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Divergent modes of integration: the Canadian way

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Abstract

Introduction: The paper highlights key trajectories and outcomes of the recent policy developments toward integrated health care delivery systems in Quebec and Ontario in the primary care sector and in the development of regional networks of health and social services. It particularly explores how policy legacies, interests and cultures may be mitigated to develop and sustain different models of integrated health care that are pertinent to the local contexts.

Policy developments: In Quebec, three decades of iterative developments in health and social services evolved in 2005 into integrated centres for health and social services at the local levels (CSSSSs). Four integrated university-based health care networks provide ultra-specialised services. Family Medicine Groups and network clinics are designed to enhance access and continuity of care. Ontario's Family Health Teams (2004) constitute an innovative public funding for private delivery model that is set up to enhance the capacity of primary care and to facilitate patient-based care. Ontario's Local Health Integration Networks (LHINs) with autonomous boards of provider organisations are intended to coordinate and integrate care.

Conclusion: Integration strategies in Quebec and Ontario yield clinical autonomy and power to physicians while simultaneously making them key partners in change. Contextual factors combined with increased and varied forms of physician remunerations and incentives mitigated some of the challenges from policy legacies, interests and cultures. Virtual partnerships and accountability agreements between providers promise positive but gradual movement toward integrated health service systems.

Keywords

Integrated care, integrated health care delivery, primary care, regionalised health services, integrated care models

Introduction

In the past few decades, there has been growing interest in integrated delivery systems in Canada and other countries [1–3]. Integrated delivery systems are occasionally referred to as integrated health networks, integrated service networks, organised service delivery, and integrated care organisation

[4, 5]. Integrated delivery systems include a variety of techniques, processes, and structures that bring together different providers formally and/or informally to promote the coordination and continuum of care and achieve system efficiencies [6]. The organisation of integrated delivery systems can be understood by examining different dimension of integration, including functional or administrative, clinical or coordination

of services, professional or physician integration, and organisational or relationships between different organisations [1, 7, 8]. In addition, normative integration (shared values and organisational and professional cultures) and systemic integration (alignment of policies and incentives at the organisational level) are essential in promoting effective coordination and integration [7, 9, 10]. In practice, integrated delivery systems are a hybrid of different dimensions of integration.

The literature suggests that the organisation and delivery of integrated health systems is inherently linked to the dynamics of myriad interrelated factors at the national and local levels [11–13]. These contexts include policy legacies and cultures that are seen as self-perpetuating, indicative of ‘path dependencies’ [14, 15]. Policy legacies and processes are mediated and reinforced through a variety of mechanisms, such as institutions, financial levers and incentives, organisational culture, state and professional actors, and the general public. This point was illustrated in a seminal neo-institutional analysis of the United States, Britain, and Canada by Tuohy [15]. Recognition of the complexity of developing integrated care has prompted some, but limited, work in this area [16, 17]. The limited contribution to the literature underscores the need for further research to understand how these challenges are negotiated in practices in various countries to develop and sustain integrated health delivery systems.

Canada, with its public funding for private delivery of health care, provides many interesting sites for understanding the complexities of developing integrated delivery systems. Several integrated care strategies, processes and models have emerged across Canada, particularly since 2000. This paper highlights key trajectories and outcomes of the recent policy developments toward integrated health care delivery systems in Quebec and Ontario in the primary care sector and in the development of local/regional networks of health and social services. It specifically explores how the various factors that define, enhance or limit integrated health delivery systems may be mitigated to develop different models of integrated health care that are pertinent to the local contexts. Quebec and Ontario are Canada’s most populated provinces. Quebec began to implement a regional structure to coordinate and integrate health and social services as early as the 1970s; these initiatives have since undergone iterative changes, with the most recent reforms occurring in 2005. Ontario was the last province in Canada to regionalise health care in 2005. Both provinces have also established multidisciplinary team-based practices in primary care where public policies provide incentives to private group practices in primary care.

