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Care for Canada's frail elderly population: Fragmentation or integration?

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Abstract

BUDGET CONSTRAINTS, TECHNOLOGICAL ADVANCES and a growing elderly population have resulted in major reforms in health care systems across Canada. This has led to fewer and smaller acute care hospitals and increasing pressure on the primary care and continuing care networks. The present system of care for the frail elderly, who are particularly vulnerable, is characterized by fragmentation of services, negative incentives and the absence of accountability. This in turn leads to the inappropriate and costly use of health and social services, particularly in acute care hospitals and long-term care institutions. Canada needs to develop a publicly managed community-based system of primary care to provide integrated care for the frail elderly. The authors describe such a model, which would have clinical and financial responsibility for the full range of health and social services required by this population. This model would represent a major challenge and change for the existing system. Demonstration projects are needed to evaluate its cost-effectiveness and address issues raised by its introduction.

Résumé

LES CONTRAINTES BUDGÉTAIRES, LES PROGRÈS DE LA TECHNOLOGIE et le vieillissement de la population ont entraîné des réformes importantes des systèmes de soins de santé partout au Canada. Ces réformes ont réduit le nombre et la taille des hôpitaux de soins actifs et alourdi les pressions qui s'exercent sur les réseaux de soins primaires et de soins de longue durée. Le système actuel de soin des personnes âgées frêles, qui sont particulièrement vulnérables, est caractérisé par la fragmentation des services, des incitations négatives et l'absence d'imputabilité. Cette situation entraîne à son tour l'utilisation indue et coûteuse des services de santé et des services sociaux, particulièrement dans les hôpitaux de soins actifs et les établissements de soins de longue durée. Le Canada doit mettre au point un système communautaire de soins primaires géré par le secteur public afin de donner des soins intégrés aux personnes âgées frêles. Les auteurs décrivent un tel modèle qui assumerait la responsabilité clinique et financière de l'éventail complet des services de santé et des services sociaux dont cette population a besoin. Le modèle poserait un défi important au système actuel qu'il transformerait. Il faut lancer des projets témoins pour évaluer la rentabilité de ce modèle et répondre aux questions soulevées par sa mise en œuvre.

Budget constraints, technological advances and a growing elderly population have led to major health care reforms across Canada. The result is fewer and smaller acute care hospitals and increasing pressure on the primary care and continuing care networks.[1] It has also led to intense debate about and proposals on the reorganization of care and the redistribution of resources.[1]

The frail elderly comprise a particularly vulnerable group. They are typically

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more than 75 years old, have complex acute and chronic medical problems, as well as functional disabilities. Their social-support network is often overextended or at risk of breaking down.[2] These characteristics lead to increased use of medical and social resources, particularly hospital services.[3,4]

In 1995 the McGill University/Université de Montréal Research Group on Integrated Services for the Frail Elderly received funding from Quebec's Ministry of Health and Social Services to develop a model for a system of integrated care for the frail elderly (Système de services intégrés pour personnes âgées en perte d'antonomie [SIPA]). The Montreal Regional Health Board, with support of the ministry, is preparing a financial and administrative plan to implement a SIPA demonstration project. Several acute care hospitals and centres locaux de services communautaires (CLSCs) in the Montreal area have formally submitted joint requests to act as SIPA centres.[5] We will describe this model and the issues raised by its introduction.

Care for the frail elderly

In Canada, care for the frail elderly is characterized by fragmentation, lack of overall responsibility and accountability, and negative incentives. The results are costly and inappropriate use of acute care hospitals and long-term care institutions.[6]

Medical and hospital care are universally insured in Canada, but the funding and organization of community and institutional continuing care do not provide the same comprehensive coverage and vary between and within provinces.[7]

The responsibility for delivering services to the frail elderly currently lies with many agencies, jurisdictions and professionals: homecare and volunteer agencies, day centres, day hospitals, acute care and rehabilitation hospitals and long-term care institutions, as well as family and specialist physicians.[8] Since each institution is a distinct entity with its own funding mechanism, budget, jurisdiction and criteria for patient selection, services are not coordinated according to patient needs. The system's various components work in parallel and function within their own budgets, with distinct responsibilities that both overlap and leave important needs unmet.[9,10] No single institution with both clinical and financial responsibility is ultimately responsible and accountable for reducing the number of inappropriate hospital admissions and maintaining dependent elderly in the community or in the most appropriate setting.

