

**Home Care and Pharmaceuticals Division,  
Health Policy and Communications Branch,  
Health Canada**

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**Analysis of Interfaces Along the Continuum of Care**

**Technical Report 6:  
Interviews with Key Informants**

**February 2002**



**Hollander Analytical Services Ltd.**



**Home Care and Pharmaceuticals Division,  
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Interviews with Key Informants**

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## EXECUTIVE SUMMARY

Health Canada funded Hollander Analytical Services in to conduct a study on the Analysis of Interfaces Along the Continuum of Care. The study was to explore issues related to what makes for an integrated continuum, or system, of care delivery for a number of population groups including seniors, adults with disabilities, adults with mental health concerns, and children.

Four sub studies focussed on the provision of care for each of the sub populations. This report provides the findings from a fifth sub-study which sought insights from key experts with a broad perspective on health and social services, on the preliminary findings from the four population sub-studies, and on best practices for creating a continuum of care in health and social services.

Twenty-one individuals from across the country were interviewed on the following topics:

- the attributes of a “seamless system of care”;
- the role of social supports in health care;
- the influence of special interests and current structures on the continuity of care;
- the barriers to continuity of care;
- the facilitators of continuity of care; and
- three or four critical steps or success factors which would lead to integrated and seamless systems of care delivery.

The attributes of a seamless continuum of care were viewed as remarkably similar from a provider or a patient perspective, and included methods of improving access, consistency in care provision, coordination of services, responsiveness to clients, the sharing of information across providers, patient empowerment, as well as reduction in duplication of assessment and treatment.

The traditional dichotomy between health and social services and between the bio-medical and psycho-social models of care were less meaningful in today’s reality and in understanding what makes populations healthy. The role of social services were seen as essential not only to the health and well-being of the general population, but particularly of the four target groups. These groups were seen to be more dependent on these services to live independent, meaningful and healthy lives.

While respondents on the whole agreed that medically necessary care should be publicly funded, there was a lack of consensus on the role of the state in funding social services. Some were of the view that any care that is necessary, whether it was health or social care, should be publicly funded. They were more likely to take a population health and broader determinants of health approach which includes notions of well-being. From their perspective, conditions, such as poverty, isolation, restricted mobility, and squalor, not only affect the health of individuals and restrict the effectiveness of medical care, but are conditions best addressed through social services. Others felt that public funding of social services should be based on individual need and ability to pay.

There was no emerging consensus on the recommendations for system reform specifically for the four target groups. Those with research or service expertise with respect to one of the groups were more willing to discuss system barriers, facilitators, and reforms specific to their group. On the other hand, those with broad system policy expertise felt less able to comment on reforms specific to the target groups, and tended to respond for the population in general.

Facilitators of seamless care were basically mirror images to commonly cited barriers to coordinated and integrated care, and included:

- funding reform;
- re-examination of the scope of publicly funded services;
- primary care reform;
- good information systems for providers and patients;
- evaluation of performance and outcomes;
- single entry, common assessments and referral systems;
- geographic and round-the-clock availability and adequacy of services;
- discussion amongst interests to overcome resistance;
- labour reform;
- modernizing training programs;
- leadership; and
- flexibility.

The key success factors that were recommended to facilitate a continuum of care were mechanisms related to overcoming the major barriers. Reforming the way we currently fund health and social services to eliminate sector silos, and the way we currently reimburse providers, especially fee-for-service payments for physicians, was at the top of the list. Reform of primary care which included concepts of multidisciplinary teams, around the clock care, and some form of capitated funding was viewed as long overdue and essential to providing constant care that meets most of the needs of individuals. Creating a single point of entry and common assessments by a multi-disciplinary team were seen as fundamental to integrated care.

The development of good information systems that provide accessible, standardized and timely information on clients/patients, that allow for the evaluation of care and outcomes, and that can contribute to the development and dissemination of practice guidelines and care pathways was seen as the substratum of an integrated and coordinated system.

Government's role in creating a seamless system was pivotal in setting standards, providing adequate funding, and allowing flexibility for local planning and delivery. Respondents felt strongly that governments should get out of micromanaging the system and delivering services. While special interests were seen as resisting or slowing the pace of reforms, their resistance was often viewed as a natural response to covert government motives, such as cost cutting, which threatened their mandates. Respondents felt that government should be clear on their actual objectives for reform and should provide incentives to special interests to collaborate on reform. Finally, government needs to provide the leadership and political will to move forward the restructuring of our system of care to provide a seamless continuum of care.

## **ACKNOWLEDGEMENTS**

This report is part of a larger study commissioned by the Home Care and Pharmaceuticals Division of the Health Policy and Communications Branch of Health Canada for the Federal/Provincial/Territorial Advisory Committee on Health Services (ACHS) and its Working Group on Continuing Care (WGCC). The larger study is on the Analysis of Interfaces Along the Continuum of Care with specific reference to seniors (65 and over), adults with physical disabilities, persons requiring mental health services, and children with chronic conditions. The views expressed in this report do not necessarily represent the official policy of Health Canada.

I wish to thank all those who participated in the interviews, giving freely of their time and vast experience. While the report is based on their views and recommendations, the interpretations, analyses and any error of fact are those of the author. I would like to thank Marcus Hollander, Michael Prince and Evelyn Shapiro for their helpful comments and suggestions throughout the project.

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## 1. INTRODUCTION

Health Canada funded Hollander Analytical Services to conduct a study on Analysis of Interfaces Along the Continuum of Care. The study was to explore issues related to what makes for an integrated continuum, or system, of care delivery for a number of population groups including seniors, adults with disabilities, adults requiring mental health services, and children with special needs.

The project included six sub-studies. An extensive literature review was conducted for this project. Four teams were responsible for collecting information on care delivery for each one of the specified populations across Canada. Input was sought from policy/decision makers (e.g., federal, provincial, territorial officials) service provider organizations and individuals who are affected by the services. This, sixth, sub-study sought insights from key “wise persons”<sup>1</sup> with a broad perspective on health and social services on the preliminary findings from the four population sub-studies, and on best practices for creating a continuum of care in health and social services.

This report presents the findings from the sixth sub-study.

## 2. BACKGROUND

In discussing health care, it is common to talk about the “health care *system*.” A system as defined by Stichler (1994) is a set of elements in interaction or relationship with one another. It is more than the sum of its parts because the interaction among the parts produce a synergistic outcome that is greater than the collective sum of parts. There is considerable variation in the relatedness of the different sectors of care limiting the system’s nature of Canadian health care. In all aspects of running a health care system from planning, financing, allocation of resources, structuring the delivery of care, and the clinical provision of care at an individual level there are major disconnects. Moreover, as Leatt et al. (2000) indicate, health care is structured around the needs of professional groups, especially the maintenance of their autonomy, and not around the needs of patients. Governments across Canada have been attempting to address these fractures through various reforms to create an integrated, more or less seamless systems of care. The drivers of systems integration as documented by Skelton-Green et al. (1997) include various economic, social, organizational, informational technology, and political pressures.

