The Authors Respond

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COMMENTS FROM THE AUTHORS ABOUT THE SEVEN COMMENTARIES

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ONE OF THE MOST REWARDING ASPECTS of writing a paper is reviewing the comments made by one's peers. The responses to our paper were thoughtful and insightful; in fact, they stimulated us to clarify the concepts and to better explain our analyses of the health system. We have learned a great deal from this work, and continue to learn from our observations of how the healthcare system is changing, and developing in response to consumer expectations and providers' drive of excellence in quality of care.

Leggat and Walsh provide insights about the integrated healthcare experience in Australia and New Zealand. They describe three valuable lessons. First, not everyone needs integrated healthcare. A particular episode of care may be a one-time-only event and therefore not require follow-up. We agree with this lesson but, as a population ages and the prevalence of chronic illness increases, it is likely that *more* people will need *more* services *more* often, and from *more* than one provider. In other words, we think the proportion of the population who will require integrated healthcare is going nowhere but up, at least in the foreseeable future. In their second lesson, the authors discuss financial and market incentives. Although the vast majority of Canadians live in

urban and suburban communities where consumer choice is real, this is not the case for people in rural areas. We agree that one size does not fit all, and that different models will be required for different populations. A highly regulated environment has always characterized the Canadian healthcare system and we agree that meaningful incentives to provide appropriate services are necessary to realize change. The third and final lesson offered by Leggat and Walsh suggests that the implementation of integrated health services should be a bottom-up process. In fact, this is the approach that we have always advocated. No one knows the needs of local communities better than local providers. Rather than imposing a centrally determined model, government should remove the pervasive and formidable barriers that currently prevent local providers from creating innovative, local models of integrated healthcare. This is particularly important for new models of primary care and integrated information management, the key building blocks of integrated healthcare.

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Rogers and Sheaff describe some of the British experience in moving towards greater healthcare integration. For several years, the National Health Service has promoted the organization of primary healthcare as its central focus. The GP fundholding model is illustrative of an attempt (albeit an accidental one, according to the authors) to improve the coordination of all levels of healthcare in the United Kingdom. We are encouraged by the Primary Care Groups and Trusts described by the authors because they seem to have the potential to increase real integration of primary care services. A help line operated by nurse practitioners is a good idea that Canada has been slow to adopt. Similarly, we were impressed by the importance placed on the involvement of local communities, lay people and users. Although real influence is not yet evident, we agree with the authors that it is important to engage users and community resources. The authors describe the relevance of an in-depth understanding of the use of services and we concur. Only through such understanding will a system be able to design and provide the "right service at the right time in the right place by the right provider." Finally, Rogers and Sheaff argue that self-care and informal care are significant and often hidden aspects of healthcare. An important goal of integrated healthcare is giving patients and their families the self-care information and skills that they want and need. We agree that formal primary caregivers will have to involve informal caregivers to a greater extent and that mixed models of care may be appropriate to meet the diversity and complexity of needed health services.

Marriott and Mable recount the origins of integrated healthcare in Canada and elsewhere and, in so doing, give us a rich and valuable perspective on the

usefulness of current models of integration. We strongly agree with the authors' own survey finding that vested interests of providers are serious inhibitors of greater integration. The healthcare silos are big and strong but must be dismantled if true integration is to take place. In addition to providers, we would also add various professional associations, provincial ministries and departments of health to the list of vested interests who oppose change. The authors take exception to our suggestion of virtual networks and instead argue for common ownership of assets. We agree that there can be economic and other gains from common ownership of assets in many circumstances. However, U.S. and other experience has shown that a great deal can be achieved through joint contracts and strategic alliances. In our opinion, virtual integration has greater appeal and comfort to providers who are reluctant to relinquish ownership to provide coordinated services. The authors indicate that a transition period and gradual implementation of coordinated systems is a preferred approach and we concur with their view.

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Shamian and Leclair raise some important challenges to the idea of integrated health systems as the next logical step in healthcare reform in Canada. They point out that each province has chosen its own distinct path of achieving higher quality of care at an acceptable level of cost. As the culture and character of each province varies, so do the needs and acceptability of approaches to reforming healthcare. The authors comment that the role of the physician or nurse is not defined in the article. We believe that rigid role definitions work against integration of healthcare. Instead, we argue that health services "should be provided by the health professional who can best meet the individual's needs. For example, nurse practitioners, registered nurses, chiropractors, naturopaths, midwives, optometrists, pharmacists and others (assisted by comprehensive clinical practice guidelines) should be used to provide the right services for the population. Use of these clinicians leaves the physicians' time and skills for the more complex cases needing medical treatment."

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Closson and MacLean/Zon present two excellent case studies of strategies to improve coordination and integration of care. Closson assesses the Capital Health Region (CHR) against the principles of integrated care identified by Shortell as well as against the major recommendations that we outline and points out that the CHR has made considerable progress towards greater integration of care. He concludes that we are overly critical of the progress and potential of regional health

authorities. We agree that regional health authorities have made substantial and laudable achievements in rationalizing healthcare, and the Capital Health Authority is probably one of the best examples. However, we maintain that the exclusion of physicians, drugs, and other essential health services from the jurisdiction of regional health authorities, the lack of integrated information systems, and so on, means, by definition, they have not achieved integrated healthcare. We agree with Closson that the major opportunity to improve clinical integration is in the domain of primary care. MacLean and Zon describe the progress made by Markham Stouffville Hospital in improving integration of care for their patients. This case demonstrates that, despite an absence of Ministry policy and a legislative framework, it is still possible for local providers to improve the coordination of care. The authors provide insightful comments on the challenges of moving forward in this area in Ontario.

Finally, Hernandez identifies some important findings from the U.S. experience with integrated care that we believe are relevant to Canada. First, management of processes between hospitals and physicians, and shared information systems are critical for integration to occur. Second, excess capacity and duplication must be removed if system efficiencies are to be achieved. Third, integration is really about fundamental work redesign versus diversification and other organizational strategies. Hernandez concludes with a very important question: "Will integrated care be achieved in Canada by control mechanisms of an integrated organization or market mechanisms that prescribe outcomes to be achieved by individual system components?"

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At the extreme, we believe neither of these options is viable in Canada. In the future, we think it is unlikely that all or most Canadian healthcare providers will be owned by, or employees of, an integrated health system. Conversely, we also think it is unlikely that all or most healthcare providers will be independent agents who contract with a fund-holding integrated health system. Rather we think that a quintessentially Canadian, middle-of-the-road approach will likely prevail. Greater integration of care will be achieved by a combination of integrated organizations and independent providers who contract to provide service and to meet specified outcome, access and quality goals. Furthermore, there will and should be variations on this theme. Areas with well-functioning regional health authorities and rural areas may have more services provided by a single, integrated organization. Large urban areas with highly specialized providers may have more services provided by independent agents. In a country as large and diverse as Canada, it is appropriate and probably inevitable that integrated healthcare will be achieved in different ways.