Because of the universal and comprehensive characteristics of their mandate and funding, acute care hospitals are expected to resolve all medical and social problems.[11] Between 1961 and 1992, as per capita use of acute care hospitals decreased for all other age groups, there was a 23% increase in use by those older than 75.[12–14]

Many jurisdictions have responded by developing a single entry point, with case management provided for continuing care in the community and for admissions to long-term care institutions.[15] Although this coordination represents an important step toward reduced fragmentation and improved use of resources, there are still significant limitations, including the cleavage between medical and social care, acute and continuing care, and community and institutional care. Each agency continues to function autonomously in its own jurisdiction with its own budget.

In the US, evaluations of homecare projects have shown that it is not sufficient simply to "add on" case management and home care without fundamentally changing the delivery of care and the relationship between acute and long-term care.[16–18] Several integrated care programs for the frail elderly have already been evaluated; their emphasis is on case management with clinical and financial responsibility. Some projects with different levels of integration, particularly the Program of All-Inclusive Care for the Elderly (PACE)[19,20] and the Social Health Maintenance Organization (S/HMO) in the US,[21] the Darlington Project in the United Kingdom[22,23] and the Adel reform in Sweden[24,25] have demonstrated, to varying degrees, increased patient and family satisfaction, increased use of primary care and community resources (including alternative housing), decreased admission rates to hospitals and institutions, and improved cost-effectiveness.

In Canada the current situation highlights the need for the development of a system of integrated care for the frail elderly. It should have the following characteristics:

- be a community system based on primary care, which is responsible for the full range of health and social services;
- be responsible for care of a defined population;
- provide case management, with clinical responsibility for the entire range of services provided;
- be funded on a prepayment basis, based on capitation with financial responsibility for the full range of services; and
- be publicly managed, thus respecting the fundamental tenets of Canadian health care.

SIPA: a system of integrated care for the frail elderly

SIPA is a community-based primary care system based on a patient-focused model designed to meet the needs of the frail elderly and to assure comprehensive care, integration of all available services and continuity of care by

all professionals and institutions involved. It is responsible for primary and secondary medical and social services, prevention, rehabilitation, medication, technical aids and long-term care, but not for ultraspecialized services such as transplantation.

One SIPA centre would be responsible for the entire population of frail elderly in a given region. In Quebec this would correspond to the region currently covered by the CLSCs,[5] each of which has an elderly population of about 11 000 people, 20% to 25% of whom would be eligible for SIPA.[26] In other provinces the SIPA region could be defined according to existing communities or catchment areas.

SIPA would serve as a single entry point for all frail elderly, who are deemed eligible if they have severe disability in 1 of the following areas, or mild to moderate disability in 2: activities of daily living, instrumental activities of daily living (such as financial management or meal preparation), mobility, mental status or continence. The accompanying sidebar provides eligibility criteria that correspond to the profile of frail community-dwelling elderly.[26,27] All eligible elderly people would be registered in SIPA following evaluation. Although self-referral or referral by a health care professional would be allowed, there would be incentives for a SIPA centre to seek out eligible patients.

Clinical model

Within SIPA, care would be provided by an interdisciplinary team comprising health and social service professionals, including the person's family physician. The team would be responsible for evaluating patients' needs and planning and delivering services and its goal would be to use services and resources in the most appropriate and efficient way by employing evidence-based geriatric interventions.[28–31] SIPA uses a consolidated model of case management by organizing and providing most community services. For contracted services, including those obtained in an acute care hospital or long-term care institution, SIPA maintains its financial responsibility for costs incurred and shares the clinical responsibility.

The interdisciplinary team would attempt to identify and minimize a person's risk of functional decline and to minimize inappropriate use of acute and long-term care institutions. Consequently, SIPA would emphasize flexibility and rapidity in meeting patients' needs using community-based interventions such as alternative and assisted housing instead of hospital and institutional care.

