Integrated Health Organizations in Canada: Developing the Ideal Model

COMMENTARY

John Marriott and Ann L. Mable
Partners, Marriott Mable, Consultants in Health Policy

We are pleased that healthcare integration is the focus of this issue of Healthcare*Papers* and appreciative of the opportunity to focus on Canadian experience. Expanding awareness of Canadian work in this area has never been more important as the health system repositions itself towards the path of integration. As long-term participants in design, policy, research and advocacy for the development of integrated health organizations in Canada and elsewhere, we are more than sympathetic to the important themes presented by Leatt, Pink and Guerriere to improve understanding of integrated health organizations, examine model performance and provide thoughts on how to proceed in Canada.

To round out the discussion, and to provide, perhaps, a more complete picture of integration in Canada, it is important to shift the time horizon presented by Leatt et al. Their work echoes and reinforces a considerable body of knowledge that has been under exploration and development in Canada since the 1980s by a wide variety of players – at local, provincial and national levels – but that is not yet cohesively or widely documented. Nevertheless, this work has encompassed extensive, internal government and "ground-up" community-based efforts to develop programs, policies, systems, funding strategies, quality and evaluation frameworks, and to which considerable exploration and development time,

funding and other resources have been dedicated. This is important because Canadian leaders and managers can benefit perhaps more directly from our own development work, in addition to that of other countries.

Our approach will be to first highlight particular experiences in other countries to complement the predominantly U.S. experience that forms a major part of the Leatt, Pink and Guerriere paper; and next, to highlight and expand on some additional Canadian background and experience in this area. We will then reinforce a number of important topics presented by Leatt et al. related to a better understanding of integrated health organizations and provide additional perspectives on this subject as it relates to Canada.

Other Countries

Other countries that have developed forms of integrated health organizations include the United Kingdom, the United States, New Zealand, the Netherlands and Israel. Leatt, Pink and Guerriere present a number of reasons why countries moved in this direction, and a number of themes in particular that are U.S.-based. We disagree with the suggestion of "reluctance" in looking at the United States, as Canadian exploration did consider U.S. experience. What is interesting when examining other jurisdictions that have moved in this direction is just how consistent many of the features of integrated health organizations are across other countries, as well as with the thinking and design promoted in Canada (Marriott and Mable 1998). Elements that have been part of this on-going reform and refinement in other countries include: rostering; integration of responsibility for all services in the continuum in one form or another; funding through a combination of capitation and other funding mechanisms; emphasis on primary care; and recognition of the need to develop sophisticated information systems to support management, planning and clinical decision-making.

As well, many of these countries have had experience with regionalization, containing lessons relevant for Canada. In some cases they did away with or transformed regions, as in the Netherlands, which transformed geographic monopolies into a roster-based system of regulated, competitive, integrated organizations. In other cases, such as the United Kingdom and New Zealand, they dramatically modified the structure, responsibility and functions of regions in order to support integrated health organizations within, and even across, areas. There were many reasons why countries modified the role of regions, including the need to counteract a lack of responsiveness, long waiting lists, limited choice and the tendency of the administrative systems "to become bureaucratic and insensitive to the public," which leads to consumer dissatisfaction (Chernichovsky 1995). Similar observations were made in government reports and studies within these countries (Upton 1991; Borren and Maynard 1994; OECD 1992, 1994, 1995; Glennerster et al. 1994; Klein 1995; Hatcher 1996). Chernichovsky (1995) observed the emerging dominance of integrated models and reforms as promoting "system efficiency and consumer satisfaction rather than a particular doctrine. Consequently it denotes efforts to combine the

comparative advantages of public systems (equity and social [macro] efficiency) with the comparative advantages of competitive, usually private systems (consumer satisfaction and internal [micro] efficiency) in the provision of care."

Changes in government have not necessarily resulted in a move away from this direction. For example, the new U.K. Labour government initially made some public pronouncements that sounded as if the entire GP fundholder initiative was over. While there has been refinement in how planning takes place and how input to commissioning occurs on a regional basis, the ultimate objective of building effective integrated health organizations through clear statements defining the model, and with incentives to move forward, is still clearly in place. The plan supports the evolution of fundholders to join together to form larger primary care groups of physicians and nurses, and then to encourage these groups to assume more and more responsibility for providing and commissioning services for the population they serve.