Berwick and Nolan (1996) see integration more as a process issue, i.e., process design and interaction which is achievable under many different forms of governance, organization, or finance. It is the optimizing of interactions among elements of a system to provide quality services to those the system serves. For them the acid test of integration lies in the experience of the people served by a system. Some authors (Leatt et al., 2000) have described how patients can recognize an integrated health care system. An integrated system is one that would reduce multiple assessments and diagnostic tests, provide 24-hour access to a primary care provider,

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<sup>1</sup> Wisdom, knowledge and experience lies within various people: policy makers and researchers to be sure, but also managers, service providers, and clients/users. The group chosen for this sub-study were researchers and policy makers with a broad systems perspective or expertise with one of the four target populations.

provide a single point of entry, referral and case management, have an information platform where the patient's record is available to providers, have access to information about quality of care and clinical outcomes, and have access to appropriate care.

In understanding integration, it is necessary to distinguish terms. Horizontal integration refers to alliances, mergers or coordination of activities which occur within the same sector of care, e.g., the Ontario integration of hospitals under single boards. Vertical integration refers to similar integrating strategies across sectors of care, e.g., regional health authorities (RHA) in many of Canada's provinces. (Skelton-Green and Sunner, 1997; Marriott and Mable, 1998; Markham and Lomas, 1995). Since the early 1990s, there has been considerable discussion about integrated delivery systems (IDS). Shortell et al. (1993, 1994) defined an organized delivery system (ODS) as "networks of organizations that provide or arrange to provide a coordinated continuum of services to a defined population and who are willing to be held clinically and fiscally accountable for the outcomes and the health status of the population being served." The important features of an ODS/IDS are the provision of a broad range of services, and clinical and fiscal accountability for a defined population.

Devers et al. (1994) distinguished three types of integration: functional integration, physician integration, and clinical integration. Functional integration refers to the coordination of support functions, such as financial management, human resources, information management, etc. across a number of organizations. Physician integration refers to the extent to which physicians are economically linked to a system, and use its services and facilities. Clinical integration refers to the shared use of treatment protocols, common client records, shared use of laboratories and other facilities, and joint client management. In a review of organized delivery systems in the US, these authors found that functional integration was easier to achieve than the other two forms, with physician integration being the most difficult.

Stichler discusses the developmental process of clinical integration which includes competition, cooperation, coordination, collaboration and finally integration. Shared visions, performance standards that emphasize system's integration, and the creation of cross-functional teams to promote efficiencies are some of the ways offered to facilitate integration.

Others (Konrad, 1996; Randolph, 1997) have indicated that there are a number of ways to achieve integration, documenting different levels of integration from information sharing and communication to:

- cooperation and coordination (joint planning, joint applications, and verbal agreements for expedited application processing);
- collaboration (characterized by written agreements or formal procedures defining how different agencies work together to achieve shared goals, e.g., joint funding, staff cross-training and a shared information system);
- consolidation (different agencies organized under one organization but continue to operate independently); and
- merger (single authority, pooled funding, a comprehensive range of services, a single application and assessment, and individualized services).

Leatt et al. (1996) described a model of integrated care for Canada distinguishing it from regional health authority models. For them the main failure of RHAs is the exclusion of primary care physicians and pharmaceuticals. An integrated care system according to the authors would include:

- the full continuum of care for a defined population;
- capitation funding where risk would be shared by both the providers and the system;
- primary care physicians as coordinators;
- consumer choice;
- performance oriented system governance;
- needs-based planning; evidence-based decision making; and
- strategic alliances as an important organizational arrangement.

In their review of the international evidence, Leatt et al. (2000) provide some lessons for Canada in its attempts to achieving coordinated care. These include:

- a focus on the individual and their families;
- primary health care as one building block and the first point of contact;
- development and sharing of information and exploitation of technology;
- creation of virtual coordination networks at local levels without the need to share assets;
- development of practical needs-based funding models;
- the development of mechanisms to monitor and evaluate change and its impact;
- flexibility in ways to achieve coordination and integration; and
- the introduction of change in incremental steps.

### **3. METHODS**

Thirty-three key informants from across the country, with broad expertise in policy, decision-making and/or research in health and social services were contacted either by telephone or by email to participate in an interview. They were provided information regarding the study, the voluntary nature of their participation, and the types of questions they would be asked if they agreed to participate. See Appendix 1 for the invitation template. Twenty-one individuals agreed to participate, two from B.C., 2 from Alberta, 1 from Saskatchewan, 1 from Manitoba, 11 from Ontario, 3 from Quebec, and one from the Atlantic provinces.

Those who agreed to participate were sent preliminary results from the four sub-studies which examined issues regarding the continuity of care for seniors, persons with disabilities, persons with mental illness and children with chronic conditions, as well as the interview questionnaire. This information was to provide them with an opportunity to reflect on the questions and the preliminary findings in advance of the actual interview.

All interviews were conducted by telephone, with one exception, which was done in person, and simultaneously type-recorded. Respondents were asked questions regarding:

- the attributes of a “seamless system of care”;
- the role of social supports in health care;
- the influence of special interests and current structures on the continuity of care;
- the barriers to continuity of care;
- the facilitators of continuity of care; and
- three or four critical steps or success factors which would lead to integrated and seamless systems of care delivery.

Where appropriate, respondents were asked to address their answers with respect to the four population groups, and to the population in general. Appendix 2 contains the interview schedule.

## 4. RESULTS

Although respondents saw the four population groups as heavier users of health care, with fewer resources, more marginalized in society, and often stigmatized because of their condition, most found it either difficult to separate their answers for these groups from the general population<sup>2</sup>, or believed that the four groups should not be dealt with separately. They did, however, believe that a seamless or integrated system of care would disproportionately benefit these groups. The general population, it was thought, was more capable of navigating a disjointed system. One respondent, however, felt that young adults with disabilities and the “new crop” of seniors were more vocal and had more political leverage now than in the past. Another believed that, if the four target groups were chosen because of their vulnerability, we should also look at the provision of services for two more sub groups of the population, namely, women and new immigrants. These two groups also have special needs and have difficulty navigating a non-system.

### 4.1 Attributes of a System of Care

Respondents were asked to reflect on the factors/attributes that would contribute to patients and providers perceiving that a set of health and social services constitutes a system of care and is recognized as a system of care.<sup>3</sup>

#### 4.1.1 Client/Patient Perspective

Interviewees’ responses of the *client perspective* can be categorized around the following attributes: ease of access, consistency and integration/coordination of care, team approach/multi-disciplinary nature of care to meet complex set of client needs, comprehensiveness of services, responsiveness of the system, and empowerment of clients.

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<sup>2</sup> The general population refers to those 19 to 64 who are currently able, with no disabilities or need for mental health services. It is necessary to keep in mind that this population is neither static nor homogeneous.

<sup>3</sup> Respondents were not asked the attribute of a system of care from government’s perspective.

### **Access**

- timely access to appropriate care by the appropriate provider regardless of where that care is delivered (i.e., in the home, hospital or LTC facility). “Care when I need it, where I need it.”;
- single point of access/entry (for some people, multiple points of access meant it would not be recognized as a system; for others, multiple points of entry should be available to enter the system); and
- an awareness of what is available in the system

### **Consistency**

- consistent information on patients, that travels with the patient (i.e., a single patient record that is accessible by all providers who deal with the patient);
- elimination of duplication in assessments;
- same eligibility criteria or fees from one provider to another; and
- ability to have a long term continuing relationship with an individual provider who understands the patient and his/her condition, someone the patient can contact (a primary lead person or case manager).

### **Team Approach/Multi-Disciplinary Care**

- a team approach to care that meets the multiple needs of the patient; and
- consistent and common approaches (philosophy) to care.