Methods

This article is based on review of the international literature on integrated delivery systems and the various factors that influence their development and implementation. Searches were conducted in health and social science databases, including Medline, CINAHL, and Social Science Abstracts, and on the web sites of refereed journals, including *International Journal of Integrated Health Care*, *Health Policy*, and *Healthcare Quarterly and Healthcare Papers*. Search keywords included: integrated care; integrated delivery systems; integrated health networks; organised delivery systems; health service integration; and integrated care models. Since some valuable information about health care systems is also found beyond the peer-reviewed literature, a selective grey literature search was also conducted (e.g. Canadian, Ontario and Quebec government web sites, Canadian Health Services Research Foundation and health association web sites, and newsletters of the Ontario Hospital Association, Ontario Medical Association, Quebec ministry of health and social services, and regional health authorities). Given the paucity of peer-reviewed information, particularly on the recent developments in health integration in Ontario, these sources provide useful complementary information.

Health policy context in Canada

The policy legacy of the division of power as defined in the British North America Act (1867) influences the organisation and delivery of integrated health care systems across the country. Provinces and territories have jurisdiction over health policies and the structure of delivery systems. The federal government administers the Canada Health Act and transfers funds to provinces in compliance of their meeting the criteria in the Act. Constitutional spending powers and residual powers provide levers to the federal government to influence health policy at the provincial level. A key policy legacy that significantly influences the development of integrated health care system is Canada’s public insurance system established by legislation in 1957, 1966 (Medical Care Act 1966), and 1984. It is based on a concept of publicly funded and administered insurance that covers all ‘medically necessary’ hospital and physician services. Physicians are paid directly by provincial governments; their remunerations are negotiated with their respective medical professional associations. Hospitals in Canada are largely non-profit and about one-third of family physicians/general practitioners work in solo or small private practices [18]. During the developments leading to Medicare, in return for physicians’ agreement to work for fee-for-service in a single

payer (public) system, they retained clinical autonomy and control over the administration and location of their practices. In 1984, services were further fragmented and the culture of acute care reinforced when the Canada Health Act equated 'accessible' health care services with all 'medically necessary' hospital and physician services. Consequently, it excluded public insurance coverage of numerous services, including prescription drugs, dental care, home care, long-term care, and ambulance services. Prescriptions services are generally covered in all provinces for people who are over 65 or have special needs or receive welfare. Since health care is a provincial responsibility, there are variations in coverage across the provinces, with some services covered by public funding in one province but not in others.

Integrated delivery systems have been part of the planning and delivery of health services in most Canadian provinces since the 1970s [19], largely to address service fragmentation, system inefficiencies, and escalating costs. Various strategies were carried out by provincial governments; of these, the most fundamental was the establishment of regional health authorities in all provinces except Ontario. Regional health authorities were based on the principle of providing geographically-based coordinated and integrated services. These authorities lack key components of integrated delivery systems, such as integration of physicians and drugs in most provinces [20]. Many changes have been made to regionalised health services across Canada since their enactment, including the alignment of boundaries and consolidation or elimination of agencies. As yet, there is little evidence that regional health authorities are achieving effective service coordination and integration. Some progress has been made across Canada in promoting multidisciplinary primary care practices [21, 22]. Most provinces have also developed a variety of other integrated care strategies, including chronic disease prevention and management [23]. In sum, there is a momentum across Canada toward integrated delivery systems, but the process has only just begun.

Toward integrated delivery systems in Quebec

Over the years, increasing efforts have been made in Quebec to reinforce integrated health and social services and primary care. Starting in the 1970s, local community centres (CLSCs, *centres locaux de services communautaires*; n=170) and regional authorities were created. Local community centres provide clinical and social services, while developing community-based action [24]. Family physicians were

encouraged to practise in local community centres, but salary-based remuneration did not attract many physicians. Today, however, 12–28% of family physicians practise in local community centres, part time or full time [25]. The limited powers of the regional authorities of the 1970s were expanded in 1991 to include responsibilities for planning, financing, coordinating, and monitoring primary and specialised care and public health in their regions. Eighteen new public health regions replaced the 12 existing regional authorities. In the 1990s, health and social services, which are integrated in Quebec, were reorganised progressively into specific programs (e.g. elderly care, mental disorder, intellectual disability, public health). Quebec's ministry of health and social services retains authority over most health and social service areas such as: financial; resources; drugs (provincial plan coverage since 1997 for those without employer-based medication insurance); policy; and strategic functions [24].