The ultimate objective is for primary care groups to evolve into primary care trusts. At this point, all financial responsibility for commissioning work from hospitals, for prescribing and for community services would devolve from the Health Authority. Savings would remain with the primary care trust. As well, policy expressed in the U.K. White Paper provides the option beyond commissioning for the primary care trusts to "employ all relevant community health staff and run community hospitals and other community facilities, ensuring these work effectively as part of an integrated system. The precise arrangements will, however, depend on local circumstances" (U.K. White Paper 1997; Wright 1998). While authors still refer to purchaser/provider split in these jurisdictions, the reality is that the integrated organizations can purchase all services, or provide some and purchase others, or provide all, depending on the jurisdiction and local circumstances.

Canadian Background

"Regionalization" characterizes the overt direction taken to date by most provinces in Canada except Ontario. Leatt, Pink and Guerriere have pointed out correctly that the regional structures put in place by most provinces do not include such important elements as integrating physicians or rostering of populations. Without physicians, there is no direct medical influence over primary care and a reduced potential to engage specialist physicians as full partners and supporters. Without rostering, the regional "organization" is bound to responsibility for both the providers and the population within its designated boundaries. This presents very real challenges for policy when it is understood that the boundaries seldom represent natural population flows within health systems. Population in one region will naturally flow into another, not just for secondary care if it is closer, but for primary care if the physician resides "across the line." This imposes continual adjustments for these factors, challenging the introduction and refinement of more equitable means of funding such as capitation funding for "regions" in a given area, particularly if physicians become part of the regional authority's responsibility (Marriott 1992).

A system of integrated health organizations would eliminate the imposed boundaries of "regions" and focus instead on flowing population-based funding to organizations with rostered populations and associated primary care physicians or groups. In metropolitan areas, population density would allow for evolution of multiple organizations and rosters, which could include both heavily populated areas as well as population in surrounding areas, according to citizens' and providers' choices. In some rural and northern areas, integrated organizations might evolve to encompass 100% or a major portion of the rostered population, establishing a self-selected, locally created "monopoly" in a geographic area, if expedient to community needs, with the flexibility to change over time.

In addition to regionalization, there has been considerable "hands-on" investigation, planning and design in the area of integrated health organizations since the 1980s in Canada, although much of this work is not widely disseminated or published at this time. The Leatt, Pink and Guerriere paper introduces its integration background as though beginning in the mid-1990s, born of concepts, definitions, characteristics, methods and types of integration based on Shortell's work in the United States. In fact, Canadian governments, health policy-makers, academics and practitioners began earlier to look at notions of integrating the healthcare system in response to pressures and problems in the system and concerns of consumers and providers alike about access, quality and sustainability. Indeed, a model for a not-for-profit integrated model for healthcare began development in Ontario in the mid-1980s.

Individuals inside and outside of government were independently exploring Canadian-based modeling of integrated health organizations and examining what was happening in other countries. As a result, the Ontario Ministry of Health moved on two fronts simultaneously. Within the Ministry, a number of individuals with policy and design interest in this area were identified. These individuals reflected various routes pursued in exploration of integration at that point. Some had worked in or studied HMOs in the United States. Marriott had examined the potential to "grow" HSOs in Ontario into fully integrated health organizations by adding capitation funding and service responsibility for their rostered populations (Marriott 1985). A broader Ministry committee evolved and was formed in 1987 to review examples and prepare an initial program foundation. The result was the Comprehensive Health Organization (CHO) program, launched in the fall of 1988. The CHO model was defined as "A fully-integrated, not-for-profit, health corporation, which assumes responsibility for providing or purchasing the delivery of a full range of vertically integrated health and health-related services to a defined population" (Marriott and Mable 1994).

