



**LOCAL HEALTH INTEGRATION
NETWORKS:
POTENTIAL, CHALLENGES AND
POLICY DIRECTIONS**

Policy Challenges in Urban Health

Wellesley Central Health Corporation

Bob Gardner

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THE POLICY CHALLENGE

Ontario has embarked on a wide-ranging and ambitious reform of its health care system. Establishing new Local Health Integration Networks to plan health care on a regional basis is one important part of this transformation project. While there have been many concerns expressed about how the LHINs were established and how they will actually be governed and operate, there is no doubt that they will dramatically change the landscape for health care planning and delivery. The challenge now for government, health care providers and community partners alike is to ensure that the LHINs really do lead to more efficient and integrated planning and delivery, and that the overall result really is more equitable access to health care and better health for all.

The LHINs will only be successful if they are driven by community needs and priorities; develop effective, responsive and innovative governance and community engagement mechanisms; build on existing coordination networks and accumulated knowledge; foster innovation and spread the best of what is working well throughout the system; integrate service delivery and planning to improve overall efficiency; and coordinate the myriad of hospitals, clinics, health care providers and community agencies into a coherent system. The goal is to ensure that all communities and individuals across the province have access to a seamless, responsive and comprehensive continuum of care.

This paper provides brief background on the state of the LHINs initiative so far, looks for lessons for Ontario in other provinces' experience with regional planning and delivery; analyzes key challenges and opportunities the initiative will face; and sets out policy directions and alternatives that can achieve an integrated and equitable health care system.¹

¹ Further material is provided in our *Issue Page* on LHINs: a shorter report of the main conclusions and recommendations, an executive summary and organized links to Ministry background reports, stakeholder response to the LHINs and other background, all at http://www.wellesleycentral.com/ip_lhins.csp.

INTRODUCTION

Local Health Integration Networks (LHINs) are 14 new organizations designed to plan, coordinate, integrate and fund health care within specified geographic areas.² They are not intended to provide services themselves. Ontario is the last province to develop such regional health authorities.

The current Ontario health system is complex and in many cases fragmented, and access to the full spectrum of needed services is not available in many communities. There is no doubt that more effective planning and coordination of health service development and delivery could be tremendously useful. But only if it is the right kinds of services – not more of the same – and only if this coordination is geared to on-the-ground community interests, needs and perspectives – not driven by the assumptions and institutional needs of Ministries, agencies or hospitals.

This paper analyzes what kinds of policies, activities and approaches will be necessary for the LHINs to achieve their potential. It starts by providing background on the state of the initiative to date. It surveys regionalization in other provinces over the last decade and assesses possible lessons for Ontario. The paper then identifies critical issues and questions for LHINs and their community partners and stakeholders to address in the next months. If successfully addressed, the LHINs could make a significant contribution to enhancing Ontario's health care system. If these issues are not addressed then major problems are bound to result.

Reforms to health care delivery and planning must be seen in a wider context. A great deal of research has demonstrated that poverty, social exclusion, early childhood education, access to affordable housing, the nature of work and other social and economic factors have a pervasive impact on health.³ Addressing these social determinants and inequalities – for example, by reducing poverty or homelessness – would have the most beneficial impact on health. This does not mean that equitable access to high-quality care is not also crucial. It simply means that to be really effective, integrating planning and delivery and other health system reforms must be accompanied by coordinated action on these broader determinants of health.

² Ontario Ministry of Health and Long-Term Care (MOHLTC), "Local Health Integration Networks, Bulletin # 6, January 2005."

http://www.health.gov.on.ca/transformation/lhin/011905/lhin_bul_6_011905.html accessed August 17, 2005; references to subsequent Bulletins will be abbreviated to number and date.

³ From a large international literature see Richard Wilkinson and Michael Marmot, eds, *Social Determinants of Health, The Solid Facts* World Health Organization: 2nd edition, 2003 and Richard Wilkinson, *The Impact of Inequality How to Make Sick Societies Healthier* New York, The New Press: 2005. The leading Canadian collection of research and analysis is Dennis Raphael, ed, *Social Determinants of Health, Canadian Perspectives*, Toronto, Canadian Scholars Press: 2004. Among many valuable official sources see Canadian Population Health Initiative, *Improving the Health of Canadians*, Ottawa: the Initiative, 2004.

BACKGROUND AND CONTEXT

Health Care Transformation Plan

In 2004 the Ontario government announced a wide ranging plan to transform the provincial health care system. In a major September speech, Minister of Health and Long-Term Care George Smitherman noted that:

This is an extraordinary time for health care in Ontario. Our health care system has undergone tremendous scrutiny and evaluation these past few years – the problems have been diagnosed over and over again. The solutions and the choices before us have been made crystal clear.

