – The authors compare Scottish (2015) and Norwegian (2012) reforms against the evidence of partnership working. The authors foreground the extent to which organisation, finance and performance management create room for partnerships to work collaboratively and in new ways.

Findings – The two reforms are held in place by different health and social care organisation and governance arrangements. Room for manoeuvre at local levels has been jeopardised in both countries, but in different ways, mirroring existing structural challenges to partnership working. Known impact of the reforms hitherto suggests that the potential of partnerships to facilitate user-centred care may be compromised by an agenda of reducing pressure on hospital resources.

Originality/value – Large-scale reforms risk losing sight of user outcomes. Making room for collaboration between user and services in delivering desired outcomes at individual and local levels is an incremental way to join bottom up to top down in partnership policy, retaining the necessary flexibility and involving key constituencies along the way.

Keywords Care partnerships, Public sector reform, Health and social care, Policy implementation

Paper type Viewpoint

Introduction

Partnership working, i.e. services collaborating across sectors and organisations, has been identified as central to achieving a wide range of policy objectives addressing complex "wicked" issues that cannot be solved by one agency alone (Rittel and Webber, 1973). Internationally partnership approaches have been promoted to address issues including: urban and rural regeneration; community safety; public health; health and social care; children's services and the environment (Cook, 2015).

Partnership working to improve co-ordination between and across health and social care is a particularly important policy area. Worldwide, partnership arrangements are put in place to address fragmentation of services and underpin a shift from hospital-centred to community-based care for the management of increased rates of chronic disease and

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support for an ageing population (World Health Organization, 2008). The capacity of stretched health and social care systems to deliver on key individual and social outcomes thus ride on partnership success.

The role of central policy in facilitating partnerships merits closer investigation.

The literature suggests tensions between top-down (Van Meter and Van Horn, 1975) and bottom-up (Lipsky, 1980) approaches to policy development. A consensus is emerging that a combination of the two approaches is needed for effective policy implementation (Matland, 1995). A certain amount of flexibility at local level for the interpretation and application of the policy is needed to make it work. At the same time, too much local flexibility loses sight of central priorities.

This viewpoint paper compares key features of Scottish (Scottish Government, 2015a) and Norwegian (Norwegian Ministry of Health, 2009) health and social care reforms that mandate partnership working and puts in place mechanisms for closer co-ordination at structural levels. We describe and review the policies in light of evidence about partnership working and what is so far known about the policies' achievements against key goals. We suggest a reevaluation of partnership outcomes rather than their structure and process, as a way forward.

We compare Norway and Scotland for three reasons. First, both countries have recently introduced policy that mandates partnership working. Second, Norway and Scotland are similar in terms of history, geography, economic development patterns, population and political system. The two countries' organisation and governance of health and social services are, however, surprisingly different. Third, the authors have extensive experience of research, teaching and collaborative practice in partnership working in Norway and Scotland.

Defining the context: regulating the "top down" and "bottom up" in partnership working

Evidence suggests that health and social care partnership working is difficult to achieve (Hayes *et al.*, 2011) and that partnership failure is common (Dickinson and Glasby, 2010). Ling *et al.* (2012) identified a range of issues around health and social care partnership working in a UK context. Some of these relate to large-scale organisational change generally, including: adequate finance, robust IT systems, leadership, an organisational culture facilitating change and clinician involvement. Factors identified particular to successful partnership working include: financial and governance arrangements that facilitate co-operation across boundaries, strong personal relationships between managers in different organisations to promote a clear vision and commitment across organisational boundaries, support for staff in new roles and organisational and staff stability. Importantly, a manageable scale of integration projects was important.

These findings echo a review of partnership working in public services more generally (Cook, 2015) which highlighted the challenge of establishing collaborations within hierarchical ways of working, short-term performance management regimes, the absence of links between partnerships at strategic and operational levels, the challenges engaging wider partners, notably the third sector, and the unequal distribution of power within partnerships. The mandatory nature of many public sector partnerships was also an issue.

Partnership working is primarily a task for local actors working "bottom up": partnerships need to be developed flexibly, responding to local pressures and ambitions, establishing clear local aims, manage unequal distribution of power and work through relationships that are stable over time. However, wider context is important in order to create room and stability for partnerships to be effective. The evidence does, however, not support mandated partnership working, yet both Scotland and Norway have introduced policies that attempt just that, with consequences worthy of note.