A second development track involved community individuals who were pursuing their interest in this area parallel to the internal Ministry initiative. An Ontario Ministry grant to the Toronto Hospital in 1986 resulted in the research and exploration of integrated health organization concepts, including a review of HMOs in the United States by Vytas Mickevicius. This led to the first proposal

for a CHO submitted to the Ministry CHO program in the fall of 1988 (Mickevicius and Stoughton 1988; CHO Bulletin 1991). By this time, other initiatives had emerged around the province, often led by individuals who had been thinking along the same lines or had explicitly studied and pursued them. In Fort Frances, Ken White (then CEO of the Rainy River Hospitals) and subsequently Dave Murray led teams of interested physicians, community representatives and others in the exploration of this concept.

Similar teams of physicians, hospital staff, community representatives and others investigated or pursued developments in integrated healthcare, including several initiatives in Toronto and in communities such as Wawa, Hamilton, Ottawa and at Queen's University in Kingston. Pre-dating this, Sault Ste Marie was pioneering aspects of this concept prior to medicare. The Group Health Centre (GHC), a partnership of the Group Health Association, as the fundholder, and the Algoma District Medical Association (ADMA), demonstrates some of the most advanced integration thinking in practice in Canada. The GHC was on track originally to become a "Canadian HMO," with a significant rostered population and full financial responsibility for all services. The introduction of medicare and the establishment of separate hospital and other program budgets by the Ministry disrupted a trajectory that still is viable today.

By 1990, several communities had been selected to explore feasibility more intensively. An extensive plan of interactions had taken place around the province involving stakeholders at all levels, such as the focus group comprising professional associations, colleges and other groups held at the Westbury Hotel in Toronto in 1988, and the OHA Symposium on CHOs in April 1989, including the Minister of Health (Caplan 1989). Linkages were explored from the perspective of stakeholders. Remarks by Gerald P. Turner, president and CEO of Mount Sinai Hospital, reflect some of the thinking at a Conference on Hospitals in the Future, October 10, 1990: "The aim of CHOs is to provide greater flexibility to deal with local health priorities. Projects like this are helping to make the breakthrough in the management of our health care resource ... a broadly-based partnership of hospitals, physicians and other providers who negotiate their various roles at the outset and then collaborate to provide the best possible service to patients" (Turner 1990; Marriott and Mable 1994b).

At this point, due to the combined efforts within government and throughout the province, key attributes of the model were considered in great detail. A rigorous framework for policy and program was developed in such critical areas as feasibility, public involvement, administrative and fiduciary responsibilities, in addition to organizational structure, minimum parameters for management, operations, information system development, evaluation, roles of stakeholders and flexibility of the model. By 1993, even a company-based model was explored by Magna International through an extensive feasibility study. The CHO model was summed up in 1993 by Dr. Eugene Vayda of the University of Toronto: "With CHOs, you have an opportunity to pull it all together. A system which integrates funding authority

and delivery has a chance" (Marriott and Mable 1994a).

By the mid-1990s, with successive changes in government, the program and its development work continued (supported by all three parties), including additional approvals to develop an Integrated Management Information System to monitor and manage roster, financial and encounter data on an interactive basis with communities; a financial system – a model of capitation as the basis for funding; authority to establish a CHO Program Vote or operational budget; and a Quality and Evaluation Framework (Anderson et al. 1994; Marriott and Mable 1994a). The program and model were renamed as Integrated Health Systems (IHS), to encompass examination of both partial as well as fully vertically integrated models. Additional communities developed proposals reflecting varying degrees of integration, including extensive efforts in Windsor, northeastern Ontario and Toronto, spurred by District Health Councils.

The IHS program updated its review of international experience in this area, with countries experiencing regionalization and the introduction and evolution of roster-based, vertically integrated health organizations being particularly relevant to Canada; and continued to explore implications for particular stakeholder groups, involving a widening group of participants and debate (Marriott and Mable 1997a, 1997b). Papers and effort emerged from professional associations and others, notable among which were a proposal put forth by the Ontario Nurses Association for a fully integrated model and the integration work of the University of Toronto, which brought with it the U.S. work of Shortell and greater focus to integrated delivery systems (IDS) and concepts of provider integration. The model also emerged at the national level by the mid-1990s, where it drew the endorsement of the Government and Competitiveness Project in Ottawa (Purchase and Hirshhorn 1994). The National Forum on Health issued a paper in 1996 that reviewed international experiences in integration tailored to the Canadian environment and policy and emphasized the importance of a primary care base (Marriott and Mable 1998a).