Empowerment and choice

In the organization of services and in decisions regarding resource allocation, SIPA must respect the dignity and preferences of elderly people and their caregivers. This is particularly true concerning institutional care. Without placing the entire burden of home care on the family and other informal caregivers, SIPA must encourage family participation in care and in decisions affecting care.

Elderly people will be encouraged to remain patients of their family doctors or to choose the SIPA physician. In either case, a well-defined working agreement must be established between the primary care physician and the interdisciplinary team. SIPA would have to assure that the elderly person has a choice of care providers. When choosing consultants, hospitals and nursing homes, SIPA would have to consider the characteristics of its population and preferences of patients and their caregivers.

Elderly people would enroll in the SIPA centre within their territory. However, after a predetermined period they could request a transfer to a neighbouring SIPA centre.

Financing

Under SIPA, all public financing for health and social services would be integrated, and the new organization would be responsible for all costs incurred in providing services to the population it serves. Financial resources include funds currently distributed for the care of the target population to homecare organizations, acute care and rehabilitation hospitals, long-term care institutions and physicians, as well as funds for drugs. Based on existing provincial policies, SIPA would be able to ask patients to reimburse a portion of the cost of certain services.

A single SIPA budget would be based on the number of people enrolled, the socioeconomic and demographic

Who is eligible for admission to SIPA?

Patients with a score of –5 in 1 of the following domains, or –2 in 2 domains, are eligible for entry:

- Activities of daily living (ADL)
- Instrumental activities of daily living
- Incontinence
- Mental status
- Mobility

Each domain has 2 to 8 categories. For example, there are 5 categories in the ADL domain: eating, washing, dressing, grooming and use of the toilet. Within each category, the following scores are applied: 0 = completely independent, –0.5 = independent with difficulty, –1 = needs cuing or supervision and –2 = needs help.

characteristics of the elderly population within its territory, and the budget available from the regional health board or ministry.

SIPA would be responsible for the cost of all services it organizes as well as for services contracted to other professionals and institutions, such as primary care physicians, consultants and acute care hospitals. It would not be allowed to overrun its budget. All deficits would have to be reimbursed and any surplus would be reinvested in a reserve fund or in the development of services.

Governance

Because this model is a community-based integrated system, it would be logical that the ministry or regional health board give a community-based organization, such as a CLSC, organizational responsibility. Depending on the jurisdiction, this responsibility might be given to a consortium of public institutions, including hospitals. In any case, because of its clinical responsibilities and the nature of its financing, SIPA would have to seek the collaboration of its partners, in particular acute care hospitals and long-term care institutions, physicians and other professionals, and community organizations. As well, the program would have to be evaluated independently and regularly based on 3 criteria: (1) its impact on the elderly population within its territory, including its clientele; (2) the quality of care and services that it provides or contracts to provide; and (3) its administrative operations.

SIPA in the Canadian system of care

The SIPA model proposes important changes in the way health and social services are organized, delivered and financed. The introduction of this model within Canada's health care system raises important issues regarding quality of care, target population, patient choice and physician role.

Recently there has been increasing interest in capitation in Canada, either as a method of payment for physicians[32–36] or as a funding mechanism for proposed integrated systems of care.[37–41] The interest stems from the difficulties in controlling increasing costs and dissatisfaction with the fragmentation of care.

A system of care for the frail elderly that has full clinical responsibility based on capitation would be more likely to invest in prevention, rehabilitation and home services in order to decrease inappropriate and more expensive use of acute care hospitals.[42,43] Proactive intervention would be promoted to avoid adverse clinical effects and the increased costs of crisis intervention. The intensity of services allocated could be adjusted as the patient's condition changes.[44] Intensive home care, day centres and assisted housing may prevent or reduce costly emergency visits and long hospital stays, including those of patients in hospital beds awaiting placement.[45] Contrary to PACE and its Canadian demonstration project in Edmonton (Comprehensive home option of integrated care for the elderly, or CHOICE),[46] SIPA will include not only elderly people eligible for nursing-home entry but also frail elderly people with disabilities who need help to remain in the community and who may benefit from proactive intervention, prevention and rehabilitation.