Regional health and social service planning in the mid-1990s targeted cost reduction. Healthcare budgets were cut by 10%, resulting in the closure or merger of about half of the hospitals (long-term or acute) and mandatory retirement of physicians and nurses. However, significantly increased budgets post 2000 led to further movement towards integrated care, including reforms launched in 2005. Local community centres, which play a major role in promoting integrated care, consolidated their services during this period (number of staff almost tripled between 1991 and 2001 [26]). These centres provide multidisciplinary primary care and are responsible for most care coordination (as a bridge between hospitals and community-based agencies). The rationalisation of hospitals also facilitated integration of care as the number of organisations that were part of the care continuum was considerably reduced. Concurrently, major integrated care network initiatives were implemented through the federal Health Transition Fund (1997–2001), such as projects for the elderly—for example, SIPA (*Système intégré de services aux personnes âgées fragiles*) and *Bois-Francs*, which was led by the Program for Research to Integrate Services for the Maintenance of Autonomy (PRISMA)—and patients with diabetes and cancer. These initiatives stimulated innovations in the system and the sharing of best practices in care continuity [27, 28]. These events paved the way for reforms launched in 2005.

Current reforms in Quebec [29, 30] are designed to reinforce primary care, improve social service and health care integration and their efficiency, and respond more effectively to increasing healthcare demand. To enhance coordination and integration, local community centres, acute hospitals (CHSGS, *Centres hospitaliers de soins généraux et spécialisés*)

and long-term hospitals were merged into 95 health and social services centres (CSSS, *Centres de santé et de services sociaux*). In addition, large university-affiliated hospitals (CHU, *Centres hospitaliers universitaires* or health institutes) were integrated into four university-based health-care networks (RUIS, *réseaux universitaires intégrés de services*). Each RUIS centre offers ultra-specialised care, coordinates training and research, and provides coverage for part of the province's 18 regional health authorities. The health and social service centres are responsible for planning and coordinating all health and social services in their respective local networks (i.e. CSSS territory) and for collaborating with their health and social network partners (family physicians, pharmacologists, rehabilitation centres, and community-based agencies). If services are unavailable in their local network (e.g. specialised care), they must enter into agreements with other regional providers. Regional authorities are now mainly responsible for supporting and coordinating their local networks, and monitoring network and service performance in their territory. Emphasis has been placed on accountability, implementation of best practices, and creating electronic clinical records [30, 31].

Family Medicine Groups (n=200) and network clinics (n=40), covering about 20% of the population in Quebec, have also been established in the context of the current reforms. These are designed to reinforce access and continuity of care. Family Medicine Groups have patient rostering and mandatory extended office hours (including 24/7 access for at-risk patients). Nurses work closely with family physicians in screening, follow-up, and prevention, particularly for chronic problems. Compared to Family Medicine Groups, network clinics are larger, their nurses do more liaison than follow-up work, and they usually collaborate more closely with laboratories for technical support [32]. Progressively, other psychosocial professionals are being called on to work with general practitioners at their clinics to extend psychosocial services (e.g. Integrated Family Medicine Groups).

As a result of health-care reforms, changes have been made to professional codes of practice in efforts to foster greater inter-disciplinary collaboration (Bills 90 and 21) and reduce the permissible number of professional unions in health organisations in order to facilitate employee management (Bill 30). In addition, in certain programs, policies designed to help achieve integrated care have been developed: they target specific practices or initiatives to be implemented [33]. Mental health and chronic care programs, both prioritised in current reforms, represent fine achievements following efforts to enhance primary care or integrated care. Much work, however, remains to be done.