Now, there's an appetite for action in every corner of this province....⁴

The goal is “creating a *comprehensive* and *integrated* system of care that is shaped *with* the active leadership of communities and driven *by* the needs of the patient.”⁵

Among the key components of this transformation were primary care reform, including setting up 150 Family Health Teams; a comprehensive strategy to reduce waiting times for crucial services; increased investment in prevention and health protection and community-based care; creation of the Ontario Health Quality Council to enhance accountability in the system; and improved health information technology; all with action groups of leading experts and Ministry officials.

Local Health Integration Networks

LHINs are to be a crucial part of this broader transformation. When introducing Bill 36 in the Legislature, the Minister stated: “If passed, this Bill will be the most significant, far-reaching and enduring reform of all. If passed, it will give real power to communities and people. The powers we are proposing to devolve to Ontario’s 14 LHINs amount to nothing less than a \$20 billion transfer of decision-making power out of Queen’s Park and into the hands of communities.”⁶

In discussing the overall transformation plan, the Minister had earlier emphasized that:

⁴ The Hon George Smitherman, *Ontario’s Health Transformation Plan: Purpose and Progress*, Speaking Notes, September 9, 2004, p.3; the following section is based upon this speech http://www.health.gov.on.ca/english/media/speeches/archives/sp_04/sp_090904.html accessed August 17, 2005.

⁵ His emphasis.

⁶ Legislative Assembly of Ontario, *Hansard* Record of Debates, Nov. 24, 2005.

Although most health care is local, we are not that effective at planning and responding to local needs... That's why we will be taking some of the authority which currently resides at Queen's park *away* from Queen's Park, and shifting it to local networks, closer to real people, closer to patients.⁷

There is a great deal of innovation and integration already occurring in local communities. LHINs will "provide the opportunity to spread the best of these practices much more quickly across the entire system... Goodbye Patchwork Quilt."

The Minister also stated that the LHINs would decrease the complexity of what he described as the "hodge podge" of inadequately coordinated, overlapping, conflicting health care services offered in the province. He noted that the current system is composed of:

- 155 hospitals;
- 581 long-term care facilities;
- 42 Community Care Access Centres;
- 37 local Boards of Public Health;
- 55 Community Health Centres;
- 70 community and public health labs;
- 353 mental health agencies;
- 600 Community Support Service Agencies;
- 150 addiction agencies;
- 5 Health Intelligence Units;
- 7 Regional Ministry offices.

The LHINs are intended to effectively coordinate these services to create and foster an integrated system of health care delivery.

A Ministry backgrounder highlighted the policy rationale and goals of the LHINs initiative:⁸

They reflect the reality that a community's health needs and priorities are best understood by people familiar with the needs of that

⁷ *Ontario's Health Transformation Plan* pp. 16-18.

⁸ MOHLTC, *Backgrounder: Local Health Integration Networks*, August 2005, accessed August 22, 2005.

community and the people who live there, not from offices hundreds of miles away....

LHINs will determine the health care priorities and service required in their local communities....They will improve planning and integration at the local level in order to improve health results for patients in every part of the province.

Key benefits of the LHINs will be to:

enhance integrated health care delivery so that patients can more easily navigate across the continuum of health care;

reach accountability agreements with providers that will ensure that resources intended for patients are used for patients;

provide more community-based input into health care decision-making.

Transformation Plan One Year On

In October 2005 the Minister returned to the St Lawrence Market in Toronto to update the plan. His speech was upbeat and positive, detailed specific changes and results that have happened, and reiterated the government's commitment to a thorough restructuring of health care in Ontario.⁹

- Referring back to Tommy Douglas as founder of Medicare, the Minister stressed that a top priority will be prevention rather than simply treating people when they get ill. He outlined increased provincial funding for community and home-based care, public health, vaccination, enhanced infection surveillance and other initiatives. However he did not mention poverty, inequality, inadequate housing and other social determinants of health.
- The Minister highlighted increased spending on CHCs, family health teams, information management and other areas to increase access. He spoke of significant increases in the numbers of specific medical procedures.
- He emphasized the importance of improving health care information management, not least to eliminate the huge waste of time in redundant reporting. The Minister announced that a new web site would provide current information on wait times for key procedures at specific hospitals. He

⁹ The speech can be found at http://www.health.gov.on.ca/english/media/speeches/archives/sp_05/sp_100605.html accessed October 6, 2005. At the same time, the Ministry released the first annual report of its Health Results Team.

