Learning from elsewhere: Integrated care development in Singapore

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ABSTRACT

The Singapore healthcare sector faces a myriad of challenges, including a rapidly ageing population, an increasing burden of chronic disease, and the rising cost of healthcare. The Ministry of Health has called for a restructuring and transformation of the current model of care to one that is more accessible, affordable and of higher quality, by the year 2020. In achieving quality health care, care integration through the Regional Health Systems (RHS) is seen as one approach to improving health and social outcomes, increasing healthcare utilisation and increasing satisfaction with healthcare providers. We conducted a qualitative study involving 31 elites from five policy agent clusters, and analysed organisational documents, to explore how the concepts of policy transfer and policy translation, explain the ways in which integrated care was introduced and developed in Singapore, with a focus on the SingHealth (SGH Campus) Regional Health System (RHS). The findings demonstrate that the development of integrated care is mediated by multi-scalar and multi-site networks and contextual features. The multiple and pluralistic interpretations of 'integrated care' and 'policy' are contested spaces or domains requiring further negotiation and debate. Institutional issues in the SingHealth (SGH Campus) RHS, and in the private and ILTC sectors highlight the need to consider spatial and temporal factors, and the multiplexities in the embedding of integrated care policy.

1. Introduction

Singapore is a city-state situated in South-east Asia with a total population of 5.61 million people and a population density of 7796 per square km [1]. The median age is 40.5 years, and the old age support ratio (number of residents aged 20–64 per residents aged 65 years and over) is 5.1 [1]. The constitution of the Singapore healthcare sector is such that private sector providers account for 80% of the market share in the primary care sector, while the public sector dominates the acute care sector, accounting for 80% [2]. Primary care in Singapore is provided through a network of 20 state-funded outpatient polyclinics and 1600 private clinics operated by private general practitioners (GP) [2]. The dominance of the public sector in the acute care sector has helped the nation contain costs [3]. It also prevents a situation of a dominant private sector bringing about higher costs and expenditure for both the government and patients, which would be difficult to unwind if the private healthcare system were to become the dominant entrenched player [4].

The Singapore healthcare financing ideology is based on the twin philosophies of individual responsibility and ensuring affordable healthcare for all, and offers universal healthcare coverage for all citizens [5]. It is made up of complementary programmes to encourage individual responsibility, protect the poor, and address potential market failures [6]. The healthcare financing ideology underpinning policy-making has also been that of the "many helping hands approach", where non-state actors and the family, in terms of service provision and involvement, are expected to contribute to the well-being of individuals ([7,8], p. 641). This paradigm of care, as adopted by the Singapore government in 1991 [9], is a tripartite partnership between the family, community and state [10].

The healthcare system in Singapore has generally been considered to be well-designed and financially sustainable [11]. However, with the growing sociodemographic and epidemiologic shifts, it has started to show signs of stress, presenting a challenge to policymakers [12]. Like the other parts of the world, the Singapore healthcare system is undergoing reform [13]. The thrust towards this is motivated by the global shared experience of a rapidly ageing population [14–16], an increasing burden of chronic diseases

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[17–20], increasing healthcare costs [21–23], a decreasing old-age support ratio across the nation [24], and a rising demand for healthcare [25–27]. The Finance and Health ministers have begun initiating policy shifts to address these emerging issues, such that the costs and risks in healthcare – which were previously borne by individuals and families – will shift to the state, and be borne by taxpayers [12]. The ministries have introduced new schemes to enhance the healthcare framework. These include reviewing the financing mechanisms, employing an expansionary fiscal policy, ensuring universal health coverage, building more healthcare infrastructure, and reviewing the healthcare workforce and training.

Crucially, the Singapore government has begun making gradual policy shifts in its role and looked to other countries, and explored different approaches to integrated care that have been adopted by countries with similar experiences. The WHO defines integrated service delivery as: [T]he management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system ([28], p. 4). At a systemic level, integrated care could be understood in terms of service-user types [29]. For example, according to The King's Fund, [29], the micro-level would involve integrated care being delivered to individual service users and their carers through care co-ordination, care planning and other approaches. At a meso-level, integrated care is delivered to groups of people with similar diseases or conditions, and at the macro-level, service providers, either together or with commissioners, deliver integrated care across the full spectrum of services to the populations they serve. Integrated care can also be understood from an organisational perspective in terms of five arrangements: organisational integration, functional integration, service integration, clinical integration, and other forms of integration [30]. This study draws on the WHO's principle of integrated care, as its all-encompassing definition considers the varied definitions and forms of integrated care, and it helps set the stage for this research to explore integrated care and its development and associated challenges.

The national move towards integrated care can be seen as a multi-pronged approach to addressing the demographic and epidemiological drivers confronting the city-state. The stakeholders include the Ministry of Health, Ministry of Social and Family Development, Agency for Integrated Care (AIC), the Regional Health Systems, and the Intermediate and Long-term Care (ILTC) sector. The AIC was set up in 2009 as a national care integrator, and the Regional Health Systems (RHSs) were created in 2010 to achieve the policy goal of delivering integrated care at the regional level [25]. The RHSs are specifically tasked with implementing the integrated care policy through various means, such as innovative methods of care coordination [25].

