

From the Bottom Up and Other Lessons from Down Under



COMMENTARY

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THE PREMISE OF LEATT, PINK AND GUERRIERE'S PAPER is that international experience with integrated healthcare can inform strategies for the establishment of integrated healthcare in Canada. The authors propose that based on international reforms, development of an integrated system of healthcare delivery for Canada can better meet the needs of consumers, improve quality of care and outcomes and decrease costs of service provision. A cynic might suggest that the most important global lessons to be learned are that consumers, when asked, cannot readily agree on the services they want or need (Robinson 1999); that

purchasers have difficulty defining what will be purchased in terms that ensure quality outcomes (Maynard 1994; Proper 1995; Robinson 1999); and that the level of competition, the amount of central control and the financing methods may have a greater impact on cost control than integrated service delivery (Berwick 1996). Although integration and coordination of care delivery has logical appeal, as highlighted by Leatt et al. there is limited empirical evidence on the impact of integrated healthcare on either individual or community health outcomes or value for money in healthcare delivery.

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Consistent with the experience of the United States, Leatt et al. suggest the essential characteristics of integrated health systems are coordinated service delivery with a broad range of services across the continuum of care, and clinical and fiscal accountability to a defined population. The Leatt et al. Canadian model proposes a whole-of-population approach, with individuals rostered to their primary healthcare group of choice. The primary healthcare group is responsible for coordinating the other care required, such as specialists, hospitals, home care, and long-term care. The method of funding the model is not fully developed, with the authors recommending more experimentation in alternative approaches to funding such a system of care. However, an underlying premise of the model is that funding would follow the consumer if he or she chooses to enroll with an alternative primary care group, implying capitation funding.

From the bottom of the globe, the experience of integrated care looks somewhat different to that described in the Leatt et al. paper. Since the early 1990s, Australia and New Zealand have been experimenting with various forms of integrated healthcare and have a track record of both success and failure. We present the down-under lessons learned for integrated healthcare.

Lesson 1

Not everyone requires integrated healthcare. Structure the system to serve those individuals and families that do.

Healthcare is a service, with similarities to other types of services. Although other services operate in a variety of market

environments, from free market to tightly regulated, there are lessons to be learned from the organization of service delivery in other sectors that are applicable to healthcare. If we consider the experience of other service sectors, such as banking, travel, even hair dressing, we observe that these industries have adopted similar patterns to meet the needs of consumers. Within each of these industries there is a highly integrated service package that is available to those consumers who require this attention. There are also less integrated service offerings for those consumers who desire greater control, choice or flexibility. For instance, in the retail banking industry, consumers can opt for complete packages, including mortgage services, savings, chequing and even investment options available in person or online. The bank provides a highly integrated service for those customers who choose this approach, and some customers are willing to pay a fee for this coordination. Other customers prefer the unbundled option, where they choose different carriers for their mortgage, savings account and investment portfolio. Not all banking clients want or need fully integrated financial services. A recent survey of Western Australian banking customers found that only 69% identified the ability of the bank to provide a range of services as important to them. However, more frequent users of bank services tended to value a wider range of services more highly than less frequent users (Kaynak and Whiteley 1999).

Travel agencies offer fully integrated service packages to those consumers that choose this type of service. The integrated package can include transportation, accommodation and entertainment.

Other customers choose to book their own travel, or use a combination of travel agent services and their own devices. The global success of the *Lonely Planet* and other such travel guides illustrates that not all travellers want or need fully integrated travel services. Hair stylists and beauty salons also provide the fully integrated hair, nails, massage, makeup and facial package, or enable their customers to choose a single service or a basket of services that best meets the individual's needs.

Representative of service industries in general, these industries have structured to address the needs of that group of people, often high users of a particular service, who require and choose to have their service package integrated for them. But these industries have also structured to address the needs of those individuals or groups that do not want or need integrated services. There are many people who would prefer to make service selections themselves and, given the choice, would not subscribe to a forced integrated service package. We would suggest that the healthcare sector should consider the extensive experience of other service sectors in organizing a population needs-based approach to healthcare. Basic principles of service marketing would suggest that integration of healthcare using a whole-of-population approach is neither necessary nor effective in ensuring healthcare needs are met.

Even in healthcare, successful integration efforts have used different levels of integration (e.g., collocation, linkage, coordination and full integration) to most appropriately meet community needs (Leutz 1999). Not all users of the system want or need healthcare integrated or

coordinated for them. In fact Leutz (1999) suggested that the most successful U.S. integration models use coordination of management and clinical care rather than full integration.

