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The integration of health care: Dimensions and implementation

Working Paper

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THE INTEGRATION OF HEALTH CARE: DIMENSIONS AND IMPLEMENTATION

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Abstract: This article explains the ways in which the integration of care represents a potential solution to the dysfunctional aspects of health care systems. Briefly defined, integration involves organizing sustainable consistency, over time, between a system of values, an organizational structure and a clinical system so as to create a space in which stakeholders (individuals and organizations concerned) find it meaningful and beneficial to coordinate their actions within a specific context. The consistency that integration seeks to create results from the ongoing implementation of five dimensions of the integration process: integration of care; clinical team integration (medical integration, according to Shortell, 1996); functional integration; normative integration, and systemic integration. The process of change may begin at any level of integration.

The integration of care is a popular concept whose borders are often unclear. In the first section of this paper, we will attempt to clarify the reasons justifying its incorporation into the organization of care. In the second section we suggest an overall definition of integration, and in the third, we define the five dimensions of integration. The paper concludes with a discussion of the main issues involved in implementing the integration process.

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I. RELEVANCE

Developed societies world-wide hope to overcome the tensions and contradictions that are the source of dysfunction, e.g. inappropriate use of skills, unequal access to certain services, etc., within their health care systems via the integration of health care (CESSSS, 2000; Contandriopoulos *et al.*, 2000; Ackerman, 1992). Four major factors underlie the necessity to integrate care and services to a greater degree.

(1) The general population's expectations with respect to the health care system are many and contradictory. Surveys indicate that the vast majority of the population wants a readily available system guaranteeing free and equal access to quality care, but refuses to pay more taxes or social contributions. Two examples illustrate this ambiguity. Across Canada, over 80% of the population feels that the health care system should prioritize efficiency, equal access, quality of results, prevention, freedom of choice, compassion and flexibility simultaneously (National Survey on Health, 1997). In Québec[1], 87% of those surveyed agree that basic health care should remain free of charge, public and universal, while 81% oppose tax increases to inject more money into the health care system. In addition, it should be noted that since the mid-1990s, people have become more worried about the future of health care systems. In Quebec, 78.5% of the population feels that the quality of services will deteriorate in the future (CESSSS, 2000).

These findings indicate that most democratic countries are asking a very simple yet basic question: *In the 21st century, how can all citizens, when they are ill, enjoy free and equal access to quality services in a highly competitive*

[1] Results of a *Léger Marketing* survey of a representative sample of the Quebec general population (5000 individuals), conducted in September 2000 for the Clair Commission.

economic context? This issue is fundamental, because it refers back to three main values that are central to modern democratic societies, i.e. equity, individual freedom and efficiency. In fact, the purpose of any society is to find the best way to organize its resources, taking its level of prosperity, history, traditions and culture into consideration, in order to act as consistently as possible with these three values (Petrella, 1996). The difficulty is exacerbated by the fact that the further a society progresses in relation to one of these values, the more difficult it becomes not to regress in relation to at least one of the other two. The integration of care is a process that makes it possible for a society to maintain equity and respect individual freedom while allowing it to increase efficiency with respect to resources.

(2) The second series of factors motivating recourse to integrated care is related to the increasing tension between the growth dynamic of the health care system and the economic pressure resulting from the necessity for the State to balance its budget (Contandriopoulos, 1998).

The growth dynamic is created via the expansion of the health care system's legitimate field of intervention. This expansion results, on the one hand, from the interaction between medicine's increasing capacity for intervention, brought about by the development of knowledge and techniques[2] and, on the other hand, the ageing of the population and appearance of new diseases.

[2] Scientific and technical advances in the field of health, as in all other fields, have resulted primarily in increased productivity, in the broadest sense of the term, i.e. the production of new goods and services that are better and cheaper than those that already exist. In these new goods, human capital value increases in relation to the price of raw material. Techniques do not replace people; they require that people do more and, more specifically, that they do different things. Technology is inextricably linked to change in the way things are done. Technological progress leaves behind those whose work has become redundant, but at the same time, it requires full-time workers with more and better training (Cohen, 1997 and 1999). Technological development is a process that is nourished by its own success; it allows increasingly complex problems to be solved over time. When one type of technology becomes too sophisticated and no

The pressure that globalization, especially the globalization of financial markets (Ramonet 2001), exerts on public finances, and therefore on health care system funding, requires the State to control increased health care spending. To leave sufficient space for democratic autonomy, the State was obliged to balance its budget and to accomplish this, it was forced to limit the growth dynamic of the health care system. To avoid having these constraints call its legitimacy into question by preventing the health care system from meeting the general public's expectations, it must support the integration of services. In fact, this process is a way to revitalize the health care system and moblize innovations that will enable it to meet society's expectations with respect to access to care.