While integrated care is seen as part of the solution to addressing the issues of epidemiological and demographic changes, and notwithstanding the burgeoning empirical studies on the potential benefits of integrated care [31], evidence-based information on integrated care is still relatively scarce [32–35]. This is largely attributable to methodological problems in the existing published studies. Systematic reviews showing positive health outcomes and cost savings in integrated care often simultaneously report methodological issues in the studies they have examined. These issues include a small sample size, poor quality study design, a low level of detail about the intervention, biased historical comparisons, variances in the pathways and populations served, shifting policies, different definitions of integrated care, contextual differences, and variations in outcome measures (see systematic reviews such as [32,36–39]:). Other issues include the conceptual elasticity of integrated care [40], the varied types of collaborations mechanisms [41], and the complex configurations of interventions add to

the difficulty in establishing evidence [42]. Evidence gaps involving trade-offs within and between sectors (e.g. healthcare and social services), which may lead to spill-over effects or unintended consequences [43] may also not be explicitly measured, evaluated or considered in the process.

Additionally, integrated care research sees the manifestation of Bradford's law. Bradford's law refers to a skewed concentration of articles in a small number of countries, where the population size is of little relevance [44]. The distribution of evidence in integrated care is heavily skewed towards articles from the US and Northern Europe [44,45]. Asian countries like China, India, and Japan, where there has been a recent focus on developing primary and community-based care, constitute less than 1.0% of the literature [44,45]. These factors constrain the interpretability and comparability of evaluation studies, and in particular, lessons that Asian countries such as Singapore can draw from.

More importantly, the precise way in which Singapore has approached integrated care through policy transfer and translation remains unclear. [46], p. 344) define policy transfer as: [A] process in which knowledge about policies, administrative arrangements, institutions etc. in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place ([46], p. 344). Policy translation on the other hand refers to the "process of modification of policy ideas and creation of new meanings and designs in the process of the cross-jurisdictional travel of policy ideas" ([47], p. 76). It locates the policy agents and emphasises the complexity and ambiguity of policy processes with an interpretive approach [48].

Specifically, it is unclear how policy agents might have drawn ideas from elsewhere to develop policy, and how policy transfer and translation may vary across policy agents. It is also not obvious how the concepts of policy transfer and policy translation can be used to explain the development and introduction of integrated care in Singapore. These considerations are important as they determine what gets transferred, by whom and who benefits and loses in the process [49]. There is also the issue of what is known as the Galston's problem, where it is not always obvious whether an observed pattern of common administrative practices, as in the case of integrated care development, is a result of policy transfer or indigenous development [50–52]. The obstacles in the policy transfer and translation of integrated care are also yet to be explored in the literature, prior to this research.

This article aims to understand how integrated care has been, and continues to be, developed at the RHS level in Singapore, the extent to which it can be explained by ideas of policy transfer and policy translation, and the challenges that have arisen as a result. The healthcare system in Singapore is made up of three integrated clusters [13,53]. One of which is the Singapore Health Services (or SingHealth), which is a public healthcare cluster in Singapore that manages four hospitals, five specialty centres, and a network of nine Polyclinics across the country. The SingHealth RHS looks after three regions – the SGH Campus, Eastern Health Alliance, and Seng Kang Health [53]. This study focuses on SingHealth (SGH) RHS as the region has the highest concentration of older adults in Singapore [104].

This specificity provides a geographical population health focus, with an emphasis on social place-based elements [54], situating health and social care in the context of the service-users in this particular area. It will examine how policy agents define and reproduce themselves in the context of top-down policy constraints to meet the needs of the service-users [55] in the region, within this specified complex and dense set of social spaces [56]. This in-depth knowledge of a specified system is also more useful in terms of gaining an understanding of the whole, as opposed to a less detailed knowledge of a large number of examples [57].

2. Policy transfer and policy translation frameworks

There are several forms of policy transfer in the literature, these include: 'bandwagoning', convergence, diffusion, emulation, policy learning, policy copying, policy borrowing, policy shopping, and social learning and lesson-drawing ([58,59], p. 2 [60],). Dolowitz and Marsh [46] draw these heterogeneous concepts together, by classifying all possible occurrences of transfer – voluntary and coercive, temporal and spatial – under the umbrella heading of policy transfer [61].

Policy transfer analysts are interested in four key areas in the policy development process: the pre-decision-making processes and the primary actors, which shape policy-making; transfer programme management and enhancement; policy implementation and the cause of policy failure; and the issues involved in researching and studying policy change [59]. These areas of study, which include the *description* (how policy transfer is done), *explanation* (why policy transfer occurs), and *prescription* (how policy transfer should be done) are commonplace in normal policy analysis [59]. Within the policy transfer analysis framework, the foci of study can be organised and expressed as seven fundamental questions [62,63]: Why engage in transfer, who is involved in transfer, what is transferred, where from, what is the degree of transfer, what constrains and facilitates the policy transfer process, and how is the transfer process related to policy success or failure?