A recent study directed to increasing the integration of care delivery in Australia also found that a targeted approach to coordination and integration achieved greater benefit than a whole-of-population approach. The 1995 reform agenda in Australia resulted in Commonwealth government mechanisms to trial integrated care. Nine Coordinated Care Trials with over 16,000 participants were initiated in different parts of Australia in 1997, with the interim evaluation results released in September 1999. Overall, the interim results of the effect of coordinated care on client health and well-being, service cost and use, hospitalization, readmission and length of stay were inconclusive (Commonwealth Department of Health and Aged Care 1999). The trials did suggest the need for coordinated care to be well targeted, with better results reported by those trials that addressed a more specifically defined population. The first law of integration proposed by Leutz (1999:83) states: "You can integrate all of the services for some of the people, some of the services for all of the people, but you can't integrate all of the services for all of the people."

Although the focus on high users has been questioned (Duckett 1996) in relation to difficulties in defining the target group and a potential overemphasis on cost savings to the detriment of service enhancements, the Coordinated Care Trials appear to show service enhancement as a positive outcome. The early indications from the Australia-wide

Coordinated Care Trials support a reasoned, focused approach to service coordination for a defined population of people with like needs. Long understood by the retail sector, market segmentation creates groups whose members are similar to one another in one or more characteristics and different from members of other segments. Different product, price, promotion and distribution strategies are targeted to different segments. Healthcare providers can learn from the experience of successful marketers. While the 1950s spawned mass marketing where all consumers were treated the same, the field has evolved and now uses smaller and smaller groups of consumers as marketing targets (Schiller 1989), with concepts such as mass customization (Radder and Louw 1999) and personalization (Goldsmith 1999) replacing mass marketing.

The whole-of-population approach is attractive in capitated funding schemes as it enables sufficient mix of high and low users to cover the financial risk. However, an integrated delivery system with a large mix of subscribers is unlikely to provide focused integrated programs to meet specific needs. Alternatively, focusing on the high users of the system – for example, individuals with chronic diseases – will enable the development of strong programs with proven outcomes in improving the health of these individuals. A capitated funding approach that recognized the lifetime healthcare costs of high-need individuals could provide sufficient incentive for health systems to care for these people with a genuine focus on improving their health status. Risk-adjusted capitation for the high users of the health system allows both consumer and provider flexibility in designing

packages of care and gives the purchaser/payer a financial cap and incentives to contain both consumption and costs.

In 1998 the New Zealand Health Funding Authority indicated that primary health service organizations would receive capitation funding for an enrolled population for all primary health services. Analysis of the predicted impact of this change suggested that while there would likely be some redirection of resources to those with greater need, it was unlikely that this move would result in clinical equity (Cumming and Mays 1999). It was suggested that without a very sensitive capitation formula, cream-skimming could be a significant problem. We would suggest that an integrated healthcare system that only focused on the needs of the highest users would eliminate the issues associated with cream-skimming.

Davies (1999), in a commentary on the New Zealand reforms, stressed that purchasing decisions should not be devolved to a single level, but that different services were most appropriately purchased at different levels. Contrary to the single-level primary care group purchaser proposed in the Canadian model, Davies suggested that high-cost, rarely used services should continue to be purchased centrally; low-cost, predictable services such as primary care should be purchased by individuals or their agents; and in between, moderate-cost, high-use services, such as those required for chronic diseases, should be purchased by local purchasers. This view provides support for integrated healthcare that focuses on the need of high users, with the primary care group assuming responsibility for integration of the moderate-cost, high-use services.

Individuals and families who are not high-need users require the assurance of public health services, health promotion services and the ability to access the healthcare system for episodic care when required. There is little need for integration of these services for the majority of the population, and funding should not be directed to this level of integration. In a 1999 interview, Uwe Reinhardt stated, "I think this whole notion of teams or integrated systems being made responsible for the health status of entire populations is a very dangerous path to think about or to go down. We have so much more to do just serving individuals who want to be served" (Carlson 1999:74).

Lesson 2

Integration can only be achieved through the establishment of appropriate financial and market incentives.

International experience with integrated healthcare suggests that an integrated health system such as the model proposed by Leatt et al. would require planned reform to establish the appropriate incentives. We believe that mechanisms to ensure consumer choice without penalty, risk-adjusted capitated funding for the enrolled population and a strong regulatory framework are required. Each is discussed below.

Consumer Choice without Penalty

Leatt et al. contrast the characteristics of integrated delivery systems with those of regional health authorities. The defining characteristic is choice. Integrated systems enable consumer choice and therefore consumer "exit" if needs are not met. There are no barriers to changing enrolment or to service out of the plan.