As part of a publicly managed health care system, SIPA would be responsible to its board, the regional health board and the ministry. No profits would accrue to individuals or organizations. Reimbursement for physicians, other health care professionals and administrators would not be linked to the organization's performance. Therefore, they would not be a factor when determining a patient's care plan.

The evaluation of quality would be an essential component of this system. The SIPA model proposes ongoing evaluation of clinical care and administrative and financial activities based on an information system that is monitored not only internally but also by independent external groups.[47]

Quality is also ensured by patient empowerment. The proposed model introduces the notion of contestability: the elderly person can choose, within a certain framework, to be served by the SIPA centre in a neighbouring area.[48,49] The fact that patients can change centres and "carry with them" the capitated budget means that all SIPA centres would have to be responsive to their needs and provide quality care that is at least comparable with that in the neighbouring centre. It is this potential for portability that would influence the response of providers.[50]

The primary care physician would play a key role in the SIPA model and the elderly would be encouraged to remain with their primary care physician. Physicians in general, and primary care physicians in particular, find it difficult to assure continuity of care for the frail elderly. With the ability to mobilize community resources quickly and flexibly, including comanagement with the SIPA physician when necessary, SIPA would facilitate the work of the family physician. SIPA would also be responsible for physician payment; in keeping with blended-payment proposals from family medicine organizations,[34] the most feasible system would be to maintain fee-for-service payments and add sessional fees to account for the increased time needed to provide care for the frail elderly and their families, for home visits and for communication with the multidisciplinary team.

Conclusion

SIPA represents a major challenge and change to the

existing system of care. Before a major reform to the present system can be proposed, the issues raised in this paper need to be addressed. The next step, therefore, is to organize demonstration projects to develop the experience of integrated care in the Canadian context and to evaluate SIPA as an effective and cost-efficient model.