Despite a broad theory in explaining policy development, policy transfer critics have taken issue with its absence of a distinctive domain of enquiry, the lack of an explanatory model of policy development, the absence of rigorous tools to determine its occurrence, and the lack of focus of policy transfer in developing world [64]. Recent criticisms have interpreted the policy transfer framework as methodologically positivist [65,66], as mechanistic in its assumption [66,67], as lacking a clear definition of what constitutes success in policy transfer [68], and for not taking into account the politics of scale [47]. Centrally, the shortcomings of policy transfer are in the assumptions about the policy actors and the process of the travel of ideas [47].

Beyond policy transfer, some scholars argue that policy translation offers a social constructivist approach to explore the travel of ideas [47,69], and considers the multiple spatial and scalar contexts in which policies are implemented [70]. Policy translation is "part policy transfer, part operationalisation, and part implementation" ([71], p. 3). It augments policy transfer as it considers the translation that takes place in policy transfer, and focuses on how "policies and their schemes, content, technologies and instruments are constantly changing according to sites, meanings and agencies" ([72], p. 15). It explores how policy ideas morph, and are transformed as policy actors act on a particular geographical scale within the contingencies of the relevant politics and context [47,67].

Unlike policy transfer, policy translation underscores the need to engage more with constructivist ideas, which are often influenced by culture, as opposed to rationalistic or neo-positivistic ideas [65,69,73], to address the issue of the modification of meaning and the multiple interpretations of policy ideas in various contexts [47,73]. It highlights that geography and history need to be conceived of as integral to policy translation and assemblage. This is because geography and history, or space and time, constitute the social world of policy, and are deeply social, political and contestable [67]. This also relates to the concept of the politics of scale as it concerns the production, reconfiguration and contestation of orderings and hierarchies among geographical scales [67,74,75]. Further, policy translation focuses on sites of practice, involving acting, speaking, feeling and doing ([67], p. 55). It reconfigures what it means by intentionality, rationality, consequentialism and directionality, which are often taken for granted notions of policies [76].

This study adopts the concepts of policy transfer and translation as augmenting lenses through which to gain a greater appreciation of the context in order to explore the development of integrated care in the SingHealth (SGH Campus) RHS in Singapore.

3. Methodology

3.1. Sampling

Utilising a qualitative approach as the primary theoretical methodological approach to address the research questions, this study looks specifically at the SingHealth (SGH Campus) Regional Health System, as the region has the highest concentration of older adults in Singapore [104]. This specificity further provides a geographical population health focus with emphasis on social place-based elements [54], situating health and social care in the context of the service-users in this particular area [77].

The study involved both semi-structured interviews by the primary author of this study, with policy agents, which constituted an elite group, and document reviews of the existing materials internal to their organisation. Prospective respondents were purposively sampled with maximum variation from five distinct clusters of policy agents, who were involved in their respective mandates to developing integrated care at the various stages. The policy agents included government officials, Singapore Health Services (or SingHealth) officials, service providers, and representatives from professional associations and academic institutions/ think-tanks. They represented the various policy agent clusters, could be in or outside government, and were located at multiple points within the policy community [78]. The respondents constituted political elites and organisational leaders in the health and social care sectors, who had a direct influence on the development of integrated care in the SingHealth (SGH Campus) RHS. They were best placed to provide a unique insider perspective on the policy transfer and translation of integrated care. In this study, access to the key informants facilitated a rigorous validation of policy transfer. The policy agents were also able to provide first-hand accounts of the development of integrated care.

The respondents fulfilled the following inclusion criteria: a senior official within the agency (e.g. director, assistant director, centre manager, or manager), and involved in the development of integrated care in their professional role. It should also be noted that among the service provider respondents, while they were segregated into sub-groups to represent home care services, senior activity centres, and institutional homes, many were concurrently delivering more than one service. They were however purposely sampled to represent a specific service type so that the voices of these services were represented. The study recruited a total of 31 elites from the five policy agent clusters between the period 1 November 2015 to 29 February 2016.

3.2. Ethical approval

Ethical approval from the SingHealth Centralised Institutional Review Board was obtained prior to the research (CIRB Ref: 2015/2881). All data collected in interviews were anonymised and are reported here using individual codes.

3.3. Analysis

The data analysis phase consisted of two parts: the interpretative phenomenological analysis (IPA) and the documentary analysis phases. The documentary analysis component consisted of a two-fold analytic approach: content and textual analyses. Interviews with elites were recorded using a digital recorder, transcribed verbatim, and analysed using IPA. Data deriving from the interviews

and documentary analysis were triangulated to enhance reliability and validity. The documents included respondents' organisational annual reports, meeting minutes, government press releases (such as, government statements such as Committee of Supply speeches, speeches for conferences, opening ceremonies, visits and events by ministers). All relevant documents beginning 2007 – when integrated care was first alluded to – till 28 October 2016 when the study ended were reviewed. Using a data extraction pro forma, the data were coded based on the a priori operationalised measures [79]. This was based on the policy transfer framework articulated by Dolowitz and Marsh [46]. Texts were read for the meaning-making and influences of the socio-political, economic and institutional structure and processes.