### **Integration/Coordination**

- ability to navigate the system, across levels or components of care without blockages (smooth transitions);
- someone who knows the patient’s itinerary through the system and is managing/tracking their care to accommodate changing needs;
- integrated response to client’s needs;
- an organized process of care from first contact all the way through, rather than a random collection of providers; and
- being followed up, not falling through the cracks.

### **Comprehensiveness**

- availability of a range of services from ambulatory/primary care through to acute or chronic hospital care. (If services are unavailable, there can be no continuity of care).

### **Responsiveness**

- individualized care/response to client (match the service to the client, and not the client to the service);
- care that is provided around the clock (24 hours, 7 days a week);
- providers/systems willingness and ability to meet client needs;
- provider understanding of the patient’s social/familial/cultural relationships and position in the community; and

- creation of a system of ‘care’ (and not just ‘health care’) which would incorporate health, social, housing, and education services to allow people to attain increasing levels of well-being.

### **Empowerment**

- access to information in order to make a decision;
- patient is part of the team in deciding on care plan; and
- patient’s ability to choose care/provider.

#### **4.1.2 Provider Perspective**

From a *provider’s perspective*, the responses clustered around the following attributes: multi-disciplinary care, access, and responsiveness. A few respondents felt that the client/patient’s perspective should be the only consideration in promoting continuity of care.

### **Team Approach/Multi-Disciplinary Care**

- interdependence of competencies (flexibility on who and what can be provided to meet the patient’s/client’s needs);
- integration of different types of providers into teams;
- a shared philosophy of action (what and how things should be done, a melting of different approaches - medical, biological, social, psycho-social);
- multi-disciplinary assessment and case management; and
- a more sensible division of labour.

### **Access**

- good information about patients;
- good information about care options and available services; and
- a single entry.

### **Responsiveness/Accountability**

- an orientation towards providing quality care with more measurement of performance and outcomes;
- clinical responsibility for various aspects of care - promotion, prevention and care; and
- responsibility for meeting the health needs of a defined population.

#### **4.1.3 Commonalities in Perspectives**

While these are not the direct responses of either clients or providers, but rather experts’ views on their perspectives, some of the respondents are or have been providers and all undoubtedly have been clients of the system at one time or another. As such, they have personal experience to reflect on both points of view. The commonalities between client and provider points of view include: a single point of entry; a multi-disciplinary care approach; evidence-based care; access to complete and reliable information on clients and services; and provider accountability for the provision of the whole spectrum of care. On the whole, the interviewees described the patient/client’s perspective more in terms of products or outcomes (the ‘what’), and

the provider's perspective in terms of process (the 'how'). A single point of entry was seen as important from both perspectives, to limit confusion and to provide consistency. Care provided by a multi-disciplinary team was thought important to eliminate duplication in assessments and treatment while giving consideration to the multiple needs of the client. Evidence-based care ensures effective care. Information was seen as essential for both providers and clients in making decisions, and easing transitions from one setting or provider to another. Accountability for meeting the multiple needs of a client as well as the entire population ranging from health promotion, disease prevention, to care around the clock was seen as critical for seamless care.

The patient's perspective constituted a longer list and included the following attributes which did not overlap with the list for providers: consistency in eligibility criteria and elimination of duplication, continuity of provider, the availability of a full range of services, and empowerment.

## 4.2 Role of Social Supports in Health Care

### 4.2.1 Appropriate Role of Social Services in the Provision of Health Care

Social services, were seen as having a prevention, maintenance and substitution role. These functions were ones commonly ascribed to home care services.<sup>4</sup> The appropriate use of social services was generally perceived as constituting ways to delay or prevent an acute care episode or to prevent and delay institutionalization. These services were also viewed as a necessary complement for the effective deployment of medical services.

Many respondents spoke of the false distinction that is commonly made between health and social services. For them social services are health services; i.e., if these services are needed for care rather than for socialization purposes, they should be considered health care services. One respondent spoke of our tendency to think in an "industrial" way, of putting everything into discrete boxes. This results in providers trying to match people's needs to the way we structure services rather than matching services to client/patient needs. Rather than thinking health or social services, we should be thinking about the care package required by the client.

Better clarity about goals, according to some, would eliminate the false distinction that is made between the two types of services and the over reliance and relative over-resourcing of the medical versus the social services. Part of the problem was viewed as stemming from the focus of the traditional medical model on the individual rather than the population as a whole, and on illness and disease rather than health promotion and the needs of the whole person. If the overall

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<sup>4</sup> • The *maintenance and preventive* model, which serves people with health and/or functional deficits in the home setting, both maintaining their ability to live independently, and in many cases preventing health and functional breakdowns, and eventual institutionalization;

• The long-term-care *substitution* model, where home care meets the needs of people who would otherwise require institutionalization; and

• The acute-care *substitution* model, where home care meets the needs of people who would otherwise have to remain in, or enter, acute-care facilities.

(Federal/Provincial/Territorial Working Group on Home Care: A Working Group of the Federal/Provincial/Territorial Subcommittee on Long Term Care. *Report on Home Care*. Ottawa: Health and Welfare Canada, Health Services and Promotion Branch. 1990.)

goal is to optimize the health of the population, social services were seen as far more powerful as a determinant and enhancement of health than medical care. A broader determinants of health approach which values the well-being of the individual would also give social services a much greater role. Social integration and independence were viewed as essential for a healthy population.

One respondent indicated that the problem stems from the fact that Canadians have been conditioned to view “Medicare” narrowly as medical care and not more broadly as health care. As a result, this reinforces the false dichotomy and leads to perverse incentives to medicalize patients’ conditions in order for them to receive the more appropriate, less expensive and more effective service. Rather than promoting independence we encourage situations that incur over-dependence.

Isolation, malnourishment, squalor, restricted mobility, are viewed just as, if not more, detrimental to health status than illness and disease. While these conditions limit the effectiveness of traditional medical care, some indicated that social services must be viewed as more than a hand maiden to health care. For example, the objective of home care, as one respondent put it, should not be to be hospitalized in the home, but to be able to continue a meaningful and independent existence in the community.

Social services were generally seen as more critical for the four target populations than for the population in general. One respondent indicated that most people in the general population who experience an acute care episode usually require medical services and have no need for social services. Some groups, such as the relatively well elderly as opposed to the frail elderly, may have more need for social services than health services. One respondent indicated that a recent para-transport strike in his jurisdiction made a greater negative impact on the elderly and people with disabilities than the recent reduction of hospital beds. Another spoke of long waiting lists for LTC beds in Alberta because of a shortage of assisted living arrangements for seniors. The four target groups, generally speaking, however, were seen as needing a more complex combination of both sets of services.

People with mental health problems were viewed as more vulnerable and less capable of arranging their services. They were identified as needing income support, safe and secure housing, transportation, recreation, training, access to community activities, and access to legal aid. People living with disabilities who also tend to live in poverty, isolation and to be stigmatized by their condition were identified as needing income support, social housing, personal support, transportation, and access to technology in order to live integrated and independent lives in the community. Income support, social supports (homemaking, meals), supportive housing, transportation, income support, and friendly visiting as well as personal supports were seen as necessary for the elderly to delay institutionalization and hospital admissions. Social services such as education, personal supports, recreation, and social supports, such as meals and respite care, were seen as critical for children with chronic problems and their families. Although the aging of our population may not create a crisis in health services, the need for social services will undoubtedly become greater in the future. Moreover, without adequate social services, the health system becomes the default option for individuals in the four target groups, much more than for the general population.