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References

1. National Forum on Health. *Canada health action: building on the legacy. Final report of the National Forum on Health, Synthesis reports and issues papers*. vol 1&2. Ottawa: Minister of Public Works and Government Services; 1997.
2. Thouez JP, Buissières Y, Chicoine N, Laroche P, Pampalon R. L'aide à domicile aux personnes âgées dépendantes de la région de Montréal: analyse secondaire de l'enquête Canadienne sur la Santé et les Limitations des Activités 1986–87. *Can J Aging* 1994;13:187-200.
3. Guralnik JM, Fried LP, Salive ME. Disability as a public health outcome in the aging population. *Annu Rev Public Health* 1996;17:25-46.
4. Novak M. *Aging and society: a Canadian perspective*. 3rd ed. Scarborough (ON): ITP Nelson; 1997. p. 141-67.
5. Bozzini L. Local community service centers (CLSCs) in Quebec: description, evaluation and perspective. *J Public Health Policy* 1988; autumn: 346-75.
6. Bergman H, Béland F, Lebel P, Contandripoulos AP, Brunelle Y, Kaufman T, et al, for the McGill University/Université de Montréal Research Group on Integrated Services for the Elderly. *Système de services intégrés pour personnes âgées en perte d'autonomie [SIPA]*. Québec: Direction générale de la planification et de l'évaluation, Ministère de la Santé et des Services sociaux du Québec; 1997.
7. Béland F, Shapiro E. Ten provinces in search of a long term care policy. *J Can Studies* 1993;28:166-90.
8. Clarfield AM, Bergman H. Medical home care services for the housebound elderly: a program description. *Can Med Assoc J* 1991;144:41-5.
9. Rochon J, Gélineau G, Barkun H, Bernatchez-Simard J, Bertrand R, Duplantie JP, et al. *Rapport de la Commission d'enquête sur les services de santé et les services sociaux*. Québec: Les publications du Québec; 1988.
10. Trahan L, Bélanger L, Bolduc M. *Une évaluation de la prestation de services dans les CLSC et les centres hospitaliers pour des services de qualité aux personnes âgées en perte d'autonomie*. [Collection études et analyses no 19]. Québec: Direction générale de la planification et de l'évaluation, Ministère de la Santé et des Services sociaux du Québec; 1993.
11. Bergman H, Béland F, Lebel P, Leibovich E, Contandriopoulos AP, Brunelle Y, et al. L'hôpital et le système de services intégrés pour personnes âgées en perte d'autonomie. *Ruptures : revue transdisciplinaire en santé* 1997;4(2):311-21.
12. Barer ML, Evans RG, Hertzman C. Avalanche or glacier? health care and the demographic rhetoric. *Can J Aging* 1995;14(2):193-224.
13. Levasseur M. *Evolution de la consommation de soins hospitaliers de courte durée par les personnes âgées : une mise à jour*. [Collection études et analyses no 27]. Québec: Direction générale de la planification et de l'évaluation, Ministère de la Santé et des Services sociaux du Québec; 1996.
14. Leibovich E, Bergman H, Béland F. Puzzling issue #3: Health care expenditures and the aging population in Canada. In: Hollander MJ, editor. *Report on five puzzling issues, and fact sheets, on Canadian health services in an international context*. Report prepared for the National Forum on Health. Ottawa: Minister of Public Works and Government Services; 1997. p. 48-67.
15. Hollander MJ, Pallan P. The British Columbia continuing care system: service delivery and resource planning. *Aging: Clin Exp Res* 1995;7(2):94-109.
16. Weissert WG, Hedrick SC. Lessons learned from research on effects of community-based long-term care. *J Am Geriatr Soc* 1994;42:348-53.
17. Hollander MJ. *The costs and cost effectiveness of continuing care services in Canada*. Ottawa: Queens's–University of Ottawa Economic Projects; 1994.
18. Shapiro E. There's no place like home. In: Deber RB, Thompson GG, editors. *Restructuring Canada's health services system — How do we get there from here?* Toronto: University of Toronto Press; 1995. p. 99-104.
19. Yordi CL, Waldman J. A consolidated model of long-term care: service utilization and cost impacts. *Gerontologist* 1985;25(4):389-97.
20. Eng C, Pedulla J, Eleazer P, McCann R, Fox N. Program of All-Inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. *J Am Geriatr Soc* 1997;45(2):223-32.
21. Kane RL, Kane RA, Finch M, Harrington C, Newcomer R, Miller N, et al. S/HMOs, the second generation: building on the experience of the first social health maintenance organization demonstrations. *J Am Geriatr Soc* 1997;45(1):101-7.
22. Challis D, Darton R, Johnson L, Stone M, Traske K. An evaluation of an alternative to long-stay hospital care for frail elderly patients: I. The model of care. *Age Ageing* 1991;20(4):236-44.
23. Challis D, Darton R, Johnson L, Stone M, Traske K. An evaluation of an alternative to long-stay hospital care for frail elderly patients: II. Costs and effectiveness. *Age Ageing* 1991;20(4):245-54.
24. Johansson L. *Swedish elder care in transition: results from an ongoing evaluation of legal reforms*. Paper presented at the 48th GSA meeting in Los Angeles; 1994 Nov 15–19. Stockholm: National Board of Health and Welfare; 1995.