International experience suggests that integrated care is achieved most successfully in systems where providers strive for the highest quality at lowest cost to attract and retain a client base. In a review of various HMO markets in the United States, Miller (1996) found that integration was accelerated within environments where there was competition for enrollees, and that all of functional, physician and clinical integration (as defined by Shortell et al. 1996) was achieved more quickly in areas where there was greater competition.

Scotton (1998) defines this use of market tools within a regulatory framework as managed competition and suggests that it is a natural progression of healthcare financing. In reviewing healthcare reform around the world (except for the United States, which, despite several attempts, has not implemented national health insurance), Scotton (1998) notes the establishment of national health/health insurance programs designed to promote equitable access to healthcare as the first stage of development. The second stage, in response to growing costs, is the imposition of budgetary ceilings and controls. A large number of countries (for example, the United Kingdom, New Zealand, the Netherlands) have embarked on the third stage, microeconomic reforms involving managed competition, seen as the most promising means to deliver high-quality healthcare at a sustainable cost. Canada, it appears, remains in the second stage, using forced restructuring or regional health authority mechanisms to deliver the cost controls.

We believe that to be consistent with the principle of consumer choice and to target those most in need, consumers

should have the choice of “opting in” to the integrated system or remaining with the existing care delivery system. Those consumers that opt in would enroll with their care purchaser/provider of choice. This level of consumer choice tied to capitation payment would ensure that the purchaser/providers have identified and planned their service offerings to best meet the needs of their target communities. Giving consumers the choice to participate, with no penalties imposed for not participating, provides the most powerful demonstration of consumer choice and ensures strong accountability to the enrollees by the purchaser/providers.

The quality and outcome provisions of the proposed model for Canada are largely dependent upon the availability of competing primary healthcare groups. While this may be realistic in urban areas, it is unclear how this competition can be achieved in rural/remote areas where there is a limited population base and few providers. The states in Australia face many of the same issues as the provinces in Canada, with concentrated urban centres and large geographic areas with sparse populations. Recognizing that needs are different, different healthcare system models have been established for the urban and rural areas of the country. We suggest that there should be a number of models for Canada, with urban models having similar structures, but using a number of different rural/remote approaches.

Risk-Adjusted Capitated Funding for the Enrolled Population

The benefit of consumer choice in ensuring needs-based, high-quality care, achieved through enrolment, changing

enrolment and disenrolment by consumers, is only possible when funding follows the consumer. This model is premised on enrolment with a purchaser/provider group, such as the primary care group proposed by Leatt et al., which agrees to share the financial risk for service provision for this enrolled membership. Wilton and Smith (1999) have argued that budget holding has been successful in ensuring cost-effective care because of the financial incentives inherent in risk-adjusted capitated payments when the budget holder assumes the financial risk for the healthcare of the enrolled population. Chernichovsky (1995) has stated that enrolment ensures the purchaser/providers have both incentive and ability to monitor care practices and outcomes for cost-effectiveness, efficiency and quality of care.

The capitated funding model is dependent upon a defined basket of services that are included in the funding. While healthcare consumers receive a large amount of care through the formal system, consumers also choose alternative therapies and over-the-counter remedies that fall outside of the formal system. Clearly, it will not be possible to integrate all discretionary care choices of consumers, and the model must identify the services that will be included.

Strong Regulatory Framework

Although it appears to be fundamental to the model, Leatt et al. do not include regulated market-based reforms as a strategy – possibly because, unlike some of the international systems that have implemented market-based healthcare reforms, Canadians continue to value publicly funded and administered

healthcare that ensures access for the entire population. Any mention of competition evokes images of the U.S. healthcare system next door. Canada is an ideal country to demonstrate that appropriately regulated, managed competition can strengthen a public healthcare system, improving access through more effective cost and quality control.

Regulation of the health system should focus on financial incentives for consumers to enroll in their provider organization of choice and to encourage providers to participate. The international experience is clear on the need to ensure sufficiently sized and resourced general practice (GP)/primary care organizations. Experience from the United Kingdom, the United States and Australia suggests the need to consider the limits on integration expectations where smaller GP practices exist (Miller 1996; Leutz 1999; Commonwealth Department of Health and Aged Care 1999). Historically, primary care physicians have not had the necessary resources to enable proactive organization within their communities (Miller 1996) and have required system efforts to ensure primary care organization that can effectively support the increased expectations placed on primary care.