Table 1 summarizes the complex set of social services identified by respondents as often required by the elderly, people with disabilities, people with mental health problems and children with chronic conditions. The need for these services, more than health services, separates the four population groups from the general population.

#### 4.2.2 Appropriate Role of the State in Paying for Health and Social Services

All, with the exception of one individual, agreed that the state should publicly fund all medically necessary services on a universal basis. Most cited equity but also the international evidence of the efficiency gains through the monopsonistic power of a single payer, publicly financed system. A number of respondents added, however, that the state should only pay for services that are proven to be effective. In other words, with the reality of finite budgets, resources should be channeled into evidence-based care. The one respondent who did not share the view of publicly funding all medically necessary services, saw the need for some form of private payment, geared to income through the tax system, to ensure that individuals use services judiciously. However, as one proponent of the majority view saw it, that while we want to encourage individual responsibility, ill health is not equally distributed across the population. Individual responsibility often breaks down into blaming people for their health situation, and to a reactionary backlash against some of our more vulnerable members of society, such as the four groups.

With respect to the appropriate role of the state versus the individual in paying for social services, respondents fell basically into three categories:

- those who felt that social services necessary for the health and well-being of individuals should be universally available and publicly financed in the same way that medically necessary services are;
- those who thought that public funding of these services should be based on need and on one's ability to pay (i.e., government funding is a safety net for those without adequate means), thereby seeing a role for private financing; and
- those who saw no correct answer, but rather viewed public funding of these services as a societal decision that should reflect prevailing values and, as such, is subject to change over time and context.

Those supporting full public funding of necessary social services tended to have a broader definition of health as including well-being and quality of living. From their perspective the psycho-social services should be on an equal footing with the bio-medical services.<sup>5</sup> Proponents of this view usually argued their position on efficiency grounds. Respondents saw efficiencies coming from the prevention function of social services. From their perspective, the use of more appropriate health or social services often delay or prevent the onset of more serious

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<sup>5</sup> 'Bio-medical' typically underlines the concept of medical necessity, and services provided by physicians and in hospitals; puts greater emphasis on the curative aspects of care rather than on health promotion/disease prevention; and the focus of care is on parts of the body rather than the individual as a whole. 'Psycho-social' typically encompasses services provided by allied health professionals and support workers; gives heavy emphasis to health promotion and disease prevention; and considers the multiple needs of the whole individual.

**Table 1: Social Services Often Required by the Four Population Groups**

<b>Social Service</b>	<b>Children with Special Needs</b>	<b>Elderly</b>	<b>People with Disabilities</b>	<b>People with Mental Illness</b>
Income Support	x	x	x	x
Safe & Secure Housing (e.g., supportive housing)		x	x	x
Social Supports (e.g., meals, homemaking, respite care)	x	x	x	x
Personal Support	x	x	x	
Recreation	x	x	x	x
Access to Technology	x	x	x	
Transportation		x	x	x
Education/Training	x		x	x
Legal Aid/Legal Supports				x

or acute episodes of care that need to be dealt with by the more costly medical system. As one respondent indicated it is foolish not to pay for the less expensive social service in a more timely manner than to wait for a person's condition to deteriorate to the level where the more expensive, medical intervention is required. "You either pay less now or more later"

Moreover on a collective level, some discussed the competitive advantages of a good health care system for a country. For the target groups in particular, social services were seen as allowing them to be more independent and productive members of society.

Proponents of the second view would either restrict the full public funding of social services to those situations where it was medically necessary, or see the funding of social services as shared across the state, the individual and the community. To paraphrase one respondent, "If the service is the sort of thing you would only want if you were ill, then it should be considered medically necessary (and funded by government). If the house is dirty and not a safe place to provide home care, then you would want to pull in charitable organizations to do the cleaning. This doesn't mean that social services are not important but that we need to treat them differently." While others were of the view that social services should be cost shared based on income, with the state providing a safety net for those who could not afford them. As one stated, if one normally provides social services for oneself, the government should only pay for them if they are needed for health and one is unable to pay for it. For these respondents, social services were seen more as a life-style issue, and, therefore, a two-tiered system was permissible.

Those who saw the appropriate role of the state in health and social services as a philosophical and normative question recognized that these decisions can change and should be reviewed and decided on an ongoing basis by society. Emphasis on values such as equity and social solidarity means a larger role for the state in redistributing benefits according to need regardless of income; i.e., a compassionate society should provide a minimum quality of life. Emphasis on individual liberty and vertical equity is likely to translate into less state involvement and the distribution of benefits according to means. Those who adopt a broader determinants of health approach see the distinction between broader social services and health related social services as meaningless. Because of the changing site of care from hospital to home, many saw that the need for this discussion (the appropriate role of government in paying for health and social services) as both essential and timely.

In such a discussion, many respondents felt that rather than rigidly defining a basket of health and social services that should be publicly funded, the definition should allow flexibility to match patient/client needs. Rather than slotting patients/clients into care slots, care packages should be tailored to their needs. As a result, providers should be allowed the discretion to prescribe any social service as long as it is essential for the health of particular clients and necessary for them to live independently in the community. Another respondent indicated that it is important that the funding for social services be sustained and that we should be more creative in how these services are funded or subsidized. We could for example, make accommodations in the tax system to provide better exemptions for dependent care.

While there was more or less consensus on the role of the state in financing health services, as is clear by the discussion above, experts were more divided in their views with

respect to social services. This distinction reflects differences in philosophical, political, and professional values, as well as the historical development of the system of care.

### **4.3 Barriers to the Provision of Seamless Care**

Respondents cited the current ways of funding of health and social services, the current organization of primary care, resistance of special interests, lack of good information systems and evaluation of outcomes, and lack of political will as the major barriers to seamless care.

#### **4.3.1 Current Ways of Funding and Administering Health and Social Services**

Most respondents saw the way we currently fund health and social services as a major barrier to the integration of health and social services and the seamless provision of care. With changing sites of care, the definition of medical necessity under the Canada Health Act severely restrains our ability to fund appropriate care. The practice of silo funding of primary care, hospital, community care, and pharmaceuticals, as in Ontario, promotes cost shifting and makes the reallocation of financial resources from one sector of care to another to match changing needs extremely difficult. Separate global budgets for hospital and community services not only encourages cost shifting from one institution to the other, but from governments to the individual. With single funding envelopes, the money saved from the closure of hospital beds could more easily be reallocated to the community. Silo funding structures also hinders providers from viewing the patient as a whole person with a complex set of needs, and impedes the ability to provide the most appropriate service. These barriers were seen as having a disproportionate effect on high need groups, such as the four target populations.

The separation of health and social services into different ministries further perpetuates the silos even within provinces with regional authorities. As one respondent explained, if regional authorities receive their budgets from two different sources, there is no reason to believe that the silos would break down. Moreover, if resources for physician services and drugs are not included in regional budgets, as is usually the case, even well-constructed regional budgets will have limited impact in planning services effectively.

As stated earlier, a couple of interviewees noted that rather than directly funding services, we could make more creative use of the tax system for subsidizing care. One respondent felt that changing demographics and the nature of the workforce will have a negative impact on civic involvement and the capacity of the extended family to provide support. Currently the tax system provides differential exemptions for various volunteer activities. We should revisit the nature of our tax exemptions to ensure that we encourage continued civic involvement in needed areas.