(3) The organizational difficulties that health care systems experience in order to meet the public's expectations consistently and efficiently are partly the result of their inability to rethink the foundations on which their regulatory mechanisms are based. This, in turn, results from the coexistence of four different types of regulatory logic—professional, technocratic, market-based and democratic—which are difficult to overlap (Contandriopoulos & Souteyrand, 1996). This holds true not only because they are built upon highly incompatible foundations, but especially because they constitute a major source of legitimacy for any of the major groups of stakeholders, i.e.

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longer meets social demands, it leaves room for a newer, simpler and cheaper technology to be introduced and disturb the order instituted by the dominant technology (Christensen et al., 2000). Over time, scientific advances and technological development change the way problems are considered (problems that are complex or relatively complex become simple and at the same time, new complex problems arise). They also open new fields of practice (disturbing innovations) by allowing new categories of professionals, e.g. nurses, to intervene in simple problems, and, at the same time, allowing doctors to skillfully intervene in increasingly complex problems (Christensen et al., 2000). These processes inevitably generate pressure to modify work organization methods and organizational forms.

professionals; managers and planners; politicians, in their representative and democratic capacities; and businesspeople.

If the development of the health care system is to change direction in order to integrate services more fully and thus offer the entire population quality services in an equitable and efficient manner, then we must rethink the role and functions of each of the four types of regulatory logic, and therefore, the role and functions of the various stakeholders in the health care system.

(4) The findings of recent scientific research on health determinants of populations indicate that factors, situations, and contexts that promote health, i.e. that increase *"the opportunity for living beings to self-actualize"* (Foucault, 1997; TRANSLATOR'S NOTE: This citation is freely translated, and not an official translation), are not of the same type as the mechanisms involved in diagnosis, treatment and even prevention of specific diseases (Evans *et al*., 1996; Forum national sur la santé, 1996; Drulhe, 1996). Although disease and health are not independent phenomena, one cannot be reduced to the other; illness is not the opposite of health (Canguilhem, 1966). When a population lives longer, this does not mean that individuals are less ill. Longevity is accompanied by a change in the incidence and prevalence of various types of disease and causes of mortality, not the elimination of illness. Explanatory models pertaining to health differ from those pertaining to illness. All of this obliges us to reconsider the respective roles and responsibilities of government, society at large (with respect to health), and ministries of health (Forum national sur la santé, 1996; CESSSS, 2000). It would appear that the latter must refocus their energies on prevention, diagnosis, treatment and palliative care for specific

diseases. These are the issues for which they are accountable, not the health of the population in the broad sense of the word, over which they have little or no control. This refocusing of the health care system on illness is necessary in order to reconsider the integration of care. Greater integration will most likely influence health in the broad sense of the term indirectly but significantly. Such influence results not only from the reduced burden of illness but, more importantly, the redistribution of society's resources that results from the existence of a public, universal and efficient health care system, and the option of assigning part of the gains from the system's efficiency to collective action that will promote health.

To summarize, in order to continue offering quality health care services in an equitable manner, governments have no other choice but to significantly restructure the health care system. Such an undertaking aims, in a very general way, to encourage stakeholders to work together more closely in order to use available resources and skills more efficiently, which in turn will reduce fragmentation of available care and increase efficiency within the health care system.

The concept of integration encompasses all of these operations.

II. DEFINITION

We will begin by providing a general definition of integration, and then clarify how it applies to the field of health care.

The concept of integration may be defined in various ways, depending on the discipline in question. In a very general way, integration is the process involving the establishment of greater interdependence between the parts of a living being or between members of a society. Integration strengthens the connections among the stakeholders involved in an organized system who work together on a collective project (Le Robert, 1998). The integration of care and services transposes to the field of health a concept central to physiology, according to which integration involves the *"coordination of the activities of several organizations, required for harmonious operation"* (Le Robert, 1998)[3]. In the field of economics[4], integration refers, first and foremost, to actions that extend the coordination of a business to production cycles located upstream or downstream from its specific activities (in other words, outside the business in question). This type of situation involves vertical integration. Horizontal integration involves grouping similar organizations together, primarily to attain economies of scale. In the field of health, the creation of an integrated health care system responsible for the health problems of a specific population is an example of vertical integration. The merging of university hospitals is an example of horizontal integration.

Economics also deals with the issue of integration as a process of creating a common space or area of exchange between organizations and societies. The

[3] [TRANSLATOR'S NOTE: *Le Robert* is a dictionary of the French language only; therefore, in this paper, all English translations of direct citations are strictly unofficial].

[4] In the field of economics, integration has no systemic connotation. Integration is that which enables gains in productivity or economies of scale to take place.

creation of such spaces clearly illustrates the power of integration, in which the rules applicable to the collective, or, more precisely, those dominating the common space, may impose themselves upon each of its components and clash with its values and projects. Therefore, integration involves a double movement. It stems from an operation according to which entities incorporate themselves into larger entities (an individual into a group, a group into an organization, an organization into a wider social grouping, etc.). Integration is also related to the pressure that an organized collective exerts on each of its components[5]. In fact, efforts at integration must always be accompanied by the will to preserve the freedom of all parties involved and the potential for innovation that may result. This paper must be read with this perspective in mind.