Launched in 2005, mental healthcare reforms are designed to implement mental healthcare teams in health and social service centres (CSSS) and consolidate the coverage of assertive community treatment (ACT) and intensive case management (ICM) teams [29, 34]. The CSSS mental healthcare teams consist of psychosocial professionals (transferred mainly from hospitals) and general practitioners. They provide diverse forms of psychosocial intervention. A ratio of ACT and ICM teams per 100,000 inhabitants has been targeted, but the number of teams is well short of the targeted objectives [35]. Two main strategies are promoted for integrated care: (1) shared care, involving greater coordination among general practitioners, the CSSS mental health teams and psychiatrists; and (2) one-stop services in health and social service centres, which manage referrals between primary and psychiatric care and provide psychosocial services to complete care provided by general practitioners [29]. Quebec's shared care model calls for one psychiatrist per 50,000 inhabitants, who is encouraged to liaise with partners (CSSS mental health team and general practitioners) in his or her local network in efforts to provide adequate care for the treatment of mental disorders. Unfortunately, shared care is not yet well-developed (about only 50 psychiatrists enrolled), but should progress as an agreement between the psychiatry association and the government was reached in autumn 2009. One-stop services are in operation almost everywhere, but access to services is not optimal as long waiting time is very common [35].

As for the chronic care program, numerous initiatives have also recently been launched. In 2001, a provincial public health program plan was published. In 2007, a Quebec framework for preventing and managing chronic diseases was also published. Diverse funds and services were created or increased since 2000 to promote good health habits and better detection or prevention of diseases, for example, healthy villages, cities or schools; program 0-5-30 (healthy eating and exercise); breast cancer screening program; stop smoking program; and education centres for asthma and diabetes. Training and recruitment of nurse practitioners is also encouraged, but limited enrolled in the system (fewer than 100 are employed or studying). Increasingly, various initiatives are promoted to trace patient healthcare trajectory more effectively and develop multidisciplinary teams, including general practitioners to improve access and continuity of care for patients with chronic diseases. For instance, in the case of diabetes, nurses in some health and social service centres have been mandated to liaise with general practitioners to help them treat patients with the disease more effectively and to refer psychosocial resources or specialised care as needed. All of these initiatives also

imply more training for professionals and patients (i.e. self-care). Finally, regional and local plans have been implemented to promote public health [36].

Overall, current Quebec reforms are in the initial stage of implementation. Structural integration has largely been achieved (merger of organisations), but clinical integration has only just begun. Physician integration is slow, as most are still in solo practices. Close to 25% of the population in Quebec is without a family physician, and access and continuity of care in many programs or services remains a problem. Recent implementation of reforms has resulted in turnover of staff in health care organisations, impeding the change process toward integrated care. Regional health authorities and the provincial government have been criticised for inadequate support in the reorganisation of health and social service centres and local networks. Reforms are significantly hampered by vague implementation schemes and inadequate funding along with challenging objectives and constrained timelines [33, 37]. As reforms call for major changes within organisations and clinical roles (e.g. interdisciplinary practices, more bio-psycho-social interventions in the community), implementation is fraught with challenges. Networks characterised by strong leadership and a culture of consultation and innovation have generally fared well. Positive outcomes from Family Medicine Groups and network clinics are emerging; however, further improvements are needed [38]. Generally, while reforms have not yet achieved major results, a culture of collaboration and interdisciplinary teamwork is being fostered. There is greater emphasis on clinical care (team practice and best practices) and physician integration, which are both essential for full integration. With increased support from the government and regional authorities, these efforts should lead to integrated care, especially if regional authorities increasingly recruit and mobilise efficient clinical staff, including physicians [33, 35, 37]. Table 1 outlines key policy shifts towards integrated care in Quebec and Ontario.