Examples of the semi-structured interview questions include: "What is the meaning of integrated care to you and your agency?", "What is the influence of the integrated care direction on you and your agency?", "What do you think are the challenges in developing integrated care, particularly in the SingHealth (SGH Campus) RHS?", "In your opinion, how can the integrated care policy or programmes be further enhanced or expanded?", and "What else do you think would be useful for me to know to better the care for our clients in the community?" The questions were framed in an open-ended manner to allow for probing and the accommodation of new theoretical insights as they developed in the process [80]. The same questions were asked to all respondents so that their response could be compared. Most of the interviews lasted for about an hour, and they were conducted at a location convenient to the policy agent, and where privacy could be assured.

The data were coded using QSR NVIVO 10; they were organised and bracketed in the form of text, with a word written to represent a category in the margin [81–83]. Emerging themes were then identified by making theoretical connections within and across the cases. A qualitative codebook, as suggested by Guest et al. [84], was also developed in the process. Interconnected themes were detected and clustered during the exploratory analysis phase, and were represented in qualitative narratives [85]. Subthemes, specific illustrations, and multiple perspectives from the policy agents, and their quotations, were used in the representation of the data. In this research study, triangulation, reflexivity, the presentation of negative or discrepant information, and peer debriefing were used to enhance the veracity of the findings.

4. Results

4.1. Scope and agents of transfer

This study showed that the actual development of integrated care, whilst largely emanating from the global sphere, is mediated by multi-scalar and multi-site networks, and contextual features on the national, regional and local scales in Singapore.

Specifically, government officials were the primary agents in the policy transfer and translation of integrated care. They facilitated the paradigmatic ideas of care integration by establishing the structural norms. Non-government officials contributed to the process by either engaging in programmatic learning, or contributing to the academic discourse in translating integrated care. There was limited academic knowledge production on integrated care. The policy agents were motivated by issues of ageing, fragmented services and varying service delivery standards, and the need to align with national objectives to engage in policy transfer and translation.

Most policy agents voluntarily drew ideas, concepts, philosophies and integrated care principles on integrated care from across countries (e.g. Sweden, Finland, the Netherlands, Australia, New Zealand, Hong Kong, Japan), and also from within Singapore. Unsurprisingly, the policy agents mostly engaged in the emula-

tion and hybridisation of integrated care policies and programmes, rather than direct copying. For example, in identifying the presence of vicarious learning and hybridisation, a government official described it as: "[Taking] a new idea, cut it up, dissect it, put it together and throw it together, and then bring things together" (GO-AIC-2).

There was no single blueprint of integrated care that was transferred. What was transferred included the notion of a regional health system, and ideas and principles of integrated care. They include the idea of senior group homes, Social Service Offices, and Aged Care TranstION (ACTION) project, which consists of hospital-based nurses who help to guide the care for service-users discharged into the community. A respondent described how the Agency for Integrated Care (AIC) drew lessons from in-house respite care, night-time respite care, caregiver support and cottage-respite communities from various different countries including the UK and the US.

4.2. Contextual enablers and barriers

Notwithstanding the influence of globalisation, which impinges on the "major institutions of the social life and political state" ([86], p. 38), and the presence of international policy transfer of integrated care, the policy transfer and translation of integrated care requires a consideration of the contextual features. The contextual constraints reported to explain those translations include political, historical and cultural differences, variances in healthcare financing models, differing population profiles and the varying institutional capabilities and endowments. They are discussed as follows.

4.2.1. Geographical characteristics, and political and historical contexts

Geographical characteristics and political and historical contexts were the primary considerations in determining whether integrated care ideas could be transferred and translated from the various jurisdictions. Many respondents reported that ensuring geographical similarities remains to be the key consideration prior to lesson drawing from elsewhere. The political and historical features of the country from which the idea is drawn from are equally important as well.

For example, in terms of the geographical characteristics, and political and historical contexts, the Netherland's model of senior group homes could not be copied wholesale because housing policies were different in Singapore. In the city-state Singapore, due to the historical housing policies since 1960, public housing constitutes about 80% of the total housing provision [87–89]; this reflects its social democratic regime, where universal solidarity is favoured over the welfare state [90]. Coordinating housing issues in Singapore was correspondingly reported to be less of an issue compared to in the Netherlands. The Netherlands, in contrast, is characterised by a conservative welfare regime state with neoliberal influences. It had to contend with issues in developing senior group homes relating to private developers who were the primary providers of housing, according to a government official (GO-MSF-1). In the Netherlands, historically, public housing constituted 37% of housing in 1971, 32% in 1980, and 39% in 1985; this figure later stabilised, up until 1990 [91]. Like many other Western European countries, the Netherlands began shifting gear and embraced neoliberalism in the 1990s, which later saw a decline in the public housing sector [91]. As such, in exploring the introduction of senior group homes as an integrated care model, the Netherlands had to work with private developers, which had overt implications for the implementation cost. This also illustrates the role of the state's political economy and welfare regime in policy transfer and policy translation.