As a point of departure, we are adopting a very wide-ranging definition, whose dimensions we will discuss in greater detail as we apply them to the field of health.

> *Integration is the process that involves creating and maintaining, over time, a common structure between independent stakeholders (and organizations) for the purpose of coordinating their interdependence in order to enable them to work together on a collective project.*

This definition requires that the concepts of interdependence, cooperation[6] and coordination be clarified.

[5] This pressure, which may be exerted in increments or in an authoritarian manner, to a greater or lesser degree, clearly emphasizes that the term "integration" shares a common etymological root with the term "integrism", defined as "strict observance of doctrine and tradition." (Le Robert, 1998). [PLEASE SEE PREVIOUS TRANSLATOR'S NOTE.]

[6] We are not drawing a distinction between the concepts of collaboration, i.e. "the act of working in common" and cooperation, i.e. "to do something jointly with someone, participate in a common cause." (Le Robert, 1998). In literature concerning organizations, certain authors use the term "cooperation" to refer to relationships between individuals and the term "collaboration" to refer both to interorganizational and interpersonal relationships. In English-language literature, authors such as Aiken et al. (1975) consider cooperation to be the quality of the relationship between people who work together within an organization. Cooperation is, therefore, a bidimensional

Interdependence exists when independent stakeholders (individuals or organizations) must solve collective problems (Bryson & Crosby, 1993), i.e. when none of the stakeholders possesses all of the resources, skills, and legitimacy required to contribute a (scientifically, professionally, technically, or socially) legitimate and valid response to problems with which each stakeholder (individual or organization) in the field is confronted. Therefore, cooperation between stakeholders is central to the issue of integration.

Cooperation is the type of relationship that stakeholders (individuals or organizations) in situations of interdependence tend to favour over competition, when they share the same values and agree on a common philosophy for action; when they assess the work of other stakeholders positively; when they reach agreement on the sharing of their areas of expertise and coordination of their tasks; and, lastly, when they are placed in a favourable organizational context (Benson, 1975). Cooperation is never absolute; it does not exclude the presence of competitive relationships, or even conflicts, between the individual parties (and organizations) concerned. In order for sustained cooperation to exist, stakeholders (individuals or organizations) must continuously negotiate amongst themselves and assess the results of their collaboration (Friedberg, 1993).

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concept since it considers both the attitudes and behaviour of the parties involved. This relationship is basically static. Ring & Van de Ven (1994) propose a dynamic definition of cooperation that could therefore be assimilated into the definition of collaboration. Furthermore, Lawrence et al. (1999) and Phillips et al. (2000) define collaboration as the cooperative process that takes place between organizations. Collaboration is therefore considered to be a dynamic regulatory process that operates on bases that are neither hierarchical nor market-driven.

Generally speaking, coordination encompasses all of the arrangements that enable the parts of a whole to be organized logically, for a specific purpose. It is intended to put things in order, or even give orders (Le Robert, 1998). More specifically, according to Alter and Hage (1993), in the organizational field[7], the purpose of coordination is to ensure the following: first, that all the means (resources, services, skill, etc.) the organization requires to attain its goals are available; second, that access to the goods and services provided by the organization is guaranteed; and, third, that the various components of the organization interact harmoniously, over time.

In fact, there is always some form of coordination in any organization, but it is often insufficient. Coordination is built in a deliberate manner. As opposed to a method of governance intended to be loosely structured and left to itself, like the market, coordination involves a strong will to make a system operate and organize the behaviour of the stakeholders involved. Organizations constitute a space in which coordination represents the "visible hand" that controls the relationships between stakeholders, rather than the "laissez-faire" attitude that characterizes the marketplace. One of the issues of integration involves creating new spaces for coordination between independent organizations that have their own borders.

The degree of coordination that must exist between individuals and organizations concerned depends on the needs of the collective project that has motivated them to interact. In the health field, this involves the coordination required to meet social demand for accessible, high-quality services.

[7] We are defining the term "organization" very broadly, as an organized system of action.

Three types of coordination may be defined: sequential coordination, reciprocal coordination and collective coordination (Alter & Hage, 1993)[8]. These different types of coordination correspond to variable needs with respect to the management of interdependence between individual stakeholders and organizations concerned.

Sequential coordination exists when a patient encounters various professionals or organizations in succession (sequentially) during an episode of illness. Like an assembly line, few relationships exist between professionals or organizations that act one after the other. Consistency of case management is provided through the professional skill of each person who intervenes, and often by the patient him/herself. This method of coordination is adequate when the patient has a problem that is easy to diagnose and requires specific intervention that is clearly limited as to time and space. In situations with a mild degree of uncertainty, for occasional problems, sequential coordination provides a simple way to access the required expertise or professional. It becomes insufficient when the degree of uncertainty increases and the need for expertise manifests itself recurrently over time.