Toward integrated health delivery systems: the Ontario way

The trajectory toward integrated care in Ontario is marked by targeted incremental reforms to separate sectors rather than system-wide integration. Since the advent of Medicare in 1966, changing the organisation and delivery of primary care has been a major preoccupation of the Ontario government; however, little attention was paid to the province's fragmented health and social services. Over the past few decades, the reforms in health care in Ontario occurred primarily to address cost concerns and access to services

issues [18]. The health reforms in the 1970s focused on primary care, and had the objective of moving family physicians out of fee-for-service and into capitation (e.g. Health Service Organisations), or global (e.g. Community Health Centres) funding models. Expansion of the Health Service expansion halted in the early 1990s since it appeared not to meet the government's cost-containment goals [39]. Community Health Centres (CHCs) were the first multidisciplinary team established in the primary care sector in Ontario. However, there was little interest from physicians in this model with salary scale compensation structure.

In the 1980s and the 1990s, fiscal constraints and escalating health care costs prompted major reforms that focused on primary care, hospitals and home care. In primary care the objective was to broaden teams of providers with nurse support largely through telephone advisory, and two models of primary care practices were set up (e.g. Comprehensive Health Organisations and Primary Care Networks). The health and social service sectors (e.g. mental health and addiction, home care, and long-term care residential services) remained largely fragmented. They were provided by a multitude of non-profit, charitable, for-profit, and public organisations. Mental health services had more emphasis on institutionalisation and short-term community-based initiatives despite reports indicating the need to de-institutionalise the sector. In 1993 the Ontario government developed an ambitious 10 year plan ('Putting People First') to direct investment from the institutional sector to the community in response to a series of reports that had emerged in the 1980s e.g. the Heseltine and Graham reports [40]. The implementation of this was stalled by cost-cutting measures of the subsequent government in the mid-1990s. Hospitals have traditionally represented the largest expenditure in the provincial health budget. Hospital integration, which was carried out from 1996 to 2000, resulted in closures, mergers, and, in some cases, reclassification as non-acute facilities. It also led to the closure or amalgamation of psychiatric hospitals and transfer of psychiatric beds to the general hospitals without adequate investment in the community sector for mental health and home care services. A notable positive move in mental health was in 1994 with the development of 'shared care' model in Southern Ontario [41]. This model is based on bringing mental health counselors and psychiatrists into the offices of family physicians. Since then, there has been considerable increase in this form of collaboration in other parts of Ontario.

To reduce service fragmentation and enhance the capacity of the home and long-term care sectors, in 1996, several disparate home care services were integrated into 43 regionalised Community Care Access Centres (reduced to 14 centres in 2007 to align with

Table 1. Key policy shifts towards integrated care in Quebec and Ontario

Time points	Quebec	Ontario
1970s	<ul style="list-style-type: none"> • Development of clinical and social service (CLSCs) • Creation of regional health authorities 	<ul style="list-style-type: none"> • Establishment of Health Service Organisations (HSOs) and Community Health Centres (CHCs)
1980s		<ul style="list-style-type: none"> • Formation of Comprehensive Health Organisations (CHOs) • Release of mental health reports: the Heseltine and Graham reports
1990s	<ul style="list-style-type: none"> • Expansion of regional health authorities powers • Rationalisation of hospitals • Development of special integrated care initiatives e.g. SIPA, Bois-Francs 	<ul style="list-style-type: none"> • Rationalisation of hospitals • Formation of Rural-Northern Physician Group and Primary Care Networks (PCNs) • Integration of home care services: Community Care Access Centres (CCACs) • Development of ‘Shared Care’ in mental health model in Southern Ontario
2000—current	<ul style="list-style-type: none"> • Launch of the current reforms (Bills 83, 90, 21, 30) • Creation of health and social service networks (95 CSSSs) • Formation of the university-based health-care networks (4 RUIS—ultra-specialised care networks) • Implementation of family medicine groups or network clinics • Launch of mental health reforms (primary mental health care and shared care, 2005–2010) • Development of increased initiatives toward chronic care prevention and treatment (e.g. provincial public health program in 2001, and framework for preventing and managing chronic diseases in 2007) 	<ul style="list-style-type: none"> • Formation of Family Health Networks, Family Health Groups (FHGs), Comprehensive Care Models (CCM), Family Health Teams and Family Health Organisations (FHOs) • Restructuring of integrated Cancer Care Ontario (CCO) • Increased investment in mental health, specifically community-based care • Development of chronic disease prevention and management framework; implementation of diabetes strategy • Increased investment in electronic health records • Establishment of Local Health Integration Networks (14 LHINs) • Increase in Nurse Practitioner-Led Clinics