Not well known or documented is that there had been integration activity in other provinces during the late 1980s to early 1990s. Quebec had been investigating a model that was very similar to the CHO, called OSIS. Subsequent to visits and examination of Ontario's Ministry initiative, British Columbia created a CHO program, and the B.C. Medical Association was prepared to negotiate the CHO concept. Saskatchewan also convened a small internal policy group to examine Ontario's work and was developing a CHO concept to be called a THC or Total Health Centre. In different ways, these initiatives were impacted on by decisions in the early 1990s to move towards devolution and regionalization. This plus the election of a new government further impacted on Saskatchewan's initiative.

Meanwhile, other countries have moved more quickly to implement the kinds of integration reforms that have been explored in Canada. While we follow their progress with interest, the bases of their efforts – consumer and

provider implications, concerns about quality, lessons and potential directions – have been under consideration here for some time. We believe that, in particular, Ontario is uniquely positioned towards success in integration, given the wide-ranging groundwork already covered across the province – with or without a mandate. Its leadership could make a difference for other provinces. The outstanding element at present is public confirmation of a Ministry mandate to proceed.

Why is this important? Because Canada has considerable experience and expertise to draw upon. Because virtually everything that was written in the late 1980s and early 1990s about CHOs (then IHSs) – including rostering, responsibility for the full continuum, notions of integration, community and consumer-centric sensitivity and responsive orientation, health teams, electronic records and evidence-based measurement and quality evaluation, capitation funding and more – was part of public policy and model design. What has been written since is in agreement with these features and direction. The point is not so much the history lesson as the significance of recognizing that independent thinkers in Canada in the 1980s reached the same set of essential conclusions about an "ideal" set of responsibilities, features and options for the design of integrated organizations in Canada. We have much to learn from each other. And it is notable that these same features have emerged in other countries around the world, in many cases subsequent or parallel to the initial thinking here. Despite following different routes within different countries, all have reached similar conclusions about organizational modeling, policy and behaviour.

Key Features of Integrated Health Organizations

Leatt, Pink and Guerriere summarize common characteristics and types or forms of integration with functional, physician and clinical perspectives, and they identify elements of a potential model of Canadian integrated care. As the characteristics match those of an IHS, we heartily support them. But the paper omitted mention of the model framework that had been developed, which helps to explain what the model "looks like" and its flexibility. It is useful to review the key elements of integrated health organizations, to emphasize their scope and, more practically speaking, to explain what the organization does and is responsible for. These features or elements of responsibility bear review here, as they embody characteristics that interrelate to form a set of natural incentives for behaviour and internal dynamics, to motivate and compel higher performance, while allowing for variations in healthcare organizations (Marriott and Mable 1998). The features are:

- *Autonomous not-for-profit organization:* an organization independent of government and accountable to its rostered members, providers and government; includes members' input to planning and operations, a mission to support wellness and respond effectively to illness; accountable to government for the management of funds and services, and committed to quality and evaluation as a means of reinforcing mission goals and obligations of the organization. Its legitimacy is based on being selected by members/citizens and its viability in delivering appropriate and satisfactory services to them.