25. Thorslund M, Parker M. Care of the elderly in the changing Swedish welfare state. In: Challis D, Davies B, Traske K, editors. *Community care: new agendas and challenges from the UK and overseas*. London (UK): British Society of Gerontology; 1994. p. 249-63.
26. Béland F. Le critère d'admissibilité au SIPA — une modification au SMAF. In: Bergman H, Béland F, Lebel P, Contandripoulos AP, Brunelle Y, Kaufman T, et al for the McGill University/Université de Montréal Research Group on Integrated Care for the Elderly. *Système de services intégrés pour personnes âgées en perte d'autonomie [SIPA]*. Québec: Direction générale de la planification et de l'évaluation, Ministère de la Santé et des Services sociaux du Québec; 1997; Appendix 7: p. 142-53.
27. Hébert R, Carrier R, Bilodeau A. The functional autonomy measurement system (SMAF [Système de mesure de l'autonomie fonctionnelle]): description and validation of an instrument for the measurements of handicaps. *Age Ageing* 1988;17:293-302.
28. Stuck AE, Aronow HU, Steiner A, Alessi CA, Bula CJ, Gold MN, et al. A trial of annual in-home comprehensive geriatric assessment of elderly people living in the community. *N Engl J Med* 1995;333:1184-9.
29. Tinetti ME, Baker DI, McAvey G, Claus EB, Garrett P, Gottschalk M, et al. A multifactorial intervention to reduce the risk of falling among elderly people living in the community. *N Engl J Med* 1994;331:821-7.
30. Rich MW, Beckham V, Wittenberg C, Leven CL, Freedland KE, Carney RM. A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. *N Engl J Med* 1995;333:1190-5.
31. Beck A, Scott J, Williams P, Robertson B, Jackson D, Gade G, et al. A randomized trial of group outpatient visits for chronically ill elderly HMO members: the cooperative health care clinic. *J Am Geriatr Soc* 1997;45(5):543-9.
32. Federal/Provincial/Territorial Advisory Committee on Health Services. *The Victoria report on physician remuneration — A model for the reorganization of primary care and the introduction of population-based funding* [working document]. The Committee; 1995.
33. Conseil médical du Québec. *Pour un mode mixte de rémunération des médecins de première ligne lié à l'inscription de la population* [avis 96-02]. Québec: Gouvernement du Québec, Bibliothèque nationale du Québec; 1996.
34. College of Family Physicians of Canada. *Managing change: the Family Medicine Group Practice Model* [Green Paper discussion document on primary health care reform in Canada]. Toronto: The College; 1995.
35. Millette B, Nasmith L, Grand'Maison P, Lamontagne R. Le rôle central du médecin de famille dans la réforme de la santé au Québec. *Médecin Québec* 1996;31(5):87-93.
36. Primary Care Reform Physician Advisory Group. *Primary care reform: a strategy for stability* [discussion paper]. Toronto: Ontario Medical Association; 1996.
37. Leatt P. Integrated delivery systems: Has their time come in Canada? *Can Med Assoc J* 1996;154(6):803-9.
38. Brunelle Y, Ouellet D, Montreuil S. *Des organisations de soins intégrés de santé (OSIS) au Québec* [Collection études et analyses no 2]. Québec: Direction générale de la planification et de l'évaluation, Ministère de la Santé et des Services sociaux; 1988.
39. Metropolitan Toronto District Health Council. *Creating integrated health delivery systems for Metropolitan Toronto* [report of the system planning committee]. Toronto: The Council; 1996.
40. Pink G. Integrated delivery systems: providing a continuum of health care [working paper arising from an invitational think tank. Toronto, Apr 25–26, 1996]. Toronto: Hospital Management Research Unit, University of Toronto; 1996.
41. Health Services Restructuring Commission. *A vision of Ontario's health services system*. Toronto: Government of Ontario; 1997.
42. Berwick DM. Quality of health care. Part 5: Payment by capitation and the quality of care. *N Engl J Med* 1996;335(16):1227-31.
43. Kane RL. Health care reform and the care of older adults. *J Am Geriatr Soc* 1995;43(6):702-6.
44. Hennessy CH. Modeling case management decision-making in a consolidated long-term care program. *Gerontologist* 1993;33(3):333-41.

45. Challis D. The effectiveness of community care. *Rev Clin Gerontol* 1993;3(3):97-104.
46. Capital Health Authority. *Program description for the comprehensive home option of integrated care for the elderly* [working document]. Edmonton: Capital Health Authority; 1995.
47. Kane RL. Improving the quality of long-term care. *JAMA* 1995; 273(17):1376-80.
48. Ham C. Contestability: a middle path for health care. *BMJ* 1996;312(1):70-1.
49. Saltman RB, von Otter C. Balancing social and economic responsibility. In: Saltman RB, von Otter C, editors. *Implementing planned markets in health care — Balancing social and economic responsibility*. Buckingham (UK): Open University Press; 1995. p. 239-51.
50. Anell A. Implementing planned markets in health services: the Swedish case. In: Saltman RB, von Otter C, editors. *Implementing planned markets in health care — Balancing social and economic responsibility*. Buckingham (UK): Open University Press; 1995. p. 209-26.

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