Some respondents stated that the practice of creating separate funding and delivery streams for our four target groups, such as people with mental illness, may in fact have the unintended effect of marginalizing these groups further. Moreover, because of the complexity of their conditions, people in the four groups often fall into more than one target group; e.g., frail seniors with dementia or chronic disabilities. An inability to place them in a particular target group may result in patients being treated inadequately, inappropriately, or not at all.

Others referred to the problem as being a system that is organized around providers and that funds providers rather than populations. As such we are constantly trying to match patient/client needs to services rather than services to needs. This further reinforces the view that patients are a collection of body parts and care is provided in a piecemeal fashion.

#### 4.3.2 Organization of Primary Care

Related to the concept of how we fund care is the issue of how we organize and fund primary care. Many respondents spoke of the continuation of fee-for-service funding of physicians as a real barrier to the integration of services and to a multidisciplinary approach to assessment and care. This form of remuneration rewards volume and curative approaches rather than continuity and prevention. The persistence of solo physician practice prevents around-the-clock care and forces patients to seek services from emergency wards and walk-in clinics as a stop gap or to do without care until the doctor's office re-opens in the morning. The lack of a single point of entry for the patient/client was also seen as emanating from the multiplicity of services and agencies that prevail because of the tendency towards solo practices. The four target groups were seen as more adversely affected by fee-for-service medical care than the general population because as high needs groups, they often require more provider time and a complex mix of services.

#### 4.3.3 Resistance of Special Interests

Special interests such as unions and professional and regulatory bodies were often seen as resisting the provision of seamless care or reform that would result in a continuum of care. The more comprehensive and flexible the reform, the more resistance that seems to be mounted. Most respondents did not find this at all surprising given that the primary *raison d'être* for these groups was to protect and promote the interests of their members, and not just those of the clients. These "guilds" were historically set up to create high fences, which would not allow an easy flow of professionals across them. Respondents were, however, also quick to remind that these interests have performed very valuable and needed functions: unions have raised wages and working conditions for their members, and professional and regulatory bodies have raised standards.

Others stated that reform that leads to seamless care is not necessarily what is resisted by special interests. Governments as guardians of multiple programs, other than health and social services, and other priorities, such as tax cutting and debt reduction, may also be seen as a form of special interest. Respondents indicated that many government health reforms mask other goals and agendas, such as cost cutting and cost shifting. As such, it is not surprising that reforms often meet with resistance by non-government special interests.

For professional interests, the motives behind their resistance were seen to be largely about money and power, and reforms that threaten either are likely to be opposed. Professional scopes of practice often inhibit the provision of care by the most appropriate and cost effective provider. Training silos maintain the isolation and uniqueness of professions, rather than promoting their commonalities. Given the lack of socialization into a new ethos of care, it is not surprising that reforms introducing more flexibility into scopes of practice, creating generic workers, or promoting multi-disciplinary teams meet with resistance. Moreover, reforms that upset the status quo are likely to receive more opposition by the profession at the top of the

hierarchy. For many, the dominance of the medical profession and the medical model in health care were seen as the largest impediments to reform. One respondent held the medical profession in Ontario responsible for preventing the development of integrated delivery systems. The non-integration of physicians into regional authorities in other provinces was also attributed to the profession's resistance.

Union interests enter when integration threatens to undercut their membership by either changing the content or scope of their members' jobs. Integration is often viewed as synonymous with downsizing and therefore the loss of jobs; or the introduction of generic workers and, therefore, the loss of wages. Reform is particularly hampered when there is a shortage of health human resources and unions resist the introduction of substitute workers. While the shortage of nurses has increased the power of this group according to some interviewees, it has also increased the talk in government policy circles of creating another category of worker. Not surprisingly, such reform has met with considerable opposition from the nursing profession. Given current wage disparities and working conditions between the institutional and community sector, any reform that shifts the work force from hospitals and LTC facilities to the home is also likely to be resisted.

The differential power of the diverse sectors in care, i.e. medical versus allied professions, health versus social, institutions versus the community, also hinders reform that is likely to lead to a redistribution of resources. Within this environment, recognition of the effectiveness of social services, and the appropriate funding balance between institutions and the community is harder to achieve. More generally, others spoke of the "culture of contempt" between health and social services and across services; that is, a lack of mutual respect for the ability and contributions of each to the care of individuals and populations.

The resistance of professional interests and unions to efforts that would lead to better integration and coordination was seen as having a greater impact on the four target groups precisely because they are, on the whole, higher users of care, and less able to promote their own interests. Because these groups were historically institutionalized in the past, the de-institutionalization movement and at the same time the inability of governments to shift resources and introduce community reforms have had adverse impacts on this particular group of clients. For example, the shift of resources to the community has not kept pace with the closure of beds resulting in unmet or under-met needs; the resistance to generic workers results in these clients being cared for by a number of different providers, reducing continuity of care providers.

Finally, consumer lobbies were also cited as another interest that may limit integration. Usually founded along group or disease lines, their interests tend to have a narrower focus and promote a targeted approach, which was not viewed as appropriate by many respondents.

#### 4.3.4 Information Systems and Evaluation of Outcomes

The lack of information systems and networks in health and social care was cited frequently as a barrier to integration. Respondents commented on the need for common, multidisciplinary assessment tools, access to professional guidelines, an accessible single medical record for each patient, and the evaluation of performance and outcomes to ensure that resources are allocated to effective care. Rather than producing report cards for sectors of care

such as hospital report cards which continues a silo mentality, one respondent recommended a report card for systems of care.

#### 4.3.5 Political Leadership/Will

Interviewees often commented on the lack of political leadership and will for meaningful reform. Politicians' responses to pressure from powerful interests often lead to inaction or to decisions that are neither efficient nor effective. Governments were viewed as not having provided a vision for a renewed system or the incentives to entice or motivate change. Respondents mentioned not only the need for incentives to get providers to go beyond their narrow interests but also the need for incentives to get clients/patients willing to accept care from the most appropriate provider other than physicians.

Governments were reported by some as being the largest and most intractable interest. The electoral cycle limits any meaningful change and promotes quick fixes and incremental change. Any reform that takes longer than a government's term to develop and implement is likely to be shunned. One respondent likened the inability of governments to plan over a longer period of time and undertake meaningful reform in the health sector to turning an ocean liner around. Another respondent commented that the approximate four year electoral cycle has created a political dance where governments retrench in the early years of their mandate in order to flow dollars before an election; a practice which does not promote effective planning or delivery of care.

#### 4.4 **Facilitators of Seamless Care**

Not surprisingly, the facilitators of a seamless system of care cited by respondents were the converse of the barriers and mirror respondents' comments on the attributes of an integrated system; one that would allow users to move with ease from one part of the system to another and from one point in time to another. To avoid repetition, they are merely listed as follows:

- funding reform - a single budget for health and social services, population-based funding, mapping services to needs, dollars attached to clients, a realignment of incentives, changing tax structure to provide incentives for volunteer work;
- primary care reform - multidisciplinary teams, single point of access, capitation funding;
- good information systems (for providers and patients) and common platforms (integrated medical records), information highways;
- evaluation of performance and outcomes, report cards;
- single entry and common assessments and referral systems;
- geographic and round-the-clock availability and adequacy of services;
- incentives for special interests to overcome resistance, and education of public;
- labour reform - addressing wage disparities and improving working conditions across sectors;
- modernizing training programs to teach collaboration and a multidisciplinary approach, and to promote mutual respect;
- re-examination of the scope of publicly funded services;

- leadership; and
- flexibility.