4.2.2. Cultural contexts

Cultural differences, across countries, reported by many respondents, played a critical role in the policy transfer and translation of integrated care. For example, Sweden's Esther Project [92,93] had to be adapted in regard to cultural relevance to meet the needs of the local community. The Geisinger Pegasystem had to be tailored to better predict patients' or service-users' readmission to account for cultural and contextual differences. As one respondent highlighted "The Geisinger [readmission risk predictor]... doesn't gel well with our local context. The questions [in the tool]... are not helping our Singaporeans" (SH-N-1). It was also reported that it may be a cultural norm in Japan for older adults in sheltered homes to do their own cooking in a shared communal kitchen, but in Singapore, family members would expect meals to be delivered to older adults in sheltered homes as they are worried about the risk of falling. This would have implications on how sheltered homes for older adults are designed.

4.2.3. Land as a resource

As Singapore is relatively small size as a city-state, land as a resource was reported to be a limiting factor, and the notion of having one/two-bedroom type of nursing homes in Singapore for example may not necessarily be feasible. Comparisons were made to space norms in countries Japan, Australia and the US, which would have larger nursing home space norms than here, and would need to be taken into account in decision-making, particularly in the policy transfer and translation process, when exploring group or nursing home development.

4.2.4. Healthcare financing model

Differences in healthcare financing systems limited the operationalisation and implementation of integrated care policy. Many respondents reported that the way in which healthcare is funded differs from country to country, and in borrowing ideas from other jurisdictions, it is always necessary to consider how their systems are being funded prior to bringing an idea in. A respondent explained:

> [F]inancing systems in all these countries are very different and that's a big driver in how we can deliver our model here. A lot of these countries, the people they don't pay any money to enjoy these services, and it's actually funded by very heavy taxation, which Singapore doesn't have right now. And Singapore works on a very principled kind of co-payment system. So not a lot of these models can be replicated here (GO-MOH-1).

Direct comparisons to the US were often made by the respondents, where the US is seen to be a lot bigger, insurance based. In Singapore, without a steady funding mechanism, it would mean unstable income streams for private operators. This had direct implication for private operators as they were unable to transpose integrated care models in their entirety to Singapore. Private operators in this study reported the need for the national medical savings and insurance plans to be expanded to allow purchases of home care services in the market by consumers.

Additionally, price variations across countries, reflected in the costing practices in healthcare, may also differ across countries, which in turn influence the policy translation of integrated care. For example, the SPD Ability Centre's Transition Employment Programme was cited as costing S$6000 (or £3829, based on exchange rate of S$1=£0.64 in November 2018) per month in Finland, but only S$1200 (or £765) in Singapore per month. This highlights the need to consider the purchasing power parity (PPP) of the country from which ideas are borrowed. The PPP adjusts for price level differences between economies and countries, and enables more robust cross-country comparisons (such as economic output, productivity and living standards) based on a common set of average international prices [94]. It facilitates a more relevant price/cost comparison across countries. Such constraints demonstrate the relevance of policy translation as a meaningful concept to explore integrated care development.

4.2.5. Profile of service-users

Varying profiles of service-users constrained the extent to which transfer could be made. For example, the profile of older adults on a local scale and across senior activity centres in Singapore differed in literacy and expectations. The different senior activity centres also had varying levels of access to corporate support, such as funding, in the community. It was reported that as future older adults become more literate and have higher expectations, different tools and models will be required to engage them. This is important as it could help avoid a possible situation of policy myopia as a source of policy failure [95], particularly if integrated care policy and associated programmes are not planned with the future policy environment in mind.

4.2.6. Institutional capability and resource endowment

Institutional size and the social locations of institutional policy agents, characterised by institutional capability and scale, also influenced the extent to which respondents engaged in, and contributed to, the policy transfer and translation process of integrated care. Specifically, differences in institutional capability and culture, staff competency, and land constraints on the various scales were structural factors that both facilitated and limited the policy transfer process. For example, larger Voluntary Welfare Organisations (VWOs), private operators, and institutions – presumably with more resources – were better able to provide integrated care services. A relatively large-scale VWO respondent highlighted:

> [W]e believe that, okay, if we can increase our ability to integrate... for example we make sure we are better horizontally integrated... in that we have got a senior activity centre. The Senior Activity Centre caters for lower-income, relatively healthy elderly who have some social needs. But as they get frail, we should within our family [institution]... bring them to our social care centre where they can do exercise activities and therapy activities that can cater to their needs. We also have home help services that can call on them (SP–HCS[-3]).

Many respondents reported that smaller organisations, particularly the VWOs, had limited corporate band strength to implement changes that might be good for their organisations. This also had direct impact on the range of mobilising practices and assemblage activities in policy translation.

4.3. Policy meanings in integrated care as contested spaces

It is important to explore the government narratives by both the Ministry of Social and Family Development (MSF) and Ministry of Health (MOH) in relation to integrated care, the policy agents' interpretations of them, and the resulting implications. It acknowledges the role of policy translation, where it addresses the issues of heterogeneity and interdependence from a constructivist perspective, which is unlike policy transfer that fails to give sufficient weight to agency [46,65]. The policy narratives on integrated care, evident government statements, together with the interview data of the respondents, were analysed in regard to the presence of policy transfer and its implementation.