Policy is restricted by what is there already (Wilsford, 1994) and the paper goes on to describe the very different way health and social care services in the two countries are organised and regulated before turning to the policies themselves.

Two national regulatory contexts

Organisation and finance

In Scotland the important fault line is between a National Health Service (NHS) and local authority run social care. Since 1948 the NHS is a national unitary UK service, encompassing both acute, specialist hospital care and primary medical care. The NHS is answerable to central government and funded by block grants. In 1997, Scotland broke with the Westminster Government's reintroduction of the internal healthcare market and eschewed competition as a way to increase quality and reduce costs. It embarked on a "tartan" policy of weakening and shifting boundaries between health and social care and specialist and primary healthcare to manage increasing demands with limited resources (Kaehne *et al.*, 2017; Petch, 2012; Woods, 2001).

Social care is answerable to local government and funded by a combination of local taxation and state grants. There is a long-standing perception that Scotland's 32 local councils are the weaker partner in collaboration arrangements with the NHS.

Whilst Scottish health and social care organisation facilitates service integration, the organisation of health and social care in Norway compels maintenance of boundaries and management of their interfaces. The key fault line is between a state-owned specialist hospital services sector and municipal primary health and social care services. Until 2002 both sectors were managed by different local authority tiers. The Hospital Reform then removed specialist hospital care from regional municipal control and placed it within State-owned Regional Enterprises (Helseforetak), each with its own budget and organised to contain costs and maintain quality through competitive tendering (Laegreid *et al.*, 2005). Regional Enterprises purchase services from public hospitals run as provider trusts, NGOs and private providers.

Municipal primary health and social care is funded by local taxation and state grants. Norway's 429 municipalities are the weaker part in collaborations with four large regional hospital enterprises (Kirchhoff and Ljunggren, 2016).

Performance management

Performance management of health and social care partnerships are attuned to the two countries' different organisation and finance of health and social care. In both, performance management involves thorny questions of state control of autonomous local government, key players in delivery of social care.

Scotland pursues a performance-based regime (May, 2007) focussing on the attainment of centrally set targets. There is considerable freedom in how single services and partnerships reach targets, but the performance management system is pervasive, with central bodies providing both support and pressure (e.g. Healthcare Improvement Scotland). The performance management framework is tailored to NHS targets (Scottish Government, 2016). Questions around autonomous local councils' contribution to performance were pre-reform addressed by joint targets agreed voluntarily between Central Government and Council-led Community Planning Partnerships encompassing local health and other public services (Scottish Government, 2014).

Norway has developed a prescriptive regime (May, 2007) focusing on individual services' adherence to central directives. Centrally designed care – or clinical pathways – is the main mechanism of service co-ordination (Skrove *et al.*, 2016).

Norwegian Hospital Enterprises are run as separate economic units. Regulation focuses on budget maintenance and service priorities are set by the State, as principal owner,

in annual steering documents. Enterprises' space for autonomous decision making is squeezed between requirements of steering documents and pressure to maximise income by Diagnosis-related Groups (Pettersen *et al.*, 2012).

Local government autonomy is key to the Norwegian political system. Central Government cannot encroach on local government political and administrative jurisdictions. The main vehicle for State regulation of primary health and social care is therefore negotiations at state level with service central bodies about funding and its conditions (Agency for Public Management, 2015, p. 55).

The result is a complex set of services signed up to their own specific central directives, and with limited local flexibility in terms of knitting different services together.

Prior to the reforms, then, Scotland and Norway had developed different forms of partnership working, adjusted to national contexts of organisation and regulation. This history has shaped the tension between "top down" and "bottom up" in the two countries differently. Scottish managers and staff work with a degree of fluidity in service boundaries and in a context of strictly monitored central targets. Norwegian managers and staff look inwards and upwards to central directives regulating their separate services. Cross-service collaboration is highly structured and enshrined in formal agreements and procedures. In both countries, and within these frameworks, voluntary partnerships had emerged from existing relationships and histories of collaboration (Kirchhoff and Ljunggren, 2016; Petch, 2012).