It is important to note that whether respondents approach the question from a positive point of view (facilitators) or a negative point of view (barriers), there is remarkable consistency in what they believe are required for a system that provides a seamless continuum of care.

## **4.5 Regionalization**

Because it came up as an issue in the four other sub-studies, respondents in this study were specifically asked whether regionalization has been a facilitator or barrier to the provision of seamless care. Their answers fell into three broad categories: those who think that regionalization is a step forward towards integration; those who feel there are elements of regionalization that hinder seamless care; and those who believe the verdict is still out because we have not evaluated the experiment.

### **4.5.1 Supporters**

Support for regionalization on the whole appeared to be more theoretical. Respondents indicated that local planning and funding of services should be more effective in meeting the needs of the local population. Furthermore, because of the smaller size of regions, the opportunities for innovation and experimentation were enhanced. Respondents indicated that the size of regions was a critical element for success. However, there was no consensus as to whether larger or smaller regions were more effective in meeting the needs of populations. Success of regionalization was seen as heavily dependent on the calibre of training provided to regional managers. Regions with good leadership tended to do better than those with less capable leaders. Finally, there were those who stated that regionalization alone cannot achieve integration; other mechanisms need to be in place to achieve linkages.

### **4.5.2 Detractors**

Those who believe that regionalization can impede continuity of care indicated that regions sometimes cannot overcome the silo mentality if resources are strongly invested in one element of the care sector, such as a hospital. In those situations, reallocation of resources to more effective or needed services may be discouraged by the stronger interests. One respondent commented that in many jurisdictions the CEOs of the regional boards have tended to be displaced hospital CEOs whose orientations have continued the bias towards acute medical care.

Cross regional variation in care provision, while perhaps responding to more local needs, can also lead to inequities. Patients/clients can be discouraged or prevented from obtaining service from a neighbouring region if their own does not provide the care. One respondent saw the lack of good resource allocation models for funding regions as a drawback. This respondent cited a recent study (Griffin, 2001), which indicated that regionalization may have a differential impact on tertiary care, such as pediatric hospitals. Within regional models, the delivery of specialized services depends on the boundaries, the size of the catchment area, and the incentives for/against 'cross-boundary' provision of services. Repatriation of secondary and tertiary level care to local levels could reduce both the clinical and economic viability of such services.

Another major limitation of regionalization was seen to be the exclusion of resources for physicians, drugs, and mental health care from the regional budget. However, although mental health is usually excluded from regional budgets, a number of respondents commented on the positive effect regionalization has had on services for the elderly, and a more neutral effect on people with disabilities.

Finally, some of the detractors were not sure if regionalization was the problem or whether the problem was due to inadequate budgets and limited capacity.

#### 4.5.3 Undecided

Many felt that because there is no single model across Canada, it is difficult to talk about the merits of regionalization. So much depends on how it is implemented in each province. As a number of respondents indicated district health authorities in Ontario have very little authority; regions in Alberta have more than those in Quebec. Some provinces bring together health and social services; others do not, while still others include education and justice. Respondents indicated that we have yet to evaluate the impacts of the various models.

### **4.6 Appropriate Structures for Health and Social Services**

When asked how health and social services should be structured to maximize the most appropriate care a client receives and the best outcome, respondents' answers ranged from formal structures to informal linkages.

#### 4.6.1 Funding Mechanisms

##### *4.6.1.1 Regionalization/Decentralization*

Many respondents favoured the decentralization of resource allocation and delivery of services to the local level, particularly for primary care. Local levels would be responsible for meeting the needs of a defined geographic population and funding would be based on capitation. Alberta and Saskatchewan's regional authorities, Quebec's CLSCs, and Integrated Health Systems as recommended by Ontario's Health Restructuring Commission were cited as examples. While policy and standard setting should be the purview of provincial and national governments, governments should get out of the business of managing direct service provision. Many saw serious fragmentation as endemic in Ontario, which has not embraced regionalization.

As stated earlier, many felt that the way we currently fund regions limits integration because physicians and therefore, primary care, and pharmaceuticals are excluded and managed directly by the province. All who favoured regionalization saw the omission of physicians from the regional budget as limiting the effectiveness of this structure.

The creation of a single budget for health and social services at the regional level was seen as one way of ensuring that providers are accountable for the health of the whole person and entire populations. However, a number of respondents cautioned that placing the financial resources for health and social services into one budget may have adverse effects for social

services. Medical care, with the stronger and more vocal lobbies, could consume all the dollars. Global funding with protected targeted budgets for certain services was offered as a way of alleviating this problem.

Needs-based population funding was viewed as a way of ensuring that providers put more emphasis on prevention. One respondent, however, cautioned that the regionalization of budgets depends heavily on the algorithm used for needs-based funding and the ways of effectively dealing with risk selection. While these models seem to work in theory, it is unclear that they do in practice. This interviewee was concerned that models heavily favour the healthy and not the sick, and thereby, have a greater negative impact on the four target populations.

Finally, others suggested other funding mechanisms, such as, per capita funding for primary care, performance-based funding for hospitals and LTC facilities, so that outcomes and not just volume determines funding, and tax based incentives to support informal care.

#### *4.6.1.2 Primary Care Reform*

Respondents strongly favoured primary care reform that integrates primary health care, social services, pharmaceuticals and home and community care. A good primary care platform was seen as the best way of deferring and preventing the large cost care items. Replacing fee-for-service reimbursement with salary was also viewed as necessary to remove the perverse incentives in the current system. Finally, respondents favoured a multi-disciplinary mix of providers who would share the responsibility for the care of the whole individual as well as the financial risk associated with it.

#### *4.6.1.3 Money Follows the Client*

Some recommended a funding mechanism such that financial resources were tied to the client rather than the program; resources being dependent on attracting clients.

#### 4.6.2 Single Point of Entry

Many respondents favoured a single point of entry into the system which was seen as particularly important for the four target groups who, because of their conditions, are less able of finding the appropriate care and navigating the system.

#### 4.6.3 Case Management

Case management was usually recommended along with a single access point. A single and complete assessment of all the client's needs, referral to or arranging of services for the client, and the continual monitoring of the client and subsequent adjustments to the service plan were viewed as the essential features of case management that would contribute to seamless, coordinated care.

#### 4.6.4 Single Ministry

Putting health and social services under one ministerial umbrella was viewed as one way of eliminating silo mentalities and turf battles, and enhancing coordination and rationalization of resources. Some, however, cautioned that putting the two sets of responsibilities in one government ministry depended on the size of the province; it was clearly feasible in a province such as P.E.I. but less so in Ontario. However, one respondent argued that amalgamating health and social services into one ministry even in a province the size of Ontario is possible as long as the government got out of the business of managing and providing services. If the government's role was limited to governance, i.e., making policies and setting and monitoring standards, it was do-able.

#### 4.6.5 Linkages/Coordination

Some respondents were of the view that you did not need formal structures, but rather good linkages amongst providers and provider agencies. Linkages could take the form of interagency agreements, good referral systems, sharing of medical records, electronic networks, inventories of services and providers, sharing of some resources. While there was some value in co-locating services especially in urban areas, shared governance or administration was not seen as necessary. Some of these proponents suggested that we have to get beyond thinking in geographic boxes and of being all things to all people in that area. The problems associated with the separation of health and social services within government could be alleviated through mechanisms that assisted coordination across ministries, such as inter-ministerial committees, and through the development of common goals and principles.