- ***Benefits or core services:*** responsibility to plan for, and to provide or purchase, all centrally defined benefits or core services along the full continuum of health, for the population served. Emphasis is on wellness and primary care with the GP as "gatekeeper" to secondary services and accessible multidisciplinary providers. Core services include the spectrum from wellness (promotion, prevention) to primary care, acute care, secondary, tertiary and quaternary care, long-term care and home care.
- ***Roster:*** responsibility for and accountability to an explicitly identified registered population, the aggregate of individuals rostered with the (one) organization of their choice, with the right to choose to "exit"; whose specific characteristics and healthcare needs are entered into the organization's database; and an organizational obligation to assess and respond to the needs of its individual members and the rostered population as a whole. The inherent right to choose is also extended through the integrated health organization to the consumer's right to align or roster with an associated physician or physician group.
- ***"Weighted" Capitation:*** the organization receives a per-person amount of funding which is adjusted to reflect the characteristics of the organization's rostered membership (e.g., a minimum of age and gender; areas of cost or need), to pay for all health services, no matter where provided or accessed in a province. In a public environment, funding comes from government to the organization, from a single pot of healthcare funds. It represents a cash flow to the organization and does not define funding for any element, whether program, institutional, physician or other provider. This is an internal matter left to the organization to work out (discussed below). Capitation transfers with the rostered member who chooses to "exit" or roster with another organization that better serves his or her needs.
- ***Information system:*** an obligation to build an information system to collect, track and report all roster and provider encounters (e.g., roster population information, provider profiles, satisfaction surveys, etc.); to maintain other appropriate health records and data; to incorporate health service activity with environment and financial data, as well as the capacity to blend in other information such as self-reporting, demographics, needs assessment, utilization and care-mapping; a responsibility to report necessary information to government, and to use this information in planning for population and individual needs, and as a tool to support and monitor quality and evaluation.
- ***Full responsibility to determine organizational and financial arrangements with providers:*** freedom of the organization to make decisions regarding critical matters "internal" to operations to best serve its population, including: distribution of funding to support care, decisions to provide and/or purchase (contract for) appropriate services, the development of appropriate organizational and financial relationships with providers and others throughout the system, determination of an optimum environment for all participants and a commitment to planning and

evaluation, to determine the most appropriate resources to meet the assessed population needs (Marriott and Mable 1994, 1997, 1998).

The features express a set of fixed areas of responsibility that tend to define an integrated health organization, but none of them predetermines a particular organizational construct. It is this organizational flexibility that bears a distinct contrast with regional structures or provider integration models. The organization can choose to fund all services or provide some services and fund others, and in special circumstances it could elect through local processes and agreement to include all provider services through enfolding them as divisions, or by achieving dedicated partnerships. Hospitals, then, could maintain their independence as contractors to the organization, or participate as a sub-area of the organization.

Similarly, physicians could elect to be contractors or partners or even employees of such an organization, as long as a mutually satisfactory relationship is achieved. They could negotiate the transfer of all physician dollars to their control and elect their own form of remuneration within the physician group. Options here include salary, fee for service or approaches that blend base funding with prorated fee for service, with other financial recognition for such things as educational attainment, extent of participation in continuing education, years of experience, coverage of nights and weekends, locating in particular geographic areas or special competencies (Marriott and Mable 1997).

The aggregate effect of integrating autonomy and full responsibility for all services, with per-capita funding for a precisely defined and involved population, monitored and served by an integrated information system, empowers integrated organizations to more effectively mobilize and shift resources to areas of need. This flexibility to innovate or develop new standards harnesses the potential to respond more effectively to improve the health of populations served. The full model of integration provides a consistent set of parameters, commitments and responsibilities, while allowing for perpetual innovation and variation at the community level. It is not "one way" to do things, but rather a skeletal template upon which operations can be tailored to fit communities' needs while upholding consistent standards and fulfilling critical fiduciary and administrative responsibilities – to patients, to providers, to communities and to governments.

Lessons

Besides broadening understanding of Canadian background to benefit from our own hands-on experience in integration, it is useful to consider more closely what has evolved in the recent absence of Ontario Ministry policy in this area. Leatt et al. discuss networks as an appropriate model of transition. Networks or notions of "virtual" integration emphasize alliances between provider organizations that maintain their separate authority and funding. While they explore various forms of collaborative behaviour, there are concerns about the implications for resource efficiency, decision-making and overall performance effectiveness in carrying out their collective goals to benefit consumers. Such potential problems have been reinforced by "off the record" answers in interviews carried out by

Marriott and Mable in 1998 surveying a number of integration initiatives in Ontario – including networks.