4.3.1. Parallel policy narratives and multiple interpretations of integrated care as constraints

While the common message between the MOH and MSF is that integrated care and services need to be established, which reflects the collaborative performance necessary in policy co-evolution

the foci in their narratives of integrated care varied. The MSF has largely focused on enhancing integrated service delivery, whereas the MOH has focused on structural change, involving care partners (both social and private sectors), and shifting the focus from healthcare to health. These varying emphases of the two ministries reflect the multiple interpretations and modifications of the meaning of policy ideas in various contexts, which could well have different implications.

For example, many respondents saw policy meanings in integrated care as contested spaces. Specifically, policy agents felt that there were no clear directions on how health and social care at the policy level should be integrated. They perceived the parallel interpretations of integrated care by the MOH and MSF to have led to problems such as service duplication, which they found both confusing and illustrative of poor resource management. A service provider stated:

> Recently [AIC] announced, I think this is under the MOH (Agency for Integrated Care), they are going to roll out Active Ageing Hubs. I attended the briefing session, there was some [gripe] on the ground from other service providers. Basically, what they felt [was] that it sounded like another duplication. Because there are some social components in the Active Ageing Hub, why is the MOH AIC doing that also, pumping all this money into something not really new? What's new is the name, the Active Ageing Hub (SP−HCS^{-1}).

Policy agents had varying interpretations of integrated care: healthcare sector respondents tended to view integration as first and foremost the integration of primary, secondary and tertiary care, while social care respondents saw integrated care as central to their work in accessing services for their service-users. Service providers in the study however saw integrated care as linking their clients to any agency that would help meet their needs. Such disparate interpretations may mean that there is no one clear 'best configuration' of integrated care.

4.3.2. What is 'policy', and who is integrated care for?

Many respondents held differing views as to whether integrated care is a 'policy', and who it is for. They highlighted the lack of policy and administrative moorings to guide their behaviour in the translation of integrated care. For example a respondent stated "I don't think in today's context it is a policy because I guess if it's a policy then it'll have to be done in some ways, and then the systems and infrastructure need to support the policy" (GO-MSF-2). Yet another respondent shared that it is a policy primarily because of the presence of public communications and speeches on integrated care.

In addition, many social service providers highlighted that integrated care was not necessarily focussed on where the need is greatest. They reported that complex cases were at risk of being crowded out, and care was seen to have refracted away from service-users. For example, a service provider stated that while a Family Medicine Clinic (FMC), a multi-doctor practice supported by a team of allied health professionals and nurses [96], was set up by SingHealth to serve the population of older service-users within the Outram region, it was not meeting the needs of service-users with complex needs. She stated:

> The nearest is at Chinatown point [Family Medicine Clinic]. You know a lot of my elderly are like 90 plus, 80 plus, they have difficulty [ambulating], yeah (SP-SAC-3).

Another shared that complex cases often have needs that go beyond the health domain, to include housing and financial issues. The emphasis on accountability in the public healthcare systems, evident in the audit culture in the public and private sectors, was reported to have shifted the focus away from service-users, particularly those with complex needs, to meeting the needs of the bureaucratic healthcare environment.

The contestations about what 'policy' is, and who integrated care is for illustrate how multiple interpretations and modifications by various policy agents can challenge the stability of meaning in policy ideas, which needs to be addressed in order to translate them successfully. Crucially, addressing the different interpretations, which reflects the role of the 'interpretive turn' in policy studies [67], is important as it involves ethical concerns, as it determines who gets what and when in integrated care.

4.4. Scalar politics and temporality in integrated care

4.4.1. Implementation challenges on a regional scale

The findings showed that political will in implementing and translating care integration was affected by the politics of scale and temporality. It saw problems involving the SingHealth (SGH Campus) RHS on the regional scale, which included institutional pluralism, competing organisational goals and cognitive schema, organisational complexity, and SingHealth's institutionalised advantage in relation to power differentials and elitism. These factors presented barriers to implementation in policy translation. Implementation challenges were also seen in the private (including GPs) and ILTC sectors on the local scale, where concerns in relation to infrastructure and organisational issues were reported.

Specifically, on the regional scale, SingHealth's focus on medicine rather than preventive or community care, its institutionalised scripts and cognitive schema as an Academic Medicine Centre and complex structures and weak relations with the community, were seen to have hampered the implementation of integrated care. A service provider stated:

> SGH or Outram see themselves as being the best medical excellence, we do medicine, we do science, it's not about patient care, it's about science and medicine. So right then there, if I am a cardiologist, I am doing science, I am treating these patients because I am doing my thing, you know. They are not really thinking about the wellbeing of the population (SP−HCS^{-4}).

There was also a lack of clarity about its role as an AMC and uncertainty about its value as a RHS. These observations reflect that SingHealth is perceived as a multidimensional entity, made up of different institutional logics guiding its behaviour, with inconsistencies among these dimensions and logics [97]. SingHealth's institutionalised advantage and sense of elitism, shaped by the resources made available and the reward system it has in place, further limited its interest in working in partnership with the community. A respondent stated:

> So, if you've been brought up in that mindset. . . and you've been paid wonderfully based on that – good job, you've been known for that – why do I want to take the risk of going into uncharted waters, into something that I can't measure, and even put my hand on it, and don't even know who they are. Why should I, right? (GO-AIC-4).

These elements invariably undermined SingHealth's legitimacy, credibility and social acceptability, in terms of leading care integration development on the regional scale.