#### 4.6.6 Labour Practices

Labour unrest and shortages were viewed as having negative impacts on integration and on health outcomes. A few respondents talked about the need to reduce worker turnover, particularly in community services. Related to this was the need for governments to address wage disparities and working conditions for health and social service providers. Practices that promoted the continuity of individual providers were seen as particularly important for vulnerable clients such as those in the four target populations. Providers with multiple skills were cited as yet another way to improve continuity through the sheer reduction of the number of providers a patient sees.

#### 4.6.7 Target Population Approach

Because of the complexity of their needs and the intensity of their utilization, a one size fits all model was not thought to be suitable for the four target populations. As a result, one respondent recommended a programmatic approach for people with complex chronic conditions. However, as stated earlier, one limitation of such a model was the creation of a different set of silos based on patient conditions. The competition for resources across silos based on sectors of care would likely also play out in silos based on illness or condition. Because people may fall into more than one target group, it was suggested that a more appropriate distinction would be acute (episodic) versus chronic (continuing) care.

#### 4.6.8 One Size Does Not Fit All

Most respondents were clear that a single model or structure was not likely to work for all regions or all population groups. Under the guidance of provincial standards, most advocated flexibility at the local level to organize, allocate resources, and deliver services.

### 4.7 **Major Success Factors to Seamless Care**

There was good consensus amongst the respondents as to what are the three or four major factors to achieving better integrated and seamless care.

#### 4.7.1 Funding

Most agreed that the current reimbursement structure for physicians needed to shift away from fee-for-service. Some form of population-based funding was suggested as a mechanism

- that could incorporate and allow for reallocation of resources for a range of health and social services;
- that could adjust funding for high-need groups;
- that could provide incentives for collaborative approaches to care; and
- that could eliminated silo mentalities.

Many recommended giving authority for the allocation of funds and delivery of services to the local level. Given the changing site of care and innovations in medical technology, some also argued for a full public discussion and re-examination of what should be considered publicly funded necessary services to stop the creeping privatization of care. If people cannot afford to obtain necessary care, it matters little if the system is integrated.

#### 4.7.2 Primary Care Reform

Once again, most recommended that governments get on with primary care reform. The elements of primary care reform that were mentioned most often included:

- group practices with multidisciplinary teams;
- capitated funding which covered both health and social services;
- attaching fiscal and clinical responsibility to the group for the health of a defined population; and
- the provision of around the clock care.

However, for primary care reform to work we need to change the way we train our providers to promote within training modalities a collaborative team approach and mutual respect. Finally, it was recommended that the federal government provide federal dollars to provinces that were specifically targeted to the implementation of primary care reform.

#### 4.7.3 Single Access and Common Assessments

A single point of entry, a single common assessment, and care coordinated and monitored by case managers were viewed as essential for patients to move through a complex care system with ease.

#### 4.7.4 Information Systems

Respondents urged the development of information systems

- that collected routine, standardized data;
- that incorporated a single medical record for a given patient accessible by providers;
- that included and provided access to professional and clinical guidelines; and
- that provided better information for consumers to allow them to become part of the team making decisions about their care, and to understand better the strengths and weaknesses of the system.

#### 4.7.5 Measurement of Performance and Outcomes

Given the mounting evidence that points to the provision of unnecessary care and care that is not effective, respondents were resolute on the need to evaluate both the performance and outcomes of care. Ineffective deployment of resources in a public plan leads to increased waiting lists and unmet needs. Report cards were suggested as one way to develop more of a service relationship between consumers and providers, and to increase provider accountability. While sector-level report cards are useful, system-wide report cards (regional and provincial levels) are essential to evaluate the extent and success of integration and the seamless provision of care. Finally, there is a need for the development of population health indicators beyond the traditional “disease” indicators that are used to measure the health of populations.

#### 4.7.7 One Size Fits All?

Respondents were divided on whether the four target groups should be dealt with in separate programs. While some saw special programs for the elderly, such as Edmonton’s CHOICE or Quebec’s SIPA projects, as beneficial, others were of the opinion that these further marginalized and stigmatized already vulnerable groups. These respondents believed that a reformed and integrated system for the general population would by extension be more beneficial to the four groups. Conversely, because these four groups have a complex set of needs, are higher risk populations, and utilize more services, some respondents felt that a one size fits all approach would result in inadequate care and unmet needs. Those who had expertise in macro system design tended to be more supportive of a generic approach, while those whose research focused on one or more of these four groups favoured a targeted approach.

#### 4.7.6 Political Leadership and Will

Finally, the bottom line for most respondents was the need for governments to show leadership by

- defining a clear set of goals and objectives to guide change,
- developing a strategy for change which includes evaluation of reform,
- providing incentives for special interests to buy into these goals, and
- ultimately having the will to make the hard decisions.

### 5. CONCLUSIONS

Table 2 provides a summary of the attributes of a system of care, the barriers and facilitators of seamless care, and the key success factors necessary for creating a continuous system of care that were identified by respondents. In reviewing the factors that emanated from questions posed from different points of view, a few key ones emerge. They include primary care reform which includes multi-disciplinary care around the clock; good information systems; single point of entry; evaluation of performance and outcomes; incentives for getting special interests on board; and political will to make the necessary changes.

Respondents in this study saw the four target populations as benefiting most from a seamless continuum of care, largely because they were heavier users of the system, more vulnerable and more marginalized, and therefore, in need of more assistance than the general population. While some respondents were comfortable speaking about the needs of the four target groups, others were less so, restricting their remarks to the general population. Those who conducted research specific to the four population groups, while still somewhat hesitant, were more willing to make systems-level recommendations for their respective groups; whereas, those who would be considered broad policy researchers felt more at ease addressing their comments to the reform of the system for the general population. Consequently, there was no emerging consensus on the recommendations for system reform specifically for these population. As one respondent indicated we need to understand the experiences of the four target groups before deciding on a targeted or general approach, underlining the importance of the Health Canada project, *An Analysis of the Interfaces along the Continuum of Care*. Getting it right for these individuals would likely respond to the less demanding needs of the entire population.

**Table 2: Summary of System Attributes, Barriers, Facilitators, and Key Success Factors for Continuity of Care**

	Attributes of a System		Barriers	Facilitators	Key Success Factors
	Patient Perspective	Provider Perspective			
Single point of entry	x	x		x	x
Information systems: consistency, elimination of duplication	x	x	x	x	x
Team approach/multi-disciplinary care - primary care reform	x	x	x	x	x
Integration/coordination, case management	x			x	x
Comprehensive-ness: full range of services	x			x	
Responsiveness/ accountability: 24-7 care; evaluation of performance/ outcomes; development of population health indicators; system-level report cards	x	x	x	x	x
Patient empowerment	x				
Funding mechanisms: silos; fee for service; tax incentives			x	x	x
Special interests			x	x	x
Political leadership/will			x	x	x
Labour reform				x	
Modernizing training				x	
Flexibility				x	

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## **Appendix 1: Invitation to Key Informants to Participate in Interviews**

Dear :

Federal, Provincial and Territorial Ministries of Health, and Health and Social Services, have expressed a need to have more information about issues related to what makes for an integrated continuum, or system, of care delivery for a number of population groups including seniors, adults with disabilities, adults with mental health concerns, and children. Health Canada has recently funded Hollander Analytical Services in Victoria, B.C. to oversee the Analysis of Interfaces Along the Continuum of Care study which will examine this issue directly.