In both countries also, there was growing consensus that what was being done was not enough. Green Papers were published calling for stronger central steer to address fragmentation of services and limited value for money in terms of reducing pressures on public funds. Neither Green Paper called for structural reform-the Norwegian Wisløff report (NOU 2005:03) explicitly warned against it. The Christie Commission (The Commission Chaired by Dr Campbell Christie, 2011) recommended changes in four areas, and emphasised localisation of interventions.

However, wholesale structural reform was what both countries pursued. Known impact of the reforms so far suggests that this broad approach attempts too much and therefore risks achieving too little. Our paper goes on to argue that partnerships' potential to develop user-centred care addressing the complexity of health and social care needs is compromised, whilst tasks beyond partnership influence, notably reducing pressure on hospital resources, remain unaddressed.

The reforms at a glance

Table I sets out key features of the reforms in both countries. Important differences are indicated in italics.

The aims of the reforms are similar and can be grouped into three areas:

(1) collaboration across sectors and services around users needs;

(2) a shift of care from hospital services to community settings; and

(3) public health and prevention of ill health in community settings. This area is outside the scope of the paper.

The partnership models and structures, and the relationships between partners that the reforms put in place, are, however, very different.

Scotland: multilateral partnerships in increased regulatory complexity

In Scotland the reform forces the "Tartan" road (Petch, 2012) towards service integration. Multilateral partnerships comprise statutory health and social services, non-governmental organisations; patient and community groups and private providers within 32 local authorities and adjoining NHS Local Health Boards.

	Norway	Scotland
The reforms	The Co-ordination Reform, 1 January 2012 underpinned by the law on health and long-term care *Mandates 11 areas for binding service agreement between municipalities and hospitals*	Public Bodies (Joint working) Act implemented from 1 April 2016 mandated that 32 local health and social care partnerships: *Create joint strategic commissioning plans* *Appoint chief accountable officer* *Specify governance arrangements*
Model country	*Denmark and The Structural Reform in 2007*	*North America, Alaska, Kaizer Permanente and Institute for Healthcare Improvement*
Focus of reforms	Service co-ordination Preventative care Care out of specialist hospital provision and into the community for Elderly and chronically ill patients with complex needs Sustainability of public health and social care services	Service co-ordination, Preventative care Care out of specialist hospital provision and into the community for Elderly and chronically ill patients with complex needs Sustainability of public health and social care services
Partnership model	*Public-public bilateral partnerships* with marginal involvement of patients/users, carers, community groups, independent sector, welfare services and GPs	*Multilateral public-third and independent sector provider partnerships.* Arrangements mostly hierarchical with collaborative governance at the edges
Degree of voluntarism	Mandatory partnerships between municipalities and hospital trusts replaced voluntary partnerships	Extended mandatory requirements reduced scope for voluntary partnerships
Type of partnership integration	*Vertical integration between hospitals and municipal care.* From 2015 also horizontal integration, e.g. specialist care pathways extending into primary care (cancer)	*Horizontal integration between health and social care at primary care level*, but some involvement of hospital sector
Financing	*Continued separate budgets for municipalities and hospitals*	*New arrangements require joint financial commitments to plan. One example of integration of budgets in Highland*
Involvement of social care services	More focus on healthcare services than on social care services	Inherent, though widespread concerns of social care being marginalised through integration
Patient populations	Mainly focused on older, somatic patients. More focus on chronically ill, acute patients and mental health from 2016	Started with older adults, now across system
Performance management	*Partnerships performance managed in terms of structure, not outcomes. Objectives are relatively unclear. Some national indicators are developed, but it is difficult to measure success*	*Performance management framework of nine National Health and Wellbeing Outcomes that exist alongside existing NHS and Community Planning Partnership framework*
Patient/user involvement	*Some involvement at system level. The patient/user is not a partner in the partnership*	*Long standing involvement, often through self advocacy groups and the third sector. Requirement that plans are signed off by community representatives*
Characteristics of the service agreements (content)	Agreements are relatively similar across partnerships. Risk avoidance among partners. Unclear goals/objectives	Focussed on structures and governance and performance indicators, with variety across partnerships. Lacking clarity about improvement strategies and timescales
Future	After 2015 more focus on non-somatic (e.g. mental health) more focus on GP's and nurses' role Establishment of 8 national learning networks Inter-municipal co-operation on 24-hour emergency services	Focus on scaling up of innovative practice Leadership support Challenge of delivering on prevention with continued austerity

Table I. Ideal typical characteristics of partnerships in health and social care – Norway and Scotland (2012-2015)

The reform commits each Local Authority and Health Board partnership to appoint an officer accountable to both bodies, specify the partnership governance structures and jointly commit money to pooled funds to develop integrated care services informed by a joint strategic commissioning plan. The partnerships are legally bound to develop integrated services for older people, but can extend responsibility to other areas, for example children's services.