In Australia, divisions of general practice were established as a result of the National Health Strategy of 1992 to bring together disparate GP practices in geographic areas. The Australian Commonwealth government offered financial incentives for the establishment of the divisions, with membership climbing to over 80% of all GPs in some states. GP divisions receive outcome-based funding from the government directed to the achievement of agreed strategic

objectives. Although the divisions are still relatively new, there has been significant impact, with general practices networking for continuing education, improved communication, after-hours coverage and more accessible services (LaTrobe University 1998). The evolving organization of general practitioners in Australia is laying the foundation for the integration of primary care with other elements of the healthcare system. It has been found that it is difficult to integrate GP services with other healthcare services without first having linkage and coordination among GPs. The establishment of the GP divisions in Australia has enabled community GPs to focus on unique strategies to best serve their communities.

Health systems that have implemented managed market competition have learned, sometimes after the fact, of the importance of a strong regulatory framework to preserve standards of care. Maynard (1994) has argued that the National Health System (NHS) reforms in the early 1990s in the United Kingdom were undermined by a lack of understanding and planning for the implementation of the competitive structures. International experience would suggest that major health system reform, with a strong regulatory framework in place is essential to effective use of competition in healthcare (Enthoven 1980; Chernichovsky 1995).

Lesson 3

Once the financial and market structure is in place, integration can best be achieved through a “bottom-up” approach.

Healthcare system development can be categorized as either push or pull. In push

development, the structure is designed and implemented from the top. The approach outlined by Leatt et al. is a clear push strategy, with the intermediary primary care groups responsible for defining, purchasing and providing healthcare to the membership population. Palmer (1994) suggests the push approach treats a service as a commodity. A push approach limits the ability of the enrolled members to define their care requirements.

On the other hand, in pull developments, the strategy is communicated, the broader financial and market organization is in place and communities demand the services required to meet their needs. In many ways the healthcare systems in Canada, Australia and New Zealand have traditionally been pull developments, as communities of interest identify needs and create the services required to meet these needs. Often these services become institutionalized and are brought into the publicly funded basket of services. We would suggest that implementation of integrated health care would be facilitated by enabling the communities to plan their needs and not impose a system structure from the top. Davies (1999) indicated that a strength of the reforms in New Zealand was the encouragement for initiatives to emerge from the bottom up, eliminating the “one size fits all” approaches that have previously dominated health systems. The primary care model currently being implemented in New Zealand facilitates a variety of structural responses. There are no preconditions detailing ownership, population served or location of the primary care organization (Gribben and Coster 1999). Recent reforms to achieve more integrated care delivery in the Netherlands were

thwarted when the government attempted to impose a structure from above. The government is now using a public choice approach as described by Mur-Veeman et al. (1999) where the broad policy parameters are communicated, leaving room for local solutions to promote coordination and integration.

The model we envision – a model that targets integrated service delivery to those consumers who most require this integration and that provides real consumer choice for these individuals – can only be achieved through consumer influence on the healthcare services provided. Advances in communications and information technology can only facilitate community influence. The growing use of the Internet and other information resources has been recognized as increasing the knowledge base of consumers, enabling greater involvement and understanding in managing their healthcare (Wilkins 1999). In the future it will be much easier to involve consumers in identifying and defining their care requirements.

Conclusion

In proposing a Canadian model of integrated healthcare, Leatt, Pink and Guerriere provide six interrelated strategies to further implementation of the model. The six strategies are: focus on the individual, start with primary healthcare, share information and exploit technology, create virtual coordination networks at local levels, develop practical needs-based funding methods and implement mechanisms to monitor and evaluate. While we support the underlying principles of these strategies, they are insufficient for implementation of integrated healthcare.

We provide advice for the construction of a workable, integrated healthcare model based on the recent reforms and system trials of Australia and New Zealand.

The down-under experience has provided three important lessons. The first is that not everyone requires integrated healthcare, and therefore the system should be structured to serve those individuals and families that require and/or choose integrated healthcare. The second lesson is that integrated healthcare will only be achieved with the establishment of essential incentives. The incentives we have identified include consumer choice without penalty, risk-adjusted capitated funding for an enrolled population and a strong regulatory framework. The third lesson is that once the financial and market structure is in place, integration can best be achieved through a "bottom-up" approach. The Canadian model should allow sufficient flexibility for local solutions. This approach will ensure true community involvement and accountability and will address the different needs of urban and rural/remote areas. We will watch with interest the progress of integrated care in Canada.

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According to Dr. Robert McMurtry, GWD Cameron Visiting Chair, Health Canada: "The figure about healthcare expenditures, on page 41 paragraph 3, [HealthcarePapers Vol.1 No. 1] is not accurate. The source should have been quoted, but it is not in accord with the Canadian Institutes of Health Information which generates the definitive numbers. For the record, the correct forecast (i.e., only 1997 numbers are final) is 9.1% of GDP not 9.8%. It is a difference of more than \$560 million. Canada ranks fourth in the world now by the foregoing measure. If we were at 9.8%, we would be back at second."

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