The study is being conducted by four teams. Each team is responsible for collecting information on care delivery for one of the specified populations across Canada. Input has been sought from policy/decision makers (e.g. federal, provincial, territorial officials) as well as individuals who are affected by the services (e.g., service providers, consumer groups).

The final report, scheduled to be completed by August 1, will include findings on each of the populations under investigation. It will also contain an analysis of the following: new or reformulated conceptual models; in depth discussion of the blockages to effective service delivery and the opportunities for more integrated care provision; and analysis of the transferability or commonality of findings across jurisdictions.

We would very much appreciate conducting a telephone interview with you for this project given your broad knowledge of the health care system in Canada. The interview which will take about an hour needs to be conducted in the first three weeks of May, and will take place at a time convenient for you. Naturally, participation in this study is totally voluntary and you can choose, at any time, not to participate in the interview or not to answer any specific question or questions.

Should you choose to participate we shall ask you general questions about how to promote seamless care for recipients, what you think are the major issues which inhibit and promote greater integration, and how to improve the integration of health and social services to the above four population groups in particular. We shall also ask you to reflect on some of the early findings of our study.

If you are willing to participate, would you please email me (pat.baranek@utoronto.ca) back your availability by indicating your three preferred times (date and time) between Monday, April 30 and Friday, May 18 for an interview, and the telephone number at which I can reach you. Please note that week-ends and evenings are also available for interviews if those times are more convenient for you. I will confirm the date and time.

Please do not hesitate to contact me should you have any questions. Thank you for your consideration. I look forward to your response.

Sincerely,

Pat Baranek



## **Appendix 2: Preamble and Interview Schedule**

### **ANALYSIS OF INTERFACES ALONG THE CONTINUUM OF CARE**

Federal, Provincial and Territorial Ministries of Health, and Health and Social Services, have expressed a need to have more information about issues related to what makes for an integrated continuum, or system, of care delivery for a number of population groups including seniors, adults with disabilities, adults with mental health concerns, and children. Health Canada has recently funded Hollander Analytical Services in Victoria, B.C. to oversee the Analysis of Interfaces Along the Continuum of Care study which will examine this issue directly.

The study is being conducted by four teams. Each team is responsible for collecting information on care delivery for one of the specified populations across Canada. Input has been sought from policy/decision makers (e.g. federal, provincial, territorial officials) as well as individuals who are affected by the services (e.g., service providers, consumer groups).

Study information was collected using phone surveys and focus groups. The phone interviews examined the use of health related services by the population of interest, the perception of how well these services are integrated into a system of service delivery, how well they are linked to other parts of the health system, and how well they are linked to services outside of the health system. We also asked respondents what they thought made an effective system of service delivery, what they see as blockages or impediments to an effective system of service delivery, and what suggestions they had for improving the system of service delivery. The focus groups obtained information from consumers, families, and consumer groups regarding service delivery.

We have found that, structurally, the service delivery systems for the four population groups have a number of similarities. There is a broad community base of services, there is a residential service component and there may be speciality services in acute care hospitals. Thus, the services for the four groups appear to include the full range of services in our health and social system. We have also found that there seems to be less of a consciousness of a system of care for each of the four groups than anticipated. Respondents spoke of various factors that impeded the receipt of seamless needed care:

- geographic inequities in the availability of a full range of services;
- vast distances to access care;
- under-funding of the system;
- waiting lists and the lack of an overall human resource strategy;
- multiple points of entry;
- multiple assessments and the lack of a comprehensive assessment;
- inconsistencies in eligibility requirements;
- an emphasis on medical rather than social support services;
- ability to choose the type of service or service provider (in particular for people living with a disability);
- funding be tied to organizations or providers and not to the needs of the care recipient (i.e., the recipient must follow the money);
- lack of communication among providers, between and across sectors of care;
- “turf” battles among ministries, among providers;
- the lack of options in the type of care (e.g., home care vs. residential care vs. social housing);
- and the individual financial burden associated with some care.

The final report, scheduled to be completed by August 1, will include findings on each of the populations under investigation. It will also contain an analysis of the findings which will include: new or reformulated conceptual models; in depth discussion of the blockages to effective service delivery and the opportunities for more integrated care provision; and analysis of the transferability or commonality of findings across jurisdictions. The results of the study will provide federal, provincial, and territorial decision makers with the evidence they need to improve the way health services are organized and delivered across Canada.

We would very much appreciate conducting an interview with you for this project given your broad knowledge of the health care system in Canada. Naturally, participation in this study is totally voluntary and you can choose, at any time, not to participate in the interview or not to answer any specific question or questions. The interview will take about one hour.

Should you choose to participate we shall ask you general questions about how to promote seamless care for recipients, what you think are the major issues which inhibit and promote greater integration, and how to improve the integration of health and social services to the above four population groups in particular. We shall also ask you to reflect on some of the early findings of our study.

## **INTERVIEW SCHEDULE**

### **How to Recognize a System of Care**

1. What factors do you think contribute to people perceiving that a set of health and social services constitutes a system of care and is recognized as a system of care?

### **The Role of Social Supports in Health Care**

2. Many of the services which are helpful for clients in our four population groups are more supportive “social” services which may not be fully funded (there may be an income test or user fees), or not funded by the health system at all. In our field work, and our literature review, we have found references to a conflict or tension between the medical and social models of care.
  - a) Could you comment on the appropriate role of social services and programs such as supportive housing, homemakers, meal programs, transportation and community services in the provision of health care to
    - i) the four groups in our study
    - ii) the population in general.
  - b) What do you think is the appropriate role of the state versus the role of individuals and families in paying for:
    - i) health services, and
    - ii) health-related social services?
  - c) How should health and social services be structured to maximize the most appropriate care a client receives and the best outcomes?

### **Silos and Special Interests and the Continuity of Care**

3. In our study to date we have found that special interests, turf protection and the organization of service responsibilities in provincial governments and/or Regional Health Authorities/District Health Councils tend to inhibit the provision of seamless care by shifting the focus of the system away from the care recipient.
  - a) To what extent do the ways we currently administer and fund health services contribute to or inhibit the provision of seamless care to the client?
    - i) our four population groups.
    - ii) the population.
  - b) To what extent do special interests (e.g., unions, professional/regulatory bodies) help or hinder the development of integrated systems of care.
    - i) our four population groups
    - ii) the population.
  - c) To what extent has regionalization enhanced, or detracted from, the provision of seamless care for care recipients in
    - i) our four population groups
    - ii) the population.

### **Barriers to Continuity of Care**

4. Overall, what do you think are the three or four major issues inhibiting the development of integrated and seamless systems of care delivery for
  - i) our four population groups
  - ii) the population

### **Facilitators of Continuity of Care**

5. How can we best promote a continuum of care in health and social services in Canada? That is, how can we best link the various levels and sectors of care?
6. What supports in other sectors are essential to the success of service delivery systems for our four populations? What policy options exist or need to be put in place to strengthen the interfaces between these sectors and the broader health and social service systems.
7. Overall, what do you think are the three or four major steps, or critical success factors, which would lead to integrated and seamless systems of care delivery for
  - i) our four population groups
  - ii) the population