Local Health Integration Networks). These centres provide professional home care services (e.g. nursing, physiotherapy) and personal support to eligible clients through purchase of services. They also coordinate placement into largely private (non-profit or municipal) long-term residential institutions. Various home support services, such as transportation and meals were excluded from integration; instead these services are provided by assorted public (e.g. municipal) and volunteer or non-profit providers who usually charge user fees geared to income. During the mid-2000, home care services were dominated by those who required acute-care services, while others such as those with chronic care received either reduced services, no services or were directed to long-term care [42]. Continuity of care was not achieved in this sector, as large numbers of home care and long-term care services remain beyond the centres mandate [43]. Other notable integration strategies in the 1990s included the development of network approaches to address disease or health issues e.g. the Cardiac Care Network [44] and integrated cancer care services through Cancer Care Ontario [23].

In the new millennium, persistent health system woes of access, physician shortages and escalating costs led to further primary care reforms in the early 2000s.

They focused largely on the inclusion of registered nurses and/or nurse practitioners in the physician team practices and blended form of remunerations such as fee-for-services, capitation and performance bonuses (e.g. Family Health Networks). Consolidation of some of the previous models into Family Health Groups also occurred during this period. Since 2004, the Ontario government has led a series of reforms to improve quality of care, increase access, and promote coordination and integration in health services. These include: increased emphasis on accountability and performance; implementation of information management and electronic health records; focus on chronic disease prevention and management; implementation of a wait time strategy for surgery and diagnostic imaging; increased medical school spaces; implementation of the ‘Aging at Home’ program for seniors; and the establishment of multidisciplinary Family Health Teams and Local Health Integration Networks (LHINs).

Family Health Teams (FHTs) that were set up in 2004 are one of the more innovative of primary care models in Ontario. They consist of a multidisciplinary team of health professionals, flexible governance model and blended methods of remunerations, including graded bonuses and salaries for allied professionals. Typically, these teams would include a number of allied profes-

sionals, such as social workers, mental health counsellors, dieticians, and pharmacists [45]. In practices, the composition of the team depends on the physician group members. These teams sign a contract with the Ontario Ministry of health to provide a basket of services (e.g. mental health, chronic disease management, and prevention), but variation in services based on the needs of the population are allowed. Currently, there are about 170 Family Health Teams, which serve about 2.1 million Ontarians. There are seven different models of primary care in Ontario at this time [46]. Collectively, these models engage about 63% of the family physicians/general practitioners registered with the Ontario Medical Association (based on 2008 information) [47]. There has also been an increase in Nurse Practitioner-Led Clinics (about 11 with an additional 14 to be implemented). Possible explanations of the proliferation of primary care models in Ontario include the absence of evaluations of the benefits of different models [48].

Some progress has been made in mental health services in Ontario during the past two decades, particularly after significant investments in 2004 by the government. These investments included targeting Intensive Case Management (ICM), Assertive Community Training (ACT), early intervention program and a variety of initiatives designed to move people with mental illness away from police and the criminal justice system. In 2001, a Collaborative Mental Health Care Network was established by the Ontario College of Family physicians that links family physicians with mental health professionals for case-by-case support or mentorship, and continuing education. This is consistent with the shared care or collaborative care approaches in mental health. An online provincial information and referral service for mental health services that is accessible 24/7 provides information and support to consumers, families and service providers. Although, Family Health Teams are to provide multidisciplinary care they are still in the early stages of implementation, and little is known about the composition of their team characteristics or collaboration efforts with mental health care professionals. More work still needs to be done to provide an integrated approach to mental health in Ontario, including in the areas of housing, education, employment, and in addressing regional disparities.