When asked about issues of central accountability, or moving beyond small co-funded programs to real integration of the system, the answers were quite consistent: that any major reduction of the autonomy and power of participating agencies, institutions and providers would not happen, including any major transferal of responsibility to a central network governance, or authority or administration; nor would there be any move to transfer most or all of their respective budgets to support a central authority for the network to assume major financial responsibility for major components or "all" of the health services the participants represent. What this means is that some improvement is possible in the areas of collaboration and functional integration over what we have had. However, it is evident that one of the driving forces behind networks was to find ways to preserve the autonomy, integrity and power of participants, rather than to support the development of integrated health organizations or serve population health. There is a real risk of stalling at this level, or expending resources in ways that do not significantly approach the goals of integration.

Leatt, Pink and Guerriere review lessons learned, presenting a series of insights from international experience, leading to six interrelated strategies that in essence embody priorities already embedded in the CHO/IHS design – with a major exception. Leatt et al. fall short by recommending a focus on virtual networks, where much more is possible. This recommendation appears to contradict important elements summarized in subsequent tables, such as consumer choice, money following consumers or incentives for performance. While organizational collaboration is always to be applauded (and we would hope it would be a hallmark of the present system), it simply does not go far enough. Not addressing important areas such as asset sharing stops short of obvious areas of potentially more effective resource management strategy. Most important, it does not fulfill the public trust – to find the most responsible, efficient and effective ways to use public healthcare dollars.

Strategies

Implementation may be done all at once or in a series of steps. Our observation after review of other countries is that most redefined their goals and directions and implemented new models on a national scale. There was little attitude of waiting for others to do it first. Reform was introduced systematically and comprehensively rather than as tentative pilots somewhat isolated from the rest of the system. In Canada, however, circumstances would suggest looking at transitional approaches while encouraging decisive leadership and watching for opportunities. Leatt et al. have pointed out that one can build from primary care organizations. We certainly advocate this, and have considered optional tracks to develop integrated health organizations from primary care organizations.

For example, levels of funding can parallel the development of increased service responsibility. Physician-owned primary care organizations might not have direct access at first to funding for hospitals, specialists, drugs and other

services, but would hold the authority to negotiate arrangements with all those parties, who would then be funded by the government or health authority. If primary care organizations develop more representative governance and administration, with viable rosters of patients, they could evolve into the key features of full responsibility and could be eligible to receive full health system capitation (Marriott and Mable 1998).

Also consistent with Canadian tolerance for pluralism should be the option to recognize those who are "ready to go the distance" and are positioned to develop and implement fully integrated health organizations. Despite concerns about system-wide restructuring, Leatt, Pink and Guerriere acknowledge that "the creation of corporate governance models may in the long run prove to be the most efficient and effective type of integrated care." Government can reactivate its support for the development of fully integrated health organizations, and facilitate ways for them to operate in parallel with "partial" integration models such as primary care reform (and its evolution) and with the rest of the health system. There is room for these options. And despite an absence of policy mandate, there are still citizens and providers who want to support integrated health organizations. The ultimate objective is to have the total population served by integrated health organizations designed to serve them.

Conclusion

Canadian work in integration has been second to none for some time. Perhaps continuous, repetitive review should be curtailed in favour of better consolidation and documentation of our own experience. Perhaps we should learn from other countries' willingness to trust their design work and move forward, rather than watching others benefit from improvements Canadians might now enjoy. An environment that defaults to no action rewards the proponents of status quo and no change. Let's not confuse endless review or consensus efforts as the Canadian way of doing things – our own history of major achievements in healthcare does not prove this out. Leadership and implementation in a forthright fashion gave birth to medicare in Canada. Tommy Douglas moved forward with the conviction that what he was doing was right, in the face of enormous opposition at the time from citizens and providers alike. But once it was established, Canadians would not do without their publicly funded system. Early on, it was also Tommy Douglas who recognized that the work to complete fundamental structural reform of our delivery system was not ended. We need leadership with vision and fortitude to finish this job.

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