Reciprocal coordination exists when a patient is treated by several professionals or organizations simultaneously. Each professional must take the work of the others into consideration in order to deal with the patient's problems appropriately. In this case, there is a high degree of interdependence between all professionals involved. When a patient uses

several professionals simultaneously, he/she often acts as his/her own agent of coordination. When the health problem placing him/her in this situation is not too complex, few professionals are involved, and the care involved is clearly defined as to space and time, reciprocal coordination can be highly satisfactory. Conversely, when this is not the case, collective coordination becomes necessary.

Collective coordination exists when a team of professionals or organizations assumes joint responsibility for patients, according to methods they determine together. This form of coordination is required when the degree of interdependence between individuals and organizations concerned is high. It is particularly well adapted to cases involving multiple or complex health problems without clearly defined borders, and whose development over time and space is uncertain[9]. Very often, this level of complexity involves chronic problems that threaten the independence of frail persons. Collective coordination requires both case management organized around the patient and formal agreements between the individuals and organizations concerned in order to ensure adequate accessibility to care, whose nature is fairly unpredictable. In order for collective cooperation to be established, resources must be available and accessible.

To summarize, the degree of coordination that must exist between the individuals (and organizations) concerned depends on the nature of the collective project motivating them to cooperate. The greater the uncertainty

[8] Based on the classification of interdependence proposed by Thompson (1967).

[9] Complex problems may be characterized as those whose diagnosis and treatment are uncertain and which require the expertise and judgment of several experienced clinicians (Christensen et al., 2000). These professionals must jointly perform a complex interpretive function. (Glouberman, Mintzberg 2001).

and equivocation, and the greater the degree of interdependence, the more necessary collective coordination becomes. Conversely, for simple, occasional problems, sequential coordination is sufficient. In an integrated system of care, it is expected that the degree and nature of the coordination adapt themselves according to the needs of each person for whom the system is responsible, given available resources, expertise and technology.

In light of the definitions of interdependence, cooperation and coordination that we have just provided, let us return to the general concept of integration.

In the field of health, integration involves organizing sustainable consistency over time between a value system, an organizational structure and a clinical system (Figure 1) so as to create a space in which stakeholders (individuals and organizations concerned) find it meaningful and beneficial to coordinate their actions within a specific context (Figure 2). Integration can only be considered within a context.

The clinical system encompasses case management methods and rules for proper practice. It must make certain that care is integrated in the best possible way, with respect to time, space and the professionals concerned. The clinical system is the space in which professional regulation dominates.