With regards to chronic diseases, the Ontario Ministry of Health and Long-term Care developed a Chronic Disease Prevention and Management Framework in 2007 that adapted Wagner's Chronic Care Model and British Columbia's Expanded Chronic Care Model [23]. It used diabetes as a starting point to implement the strategy, while trying to build infrastructures such as electronic health records and to reorganise primary

care toward multidisciplinary practices (e.g. Family Health Teams). The diabetes strategy focuses on education, prevention, timely and regular access to services, and effective treatment protocols and follow-ups. A provincial diabetes registry and portal that is in the early planning stages will provide information and education to patients, and enable health care professionals to have access to individual patient's health and diagnostic records. Evidence-based protocols have been developed for diabetes and congestive heart failure. Family physicians have been provided incentives to treat patients with chronic diseases. Other notable areas of management of chronic diseases are: establishment of nurse-practitioner clinics; inclusion of nurse practitioners in the primary care teams; tobacco control strategy; cancer screening for some cancers (e.g. colon cancer and breast screening programs), and health promotion programs (e.g. prevention of obesity, healthy eating programs in schools). Much work still remains to be done, particularly to build appropriate infrastructure and implement an integrated approach to managing and preventing a variety of chronic diseases.

The establishment of fourteen Local Health Integration Networks in 2006 was Ontario's first attempt to implement system-wide coordination and integration of health and social services. These networks have authority over local planning, funding, community engagement and facilitating integration within their region. They do not provide direct services except in the case of home care through Community Care Access Centres. Service providers within these networks (e.g. hospitals, Community Care Access Centres, Community Health Centres, and mental health institutions) maintain their individual or corporate identities (i.e. autonomous provider boards). Physicians, drugs, ambulatory care, and public health have not been incorporated, but the networks have the broader responsibility of coordinating and engaging with all key stakeholders to promote continuity of care. Since these networks have relatively modest discretionary funding, accountability agreements with providers could become a key lever to meet integration requirements, as defined in the performance agreements between the local health networks and the Ministry of health. However, the definition of 'integration' and the role of these networks in integration activities (LHINs) are unclear, and pose challenges for implementation.

As these local networks continue to evolve, there are many challenges that need to be addressed through policy and collaborative means to strengthen their capacity to promote coordination and integration at the regional level. The Ontario Ministry of Health and Long-term Care needs to go through a significant cultural change from that of a central manager to a strategic

facilitator of the health system. The Local Health Integration Networks have a considerable learning curve to become regional facilitating bodies for integration activities. In Leutz's continuum of care [49], these local health networks are at the coordination stage, a long way from achieving full integration. Another important challenge that these networks have is to attain cooperation from large hospitals to promote coordinated and integrated care. With the recent reforms, only partial structural integration has been achieved, and most of the current reforms are in the early stages of implementation. While recent developments constitute positive preliminary steps toward integrated delivery systems in Ontario, the health and social care delivery remains fragmented, and access to certain health services is uneven regionally. Key system enablers such as information management, integration of electronic health records, and health human resource workforce are some of the challenges that must be addressed if Ontario is to effectively implement integrated health delivery systems in future.

Discussion

Since 2000, Quebec and Ontario have taken major steps toward integrated health care delivery systems. Their example supports the contention by Wilsford [50] that while path dependency is a factor in influencing health care, there are ways in which this can be mediated. Context can be a significant factor in promoting reforms in an environment of policy stalemate. Post 2000, a configuration of factors emerged in both provinces that provided 'a window of opportunity' [15 p. 12] for changing the status quo and moving toward integrated delivery systems. These factors included a number of reports from various national and provincial commissions, initiatives stemming from the Primary Care Transition Fund, and an acknowledgement in policy and medical circles of the need to consider alternatives to current models of primary care. For example, in 2000, the chairs of the Ontario's five medical schools raised the issue of the lack of a holistic vision to primary care reforms, including appropriate incentives and investments (e.g. in education, infrastructure) for multidisciplinary team practices [51]. In Quebec, the Clair Commission's (2001) recommendation of the reorganisation of primary care practices as a key to improving continuity of care [52] was a driving force behind changes to recent reforms in health care. These emerging contexts combined with increased physician remunerations and diverse modes of incentives for multidisciplinary team practices helped to mitigate the primary care policy stalemate. In Ontario, for instance, the average net income of family physicians increased from \$180,000 in 2004 to \$250,000 in Family