They are held accountable to the Scottish Government for financial and governance arrangements, and for partnership outcomes, measured through a National Health and Wellbeing Outcome Framework orientated around nine broad outcomes, for example "People are able to look after and improve their own health and wellbeing and live in good health for longer", progress towards which is measured through a set of outcome indicators that combine organisational data around service use with self-report data from samples of patients (Scottish Government, 2015b). This framework draws local councils tighter into the central performance management framework, but also introduces a degree of ambiguity through a set of targets that sit uneasily beside the existing NHS arrangements and the new local outcome improvement plans that set out joint NHS and local authority targets (Scottish Government, 2015c).

The strategic commissioning process requires partners to work together to assess future needs of a local population and plan the use of pooled funds to meet them. The legislation allows flexibility in terms of content of agreements and partnership working arrangements. Service users, patient groups and voluntary organisations are partners in the development of plans (Taylor, 2015), but their voice is not necessarily influencing decisions (Sinclair, 2011).

Norway: bilateral partnerships in tighter structures

In Norway the emphasis is co-ordination (Norw. "samhandling") which regulates, but does not necessarily weaken, boundaries between partners.

Partnerships are bilateral, comprising a hospital enterprise and a municipality. Non-government organisations, service user groups, community organisations and private providers have no formal role in the partnerships (Brekk and Kirchhoff, 2015). One hospital enterprise can adjoin several of Norway's 429 municipalities and vice versa. The reform with underpinning legislation (Norwegian Ministry of Health, 2016) places added responsibilities for clinical care, public health and rehabilitation on municipalities, accompanied by shift of funding.

Partners are obliged to make mutually binding service agreements concerning for example communication and decision making around hospital admission and discharge; allocation of responsibility and funding regarding prevention and rehabilitation; and knowledge transfer from hospital to municipal services. Partnerships are monitored on their adherence to these agreements, but not on their outcomes.

Outcomes of the reform are monitored at national level by ongoing data collection measuring for example patient and funding flows at national and municipal levels (Norwegian Directorate of Health, 2016). An evaluation programme commissioned through the Norwegian Research Council reported in 2016 (Norwegian Research Council, 2016).

In summary, Scottish partnerships comprise a range of local partners, with considerable autonomy when it comes to managing a joint budget according to identified local need with outcomes measured against centrally set targets. The governance and regulatory framework is, however, more complex, and the landscape is difficult to navigate.

Norwegian partnerships consist of two partners, whose relationship is structured by legislation and financial arrangements enshrined in monitored service agreements. The agreements concern division of funding and responsibility. Partnerships are held accountable for the structure, but not for the outcomes, of the partnership. Patient and community groups and private providers are not formal partners.

Impact of reforms according to goals

A comparison of the effects of the reforms so far has to be presented with certain reservations, due to time scale, and the difference in timing of implementation between the two countries. So far, however, evidence suggests that neither reform is likely to deliver on two key policy goals that are the focus of this paper: make care user centred and bringing care out of hospital.

Scotland

In Scotland the legislation was passed in 2014 and reforms came into full effect on 1 April 2016. It is too early to establish longer-term impact, but shorter-term developments suggest challenges ahead.

Reports by Audit Scotland noted widespread support for the principles of change, but difficulties agreeing budgets, uncertainty about long-term funding, complexity of governance arrangements and workforce challenges were cited as early barriers to progress (Audit Scotland, 2015) A year on (Audit Scotland, 2016) many Integrated Joint Boards were still to set clear targets and timescales for community-based service delivery. This report also highlighted the current imbalance in performance measures in favour of acute health services, identifying this as a key barrier to shifting resources from hospital to the community.