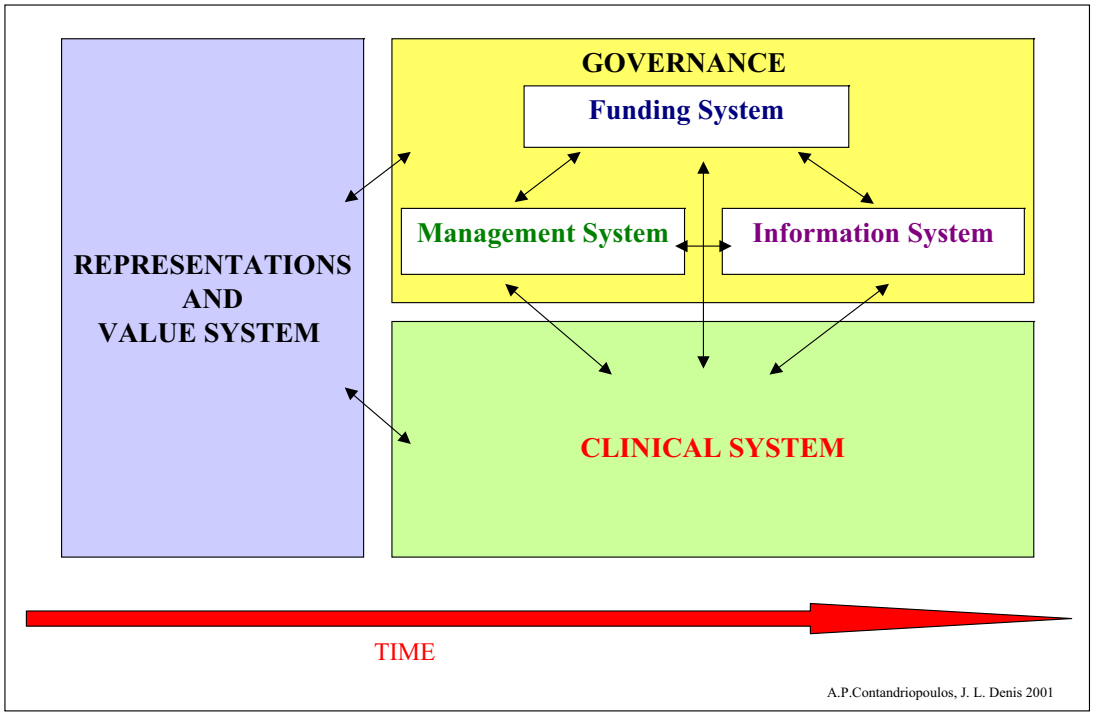

Figure 1. Components of integration

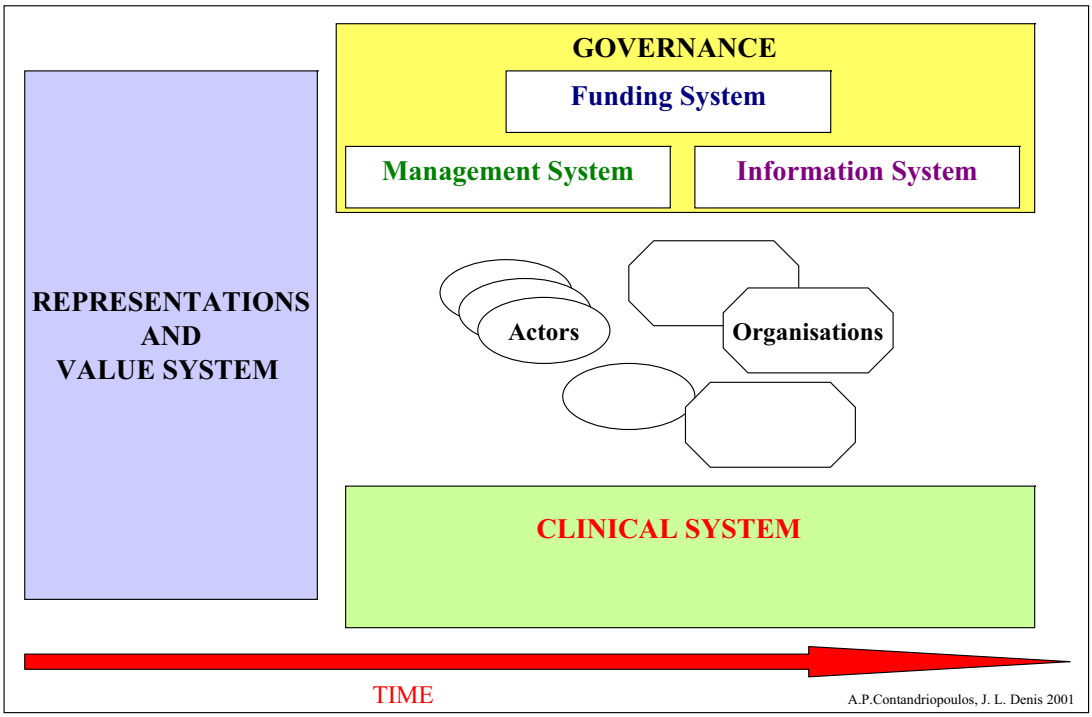

Figure 2. Field of cooperation

One of the main issues challenging integrated systems involves the establishment of a structure allowing efficient overlap between the requirements of the clinic and those of a system accountable for its use of the funds, especially technocratic and market-driven logic made available to it by the State and for the achievement of objectives extending to the entire population (accessibility, quality, coverage, etc.). In other words, the issue involves finding ways to reconcile the professional logic that dominates in the clinical system with other types of logic, especially technocratic and market-driven logic, that are mobilized within an organizational structure.

Organizational structure encompasses a ***management system*** (a group of rules that define how power and responsibility are distributed); a ***funding system*** (incentives put forward through methods of funding the system and paying the individuals concerned); and an ***information system*** (data and their operating systems required for the system to be intelligible and transparent at all times to professionals, managers, tutors, patients and the general population).

The representation and value system is defined by all of the beliefs, values and interpretative schemes that allow stakeholders to communicate among themselves and thereby coordinate their actions and cooperate. This is what provides the elements allowing them to agree on an intervention philosophy, interact in an atmosphere of mutual trust and assess their work positively and reciprocally.

These three systems constitute the space within which efforts at integration will be made, according to five major dimensions.

III. DIMENSIONS OF INTEGRATION

The dimensions of integration are intended to establish consistency between the clinical system, organizational structure and collective system of interpretation and values that structure the space in which stakeholders (individuals and organizations) interact (Figure 2). The various forms (Figure 3) that the process of integration may assume all aim, to various degrees, to institutionalize the relationship of cooperation between stakeholders in a situation of interdependence with respect to one or more common projects.