Health Teams [53]. Recent reforms in primary care in Quebec and Ontario have followed international trends toward multidisciplinary team care (England, Spain, The Netherlands), rostering of patients (Denmark, England), capitation and blended payments (England, Denmark), and the integration of nurse practitioners in primary care (United States, The Netherlands).

The different trajectories toward integrated delivery systems in Quebec and Ontario illustrate the importance of mediation by the state, an important player in a Beveridge system, for promoting effective integration outcomes in a complex health policy environment. Since the 1970s, Quebec had continued to regionalise health and social services, but numerous factors had impeded effective service delivery and integration, including the lack of interest from the family physicians and lack of adequate investment by the government in regional structures [7, 54]. In Ontario, the government continued to focus on varied models of alternative primary care without a system-wide strategy to integrate health and social services. Its culture of centralisation was one of the key impediments to decentralisation and development of integrated regionalised health and social service delivery systems. The differences in the breadth and level of integration of health and social services in Quebec and Ontario are for the most part based on the selection of different policy instruments and on the cultural orientations of governments in these provinces. In Ontario 'regionalisation' does not involve devolution and integration of authority through corporate structure. 'Authority' for integration for Local Health Networks is through negotiations and service agreements for those organisations that the networks fund, and through virtual partnerships and collaborations with service providers that are outside of their direct mandate. The retention of autonomous boards of provider organisations within these networks have the potential to hamper integration, as dominant provider interest groups can become a force for steering these networks towards organisational (provider) interests. Autonomous boards may also hinder the shared values, common organisational culture, and collective commitment that are essential for normative integration. Conversely, integrating service providers with different cultures within a single organisation (such as in Quebec) does not in itself promote effective collaboration and integration outcomes. Complex issues are involved in shaping collaboration toward integration, involving players, interests, cultures, and power dynamics [10, 55, 56].

In Québec and Ontario, developments in favour of integrated delivery systems are still in their early stages. Integrating primary care into regionalised structures remains a challenge, which is similar to other Canadian provinces and many European countries. The

limited power of the virtual partnerships among the regional agencies in both the provinces is problematic in achieving full integration, albeit more so in Ontario than Quebec. To ensure successful progress towards full integration, adequate incentives, policies, tools, and strong leadership are needed in addition to supportive infrastructures. Nevertheless, the past several years has seen positive developments toward integrated health delivery systems in both these Canadian provinces.

Conclusion

Despite common policy legacies, both Quebec and Ontario have different trajectories and divergent implementation of integrated health care delivery systems. These examples illustrate that the challenges of policy legacies, interests, and cultures may be mitigated by local contextual factors. Additionally, varied modes of physician remunerations and increased incentives to promote change in entrenched primary care practices are also necessary in a single payer system. One key insight is that integration strategies in Quebec and Ontario yield clinical autonomy and power to physicians while simultaneously making them key partners in change. Virtual partnerships between providers, including physicians, promise positive but gradual

movement toward integrated health service systems. Accountability agreements for integrated outcomes and special incentives for specific kinds of care (i.e. in primary care practices for management of chronic care) are deemed as key levers for patient-centred care in Quebec and Ontario. Further research is recommended to understand how key strategies in the recent movement toward integrated care in Quebec and Ontario translate into practices over time. Additionally, research from various national and international jurisdictions would better inform insights from this paper.

Reviewers

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