4.4.2. Implementation challenges on a local scale

On the local scale, the private sector respondents saw opportunities to ensure a fairer playing field. They were most concerned about workforce training, recruitment and retention, particularly in terms of grants and subsidies to facilitate the implementation of integrated care. They also perceived the need for the relevant authorities to consider professionalising and regulating emerging

groups of staff, such as home carers and caregivers, to protect the interests of these professions (for example, their income) and ensure service quality. Regulatory structures, such as licensing and the issuance of professional indemnity were seen to be crucial for the private sector providers to explore market entry processes, barriers, opportunities and fees to ensure competitive behaviour in the private sector. GPs on the other hand were fraught with issues ranging from varying standards of care, low public confidence in them, poor use of information and technology in their accounting and auditing activities, and limited incentives to encourage their contribution to implementing integrated care.

The Intermediate and Long-Term Care (ILTC) sector reported issues of a workforce shortage, and limited institutional capacity and corporate band strength (or capacity) to expand and implement integrated care. It is also influenced by its previous disconnect with the health sector, which has resulted in the sector being poorly resourced and less able to deliver care integration. The ILTC sector was seen to be 'slow' in implementing changes, reflecting the temporal element in policy translation, which is entangled with policy, power and politics [67].

5. Discussion

This study has identified the agents involved in, the processes of, and the limits to policy transfer as reasons for the heterogeneity as opposed to convergence of integrated care development in contrast with the countries from which the idea originated. It shows that the development of integrated care is mediated by multi-scalar and multi-site networks, and contextual features on the national, regional and local scales in Singapore, involving not only government officials but non-government officials as well. The notion of a regional health system, and a range of integrated care principles and philosophies were borrowed to develop various models and programmes. Contextual features, which are in part also shaped by a country's welfare regime, also contributed to explaining the mutation and morphing necessary in policy translation. The influencing factors include geographical, political, historical and cultural differences, variances in healthcare financing models and welfare regimes, differing population profiles and the varying institutional capabilities and endowments. The study has also shown that policy translation is also a more relevant concept to explore integrated care development, in that it identifies the multi-site and multi-scalar networks at work. It explains how differences in contextual features, necessitate morphing and mutations when policy ideas travel across space and time.

Through the lens of policy translation, the study facilitated an exploration of the multiple interpretations of integrated care policy and their influence on policy implementation. This adds to the broader exploratory power of policy translation as a lens through which to understand integrated care development. In this instance, the parallel government statements by the MOH and MSF on integrated care were reported by policy agents to be problematic and were seen to lead to service duplication. The myriad understanding of what constitutes 'policy', what integrated care is, and who it is for were found to be contested spaces in integrated care development. This reflects the need to interrogate the meaning and conceptualisation of 'policy' [98,99], and necessarily what integrated care is and who it is for. These multiple and plural interpretations underscore the role of policy translation. They exemplify the value and importance of considering the ethics in translation, where there could be potential implications for service-users in the development of integrated care. What gets produced, who produces what, and who gets what in integrated care are spaces for debate in policy translation. The contestations and the corresponding 'policy otherwise' in

policy translation are thus central issues that need to be negotiated and debated at the policy level.

The assemblage and policy translation of integrated care involve the need to consider the shifting organisational and symbolic relationships of the intertwined geographical scales, particularly between the SingHealth (SGH Campus) RHS and other policy agents on the regional and local scales. The policy translation perspective teases out the politics of scale, the temporality, and the complex role of the political and economic interests of the respective multi-scalar networks, in influencing the movement of policy. The competing organisational goals and cognitive schema, the organisational complexity and legitimacy, and the institutional advantage and elitism of SingHealth were reported to have constrained the assemblage and translation of integrated care on the regional scale. Environmental factors involving the private and ILTC sectors highlight issues in relation to workforce regulation, licensing, training and supply, financial support, and the history of a disconnect between the ILTC and healthcare sectors on the local scale. These factors draw attention to the role of temporality and the associated need for power to be exercised more effectively to address some of these issues in the translation and assemblage of integrated care. Addressing these issues and perhaps rescaling the political responsibilities and tasks to an appropriate level to address the implementation constraints need to be deliberated.

Since the completion of this research, the policy context and policy narratives surrounding integrated care have continued to change. The geographical delineation of what is defined as the SingHealth (SGH Campus) RHS is also constantly evolving. Such evolutions reflect the nature of policy, which is constantly under construction [67]. There is a need to contextualise studies within a specific time frame, which this study has done by specifying the study period. By considering the socio and geo-spatial region – as opposed to only a geographical definition – of the SingHealth (SGH Campus) RHS in this research, it takes into account a wider consideration of spaces, the opportunity structures and collective social functioning and practices [54]. This has also helped to make the research more meaningful, and facilitated the study of the politics of scale in policy translation.

5.1. Study strengths and limitations

All studies have limitations. As with any qualitative research study, there may be potential bias in the primary author's interpretation of the qualitative interview content. Additionally, the nature of this study's methodology means that the findings cannot be generalised due to its inductive, open-ended characteristics [81]. The respective representative voice of the policy agents from the different clusters, such as those from professional associations and academic institutions, cannot be generalised, as they each constituted a small number of respondents. Also, potential respondents who viewed the nature of integrated care and collaboration with the SGH unfavourably might not have participated in the study, and therefore their perspectives and experiences will not have been represented.