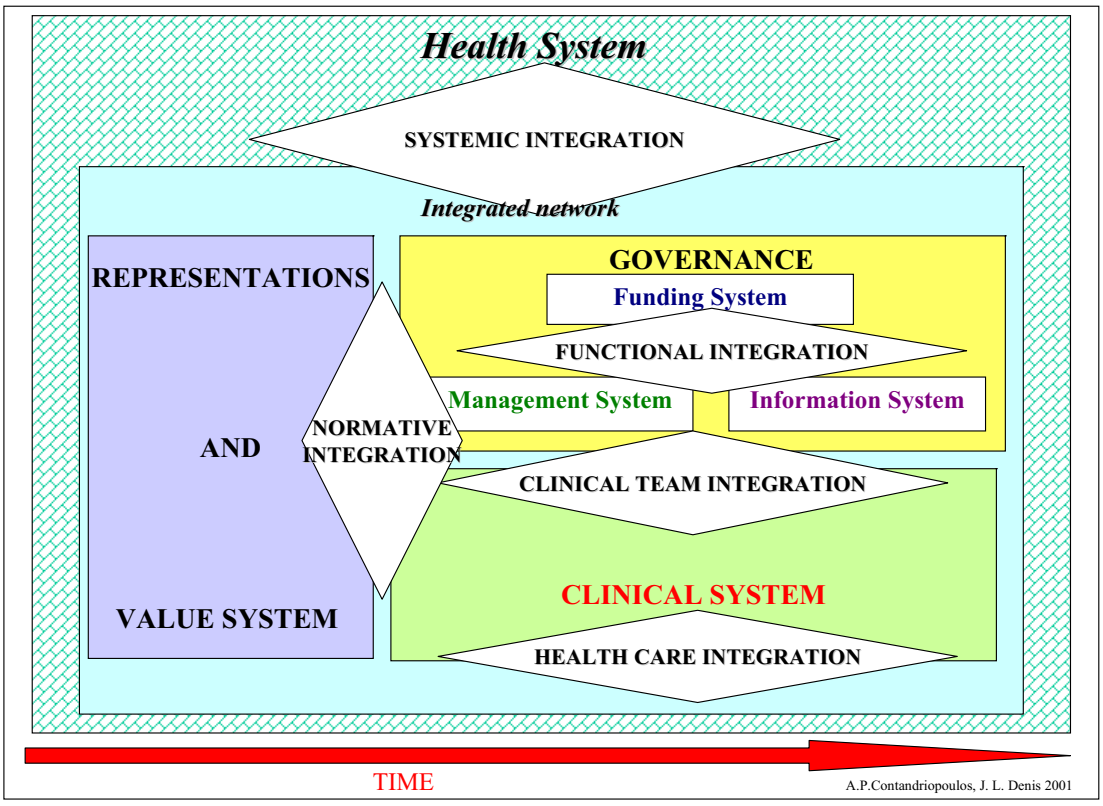

Figure 3. Dimensions of integration

The consistency sought via integration results from the ongoing implementation, over time, of the following five dimensions of the integration process (Figure 3):

- integration of care;
- clinical team integration (medical integration, according to Shortell, 1996);
- functional integration;
- normative integration;
- systemic integration.

The first four types of integration concern the interaction of stakeholders (individuals or organizations) in a situation of interdependence centred on a collective goal, and systemic integration concerns the relationships between the local system of interdependent stakeholders and the general environment. The concept of integration requires clarification of the level of analysis at which one is located. The integration of care is a process that takes place within relationships between individuals (the microscopic level); clinical team integration and functional integration describe phenomena that take place with respect to the analysis in question (a territory, organization, region, etc.); normative integration helps express the relationships between levels; and, lastly, systemic integration aims to ensure consistency between the analysis in question and the environment (macroscopic level).

The integration of care involves coordinating clinical practices around the specific health problems of each patient in a sustainable manner. Its goal is to guarantee consistent, comprehensive care; in other words, to ensure that services provided by various professionals, in various locations or organizations, meet the specific needs, over time, of each patient, given the knowledge and technology available. Depending on the nature of the problems and how they evolve,

coordination may be developed to a greater or lesser degree. Collective coordination appears to be the most desirable form in which to respond to complex and chronic problems. The integration of care is one of the dimensions of the overall process of integration and also constitutes the end result we seek to achieve via this process.

Clinical team integration (medical integration according to terminology used by Shortell, 1996) encompasses two dimensions:

- The first concerns the functioning of multidisciplinary teams made up of professionals (physicians, nurses, other professionals, community workers, etc.) The performance of clinical teams is based on the existence of mechanisms that help mobilize the skills and coordinate the expertise of the various team members (mutual adjustments) while allowing each member to exercise their professional judgement. Cooperation among clinical team members is necessary in order to guarantee the delivery of continuous, comprehensive care that remains stable over time yet adapts itself to problems as they develop and change. Coordination, ongoing quality control and effective regulation by peers are based primarily on the existence of accurate and complete clinical information systems operating in synchrony with the practice of the clinic.

