



## Quarterly Letter

# “Vertical Integration” ... Little Applicability in Canada

**M**r. Knott's article, “Vertical Integration, 80s Fad or Healthcare's Future” (*Hospital Quarterly*, vol. 1 no. 1, Fall 1997) may provide a useful perspective on the evolution of US healthcare, but its relevance to Canada is questionable. There are fundamental differences in the funding, organization and ownership of healthcare between the US and Canada.

The system described by Mr. Knott is one wherein the financing is controlled by multiple insurance companies acting as intermediaries between employers/consumers and healthcare providers. As Mr. Knott describes it, the health services integration strategy in the US was to “vertically integrate insurance, physicians and hospital functions into one company.” The focus was “vertical integration of payers and providers.” This is an American concept with little applicability to Canada.

As we know, the Canadian system for providing medically necessary health services is a publicly funded, publicly administered system. It has a single payer (the government) and comprises physicians and not-for-profit public hospitals. The focus of integration in Canada is the alignment of incentives and management of services along the continuum of care to improve population health, improve the quality and responsiveness of services, and reduce costs.

As a result, our approach of sequencing integration is different from that in the US. In most Canadian jurisdictions our first steps have focused on horizontal rather than vertical integration. We have already recognized the changing nature of

health services. We are aggressively pursuing both reduced funding and restructuring to reduce excess hospital capacity. Concurrently, we are increasing the capacity and capability of community services, especially post-acute, ambulatory and in-home care.

Initial steps toward vertical integration are focusing on relationships between organizations providing acute and post-acute care services. These relationships have been both mergers and strategic alliances among providers responding to the needs of geographic and/or functional communities.

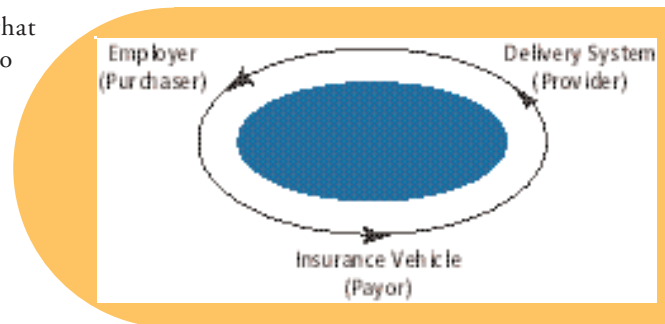
It is in this context that we are now moving to better integrate three key health levels of care:


1. primary care
2. secondary/  
tertiary care
3. rehabilitation as provided by
  - physicians
  - hospitals
  - in-home care providers.

The most commonly proposed approach to funding these integrated systems in Canada is to provide funds on a capitated basis directly to the provider(s) of service. There is little interest in creating fiscal intermediaries between the government and providers. There has not been and likely will not be any role for insurance companies in managing the funding or directing the delivery of medically necessary services in Canada.

Another major difference between the US and Canada is that the Canadian

health system has been, and continues to be, more population- than provider-focused. The Canadian system through the advent of integrated health systems is about to become consumer-focused as well. With a few notable exceptions (Staff Model HMOs such as Group Health of Puget Sound, Kaiser, etc.), the US system is much more provider-focused. Although this system claims to be “market driven,” the market is seldom a defined population or the individual consumer. Providers (physicians and hospitals) sell and market to health plans (insurers) and health plans sell and market to employers purchasing insurance/care on behalf of their employees. Patients and populations are not in the loop.



We have little to learn from this provider/profit-oriented system. Continuation of the Canadian evolution to integration will result in integrated systems focusing on the needs of populations not providers. Efforts will be directed at maximizing the health of these populations, not the profits of insurance companies. 

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