The definition of integrated healthcare or integrated care is rather broad and varies across the literature. While direct analysis and interpretation across similar spectra of care may not be possible, the heterogeneity in experience is valued in this research, particularly in reflecting the influence of the multiple and pluralistic interpretations of integrated care on policy translation.

Data sharing in terms of government policies and documents, including meeting minutes, study visit reports, sensitive data in relation to health and social care delivery, and policy documents was limited. Policy agents from the various government agencies were unable to provide many potentially relevant organisational documents. Only publicly available government documents were

accessible. This also reflects the limited access to government data in Singapore. Government data and research undertaken by public organisations is primarily meant for their own use and purposes [100].

That said, the intention of this paper was to generate a thick and rich textual description of the experiences of the policy agents in the development of integrated care in the SingHealth (SGH Campus) RHS, which this paper has done. It is also the first known study, at the time of writing, which uses policy transfer and policy translation explicitly as a lens to analyse integrated care development. Future studies could include a comparative study of integrated care development across RHSs in Singapore, the challenges involved, and to explore how the role of integrated care from service-users' perspective, which would help counterbalance provider interests [101].

6. Conclusions

Policy shift at the global level towards care integration is evident in the policy initiatives and articulations in many developed countries [49]. However, it is often less clear how the actual mechanisms and the roles of policy transfer and necessarily policy translation occur in the development of integrated care.

This research has demonstrated the value of using policy transfer and policy translation in analysing integrated care development. Policy transfer and policy translation frameworks serve as an approach to explore the interacting forces of structures and agency in integrated care development. Specifically, policy transfer remains a useful analogical model and structure to understand the introduction of integrated care, which would otherwise not have been known by policymakers, such as who transferred what, where from, why and how. Beyond policymakers, this study highlights how other stakeholders in the health and social care landscape, particularly health and social care institutions on the various scales, were also actively involved in the borrowing of integrated care ideas from other jurisdictions. Achieving and developing integrated care would mean having to be cognisant of the multi-developments that are occurring simultaneously, including the processes of borrowing and morphing of ideas, and creation of programmes and services in integrated care across the country. There is a need to have an overall view, for all stakeholders involved, of how the integrated care piece will come together at a specified time - a specified time because the integration of care is a continuous process. It would not suffice to only look at 'parts' of its development without considering the 'whole'. It would be imperative for stakeholders in Singapore, as it would in other parts of the world, where countries are learning from other jurisdictions about integrated care, to document the contextual features that facilitate or constrain its policy transfer and translation, and debate whether changes should be made in the context of translation. For example, in Singapore, it would it be useful and important to debate whether the existing healthcare financing mechanism should learn from other jurisdictions to incentivise the private sector (GPs) to better contribute to the implementation of care integration.

Furthermore, what and who integrated care is for reflect considerably larger politics and economic implications in relation to resource distribution and ethics. It is essential for countries to consider the multiple interpretations of integrated care, and the associated ethics of translation. In Singapore, this could range from considering the implications of the various government narratives, the various policy actors' interpretations of 'policy', and who integrated is for. This may help maximise the development of integrated care in the areas of needs, while facilitating a responsive model of development to integrated care. It would also be useful

to establish clearer administrative moorings to increase the legitimacy of integrated care development, where necessary.

In rationalising integrated care, it might be useful and important for countries to consider the challenges at regional scale and institutional implementation level, and to address them adequately. In Singapore, for example, SingHealth as an institution may need to move away from a state of decoupling between its role as an AMC and a RHS, to explore the reframing of its identity and forging broad-based coalitions as an organisational strategy. This could be achieved by providing cues and scripts that create and embody legitimate forms of action to further its role as an RHS. The issues faced by the private sector (including GPs) and ILTC sectors, such as the workforce shortage, and the need for further regulation and licensing, may need to be addressed at the appropriate scale and level of governance. Concerns such as increasing public confidence in GPs, facilitating their interest in contributing to the implementation of care integration, and enhancing their skills and knowledge need to be systematically addressed, as GPs are central to providing stronger primary care, which is integral to integrated care development.

To envisage the future healthcare system, establishing a legitimate government voice or body to lead integrated care would also be crucial. The role of scale where its dynamics are influenced by power, economic forces, ideological shifts and sanctioned discourses would need to be taken into account. This perspective would enable resources and issues to be framed and remobilised to justify or reconfigure patterns of entrenched power and authority [102].

As countries explore and learn from one another on integrated care approaches, it remains crucial to be cognisant of how policy ideas on integrated care get transferred and thereby translated in the process. This is important as it highlights the potential challenges involved in the embedding of integrated care policy, and the need to pre-empt and address these challenges. The facilitators and enablers in the transfer process, and the varying understanding of integrated care, and interpretations of what policy is and who integrated care is for, and the scalar polities at the implementation levels, as highlighted above, should be considered across space, time and contexts, and by the various stakeholders.

Conflicts of interest

Acknowledgements

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