- The second dimension involves the formation and maintenance of multidisciplinary teams that bring together general practitioners and specialists as well as other professionals. Successful integration of services depends on physicians' active participation in clinical teams and must adapt to the types of needs that arise. The formation and maintenance of clinical teams is one of the

major responsibilities of the organizational structure. These two functions are directly dependent on the functional integration of the system[10].

The purpose of **functional integration** is to overlap the funding, information and management systems within a health care system. In other words, its purposes are to create a common, explicit structure that will allow the integrated system to make decisions (division of tasks, responsibilities and recourse) that are consistent with the clinical project; obtain and distribute the financial resources (the creation of economic incentives) required to motivate stakeholders (individuals and organizations) within the system to coordinate their actions; and, lastly, to implement and use an information system that reflects the range of the system's activities so as to assist decision-makers and enable the system to adapt to the changing context and needs by encouraging stakeholders to adopt an introspective attitude towards their practice.

Functional integration does not necessarily imply the structural integration of interdependent stakeholders (individuals and organizations). Organizations can retain wide margins of autonomy while subject to strong incentives to cooperate with other stakeholders, in order to guarantee consistent case management and shared responsibility for collective problems.

Functional integration may be assessed by considering the degree to which functions and support activities (strategic management, leadership and organizational structure, information systems, funding) are coordinated between stakeholders and operational units of partner organizations so as to operate as a

[10] This definition closely resembles the one proposed by Shortell (1996) but we do not believe that functional integration must necessarily precede medical integration and the integration of care. These three dimensions of integration are interrelated in a much more complex ways.

single system. Contracts, strategic alliances between organizations, and institutional mergers are all mechanisms or initiatives intended, in principle, to constitute a structure facilitating cooperation among stakeholders (individuals and organizations) so that they may coordinate their actions more efficiently and thus oversee their interdependent relationships.

Normative integration is intended to ensure consistency between the collective system of stakeholders' representations and values, and, at the same time, the organizational methods of the integrated system and the clinical system.

By providing stakeholders with a common system of reference, normative integration allows them to cooperate in order to successfully complete the collective project in which they are involved. It also allows them to reflect on organizational structuring in relation to the requirements of cooperation and also sensitize stakeholders to interdependence by highlighting the importance of collective responsibility with respect to various problems and patients.

Systemic integration is required in order for an integrated system of care to operate in a sustainable manner. To accomplish this, the organizational principles of the entire health care system must be consistent with the dynamics of the local project. A clinical project that successfully deals with the complexity and uncertainty of problems cannot result from a simple agreement between professionals or organizations. It must be based on a general organizational and normative framework (the organizational principles of the health care system) conducive to clinical cooperation. Systemic integration thus implies that the complexity and nature of issues that arise locally with respect to the organization of care must be reflected in the general environment. Systemic integration implies

that integration within the health care system can be considered at several levels; in order for integration to take place at one specific level (an organization, local territory, region, multiregional entity, etc.), each dimension of integration must be consistent with all the other levels.

V. IMPLEMENTING INTEGRATION

The implementation of an integrated system of health care is a long, difficult and demanding process. It involves simultaneous and recurrent changes in stakeholders' actions and in relationships between organizations.

These processes of change may begin at any level of integration. They may begin with the integration of care, clinical team integration, functional integration or normative integration.

However, in order for the changes made to any of these levels to engender new, stable, sustainable cooperative relationships between stakeholders, integration must extend to all other levels. For example, it has been observed, in certain integration experiments funded by FASS, that the search for greater integration of care (the process of change begins with the clinic) will very quickly require reinforcement of functional integration (the need for more and new information, the need to divide money differently, the demand for more consistent decision-making, etc.), clinical team reorganization and the building of a new shared vision of what constitutes appropriate action (the development of a common philosophy of action).

We realize that any serious discussion of integration is, in fact, the expression of a willingness to make sweeping changes to the health care system. In order for an

integrated health care system to operate in a sustainable way, the organizational principles of the entire health care system must be consistent with the dynamics of the local project (systemic integration). A clinical project dealing with the complexity and uncertainty of problems cannot result from a simple agreement between professionals or organizations. It must be based on an overall organizational and normative framework specific to clinical cooperation. Similarly, it is difficult to imagine that a pilot project can operate for very long and achieve its full innovative potential if the rest of the health care system does not enter into an overall process of change. The concept of systemic integration raises serious issues. One of these concerns how pilot projects can be evaluated; the other concerns the idea that it is possible to judge the potential of local pilot projects when obstacles to their implementation and the dissemination of information about them exist at other levels of action—for example, within the organizational principles of the health care system.

The change in social systems as complex as the health care system is, in and of itself, a complex and paradoxical social process (see Figure 4) that must be analysed and understood. Its emergence and implementation on a wide scale result from the inevitable tension that exists at any given moment between the need to leave the status quo behind—the environment exerts strong pressure since it has no reason to stop—and the fulfillment of conditions necessary for the process of change to take place—a strong leadership, ideas, time and resources (see, among others, Denis, Lamothe, Langley, 2001).