The flexibility built into the legislation has resulted in 32 partnerships that differ in the extent and nature of services and client groups covered by the partnership agreements, their governance arrangements and the performance indicators used to track progress against the nine health and wellbeing outcomes. This flexibility can provide space for local innovation, with some partnerships focussed on working collaboratively to improve outcomes for users and communities. However, the lack of focus can also inhibit new ways of working. There is evidence that in some partnerships social services in general and user-centred priorities specifically have been "trumped" by NHS priorities and the need to "deliver" on integration (Audit Scotland, 2017).

A further factor complicating partnership working is a policy of austerity since the 2008 financial crisis, which has put local partnerships under strain to produce more results with less resources.

Whilst some partnerships seem set to progress service co-ordination around user needs, then, this agenda conflicts with the pressure to deliver on NHS targets.

Norway

In Norway, the reforms came into effect in 2012. The National Evaluation Programme reported on March 2016 (Norwegian Research Council, 2016) suggested limited progress towards reduced pressure on hospital care. The number of patients who remain in hospital beyond the date declared ready for discharge is significantly down, without increased mortality. However, this trend had started before the reform and the number of hospital admissions have increased, suggesting that municipal services are not able to maintain sicker patients in the community and that hospitals fail to coordinate discharges with municipal services. Cost of municipal care has increased, but without a commensurate increase in funding, and without reduction in cost of specialist hospital care (Norwegian Research Council, 2016).

Co-ordination of care around user needs has suffered from measures to reduce delayed discharges. Older patients' journey from hospital to home or nursing home has become more fragmented with the addition of municipal step-down units before final discharge home (Norwegian Research Council, 2016).

The Co-ordination Reform acknowledges the challenge of scale and is termed a "framework reform", steering future development according to national evaluation and

mutual learning across partnerships. So far, however, no significant adjustment to the policy is planned apart from measures to improve management and simplify inter-service collaboration within municipal medical and social care (NOU 2015:17). The crucial relationship between municipalities and hospitals is not discussed.

The apparent limited impact of the reforms against goals so far may say more about the goals themselves than the inability of partnerships to deliver on them. The Scottish NHS and Norwegian Hospital Enterprises have a considerable degree of political and economic muscle (Dayan and Edwards, 2017; Laegreid *et al.*, 2005), and the expansion of hospital activity has its own momentum that local councils (Scotland) and municipalities (Norway) as the weaker partners cannot reasonably be expected to curb without more support than integration policy so far offers (Erens *et al.*, 2017). Moreover, it appears that partnerships' attempts to deliver on the shift of care from hospital to the community detracts from the other key goal where partnerships are better placed to perform: co-ordinated care around users' needs.

Discussion: appreciating the potential of partnerships

Partnership working is a local concern, dependent on stable relationships between and within a range of partner agencies, and with flexibility and reasonable time frames to progress locally and nationally relevant aims. The national context clearly matters; finance and governance mechanisms are needed that minimise hierarchy and create stability, flexibility and space for partners to work creatively across service and sector boundaries (Cook, 2015; Glasby *et al.*, 2011; Ling *et al.*, 2012).

The two reforms seem to have limited the space for manoeuvre at local levels, but in different ways and mirroring existing structural challenges to partnership working. Scottish partnerships have to contend with a complex regulatory context, at best complicating, at worst stultifying partnership working. Norwegian partnerships operate with arrangements that restrict multi-partner networks across and within services. In both countries, the reforms appear to compromise ground-level participation by patients and users, the reforms' key intended beneficiaries, and monitoring arrangements do not meaningfully focus on user outcomes.

A response in both countries is that partnerships will find ways to accommodate the changes and produce results. However, this misses a key point. Both countries' reforms aim wider than partnerships can reasonably deliver and lose sight of partnership potential.

Another approach is to direct policy development around desired outcomes of partnership policies at individual and local levels, where partnerships can be at their most effective (Cameron *et al.*, 2014; Glasby, 2016), and then create mechanisms to support negotiations towards those outcomes. This would be an incremental way to join bottom up to top down in partnership policy, retaining the necessary flexibility and involving key constituencies along the way. Shift of care and public health (Wilkinson and Pickett, 2010) requires political muscle that is beyond partnerships and is best addressed in other arenas.

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