In fact, change is a difficult, long and demanding process; it requires new skills and dynamic leadership. It can only exist if the various stakeholders adopt new ideas and find mobilization strategies so that such ideas lead them to rethink

problems and apply them, i.e. give rise to new solutions. Lastly, it requires significant resources—not only material and financial resources but also time, information, new knowledge and new cognitive abilities on the part of stakeholders. Time refers to the need for interaction between stakeholders in order to develop new representations and abilities for action.

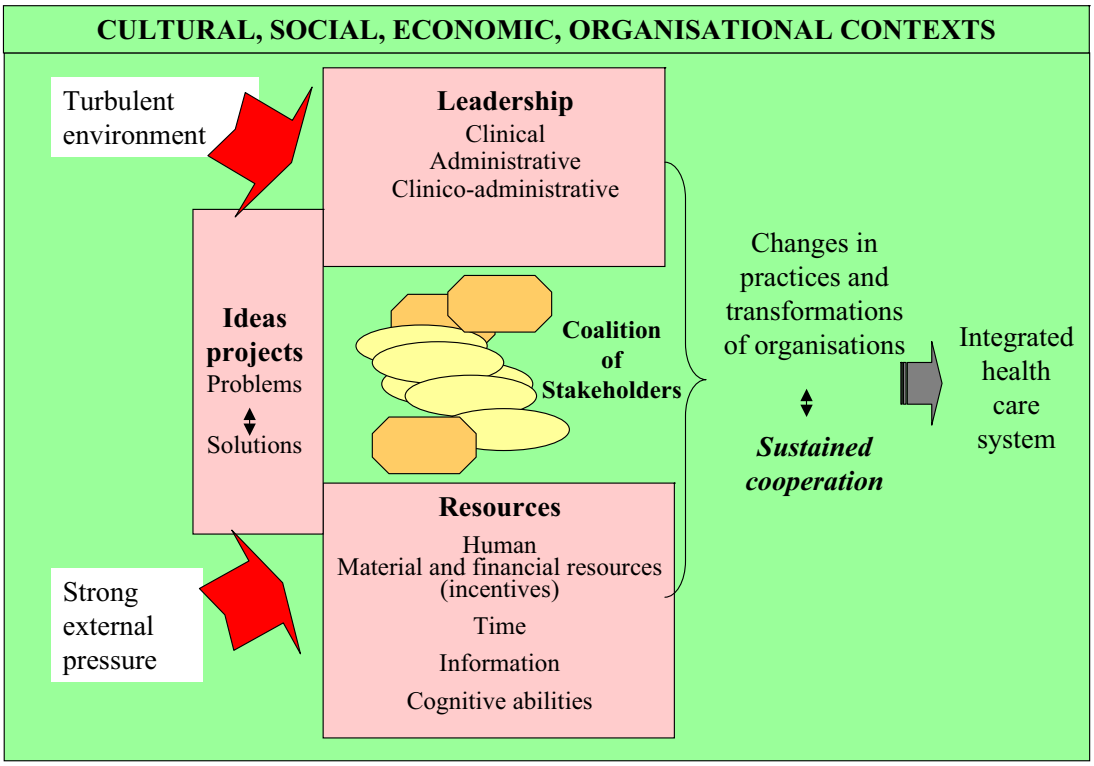

Figure 4. Dynamics of change

In other words, in order for change to occur, the following is required:

- space in order for the process to take place;
- encouragement, via organizational methods conducive to it;
- the perception, by a diverse coalition of stakeholders, that this is the way to bring an exciting collective project to fruition and not just something imposed from the outside.

The paradox of change is that when it becomes necessary, resources are generally scarce, there is insufficient time to experiment and, too often, legitimate leaders have no credible projects to suggest! It is therefore important to reflect explicitly on plans for integration, just as we must deliberately support the process of change. Thus, changes in clinical practice operate in large measure according to an emerging method (Lamothe, 1996; Denis, Lamothe, Langley, & Valette, 1999). Professionals are confronted with problems that they can only solve locally and that affect the nature of their work. Furthermore, a given professional will find it difficult to implement the type of change that the division of professional work and lack of coordination among stakeholders (individuals and organizations) impose. Concretely, current proposals to increase integration in the health care system all cite the need to reform the organizational structure by centring it around the clinic, with a view to highlighting greater responsibility on the part of professionals towards patients. The search for more extensive integration cannot settle for "natural" changes related to the development of teams and clinical practice. Integration must validate the mobilization of resources conducive to the emergence of processes of change (skills, coordination mechanisms, organization, values) required to provide "better" case management, not simply to implement a single model. Integration must take place in the spirit of flexibility and adaptation, and avoid standardizing the rules and operations of the health care system.

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