- described this as putting power in the hands of patients by allowing them to look for other hospitals with shorter wait times. However, patients have never been able to simply go to other hospitals when they wished, especially if in the near future a hospital's funding envelope is tied to its LHIN region.
- The Minister also stressed the key role the Ontario Health Quality Council will play as an independent body monitoring the health care system. A key challenge will be to work with diverse communities to identify what successful system change and performance looks like from their point of view, and to work with the Council to ensure it takes into account such community-driven indicators and objectives, not solely institutional and statistical data.
 - Finally, he highlighted the LHINs as the key way in which more effective local planning will be achieved. But he provided no new information on their governance, operations or timetables.

IMPLEMENTING THE LHINs INITIATIVE

The LHINs were officially launched on October 6, 2004 through a series of announcements and speeches:¹⁰

- Ministry officials spoke to meetings across the province;
- a regular series of monthly Bulletins was begun with the October announcement;
- a working group composed of representative from the main institutional stakeholders was established.

Consultation

The Ministry emphasized consulting with communities and stakeholders from the outset.

Initial Reaction

It posed a number of questions on how the initiative should proceed in its first Bulletin. Responses to these questions were then published in Bulletin # 4 on November 15, 2004 and in a summary report.¹¹ Some 468 responses were received from health care institutions, providers, CCACs and other coordinating agencies, community service providers and the public. Although not specifically asked, 35% expressed general support and 12% opposition to the LHINs or transformation agenda.

¹⁰ MOHLTC, "McGuinty Government Moves Forward on Building a True Health Care System for Patients," *Media Release*, 6 October 2004.
http://ogov.newswire.ca/ontario/GPOE/2004/10/06/c7765.html?lmatch=&lang=_e.html accessed August 17, 2005.

¹¹ MOHLTC, *Analysis of Responses to LHIN Bulletin #1*
http://www.health.gov.on.ca/transformation/lhin/111504/feedback_report.pdf accessed August 22, 2005.

Respondents identified many examples of local integration and coordinated planning – these will be discussed below. They were also asked to identify key success factors for the LHINs initiative:

- governance was most often cited, with respondents arguing for flexible and responsive local boards appointed in a transparent manner from across their regions;
- there was concern that hospitals would dominate;
- a related issue was boundaries:
 - especially a concern that they do not match municipal boundaries and communities may be divided among different LHINs;
 - respondents from the North worried that historical referral patterns, for example, to Winnipeg rather than the longer journey to less specialized facilities in Thunder Bay, may be disrupted;
- ‘equal voice’ so that all elements of the community are heard and involved;
- funding must be available to assist transition and ensure a continuum of care;
- other factors raised were patient focus, communications, clear divisions of authority and operating guidelines, rural and other local issues not getting lost in large LHINs, and effective IT.

Community Workshops

Workshops were held during November and December in each of the 14 areas to identify local priorities to guide the implementation of LHINs:

- 3,500 + people participated;
- the workshops addressed a series of standard questions and used resources and facilitating toolkits provided by the Ministry;
- they were asked to identify five top patient care and five administrative support issues and priorities.

The Ministry analyzed common integration priority themes among the 14 workshops.¹² Mental health priorities were mentioned in all 14 workshops, community support services in 13 and health promotion in 11. In terms of patient care, participants identified:

- integrating mental health care and addition into the continuum of care;
- integrated services for seniors;
- better bridging from hospital to community-based care to achieve a seamless continuum;
- a better balance of hospital and community care in an integrated system.

¹² MOLTC, *Report on Community Workshops*, December 15, 2004, http://www.health.gov.on.ca/transformation/lhin/121504/community_workshops.pdf accessed August 24, 2005 provides snapshots of each workshop and *Complete Findings from the LHIN Community Workshops*, January 11, 2005 http://www.health.gov.on.ca/transformation/lhin/011905/findings_report.pdf accessed September 22, 2005, provides an analysis of common themes.

The administrative support issues were:

- common health records and electronic exchange;
- good governance and accountability, including clear performance measures to permit comparisons;
- maximizing human resources through innovation and addressing shortages and skills development.

Local Priorities

Out of these workshops came working groups to identify the local priorities and each group produced a priority report for their area by February 2005. The reports would subsequently be made available to the incoming board and CEO.¹³

The Ministry summarized overall patterns in these reports:

- 142 integration initiatives were identified and action plans were developed for most. Just over 40% of the proposed initiatives were new, 20% existing and the rest a combination of new and existing.
- eight priority themes emerged (ranked by the number of initiatives in the category):
 - planning, governance, funding and other factors needed to achieve successful LHINs;
 - creating integrated systems of care targeted to specific groups;
 - developing a full continuum of care;
 - capitalizing on information technology;
 - coordinating care across the system;
 - responding to unique characteristics in each community;
 - sharing resources;
 - accessing particular kinds of services.¹⁴

LHINs Model

The Ministry continued to clarify the goals and scope of the LHINs. Its May 2005 Bulletin stressed that the “LHINs are a quality improvement initiative...the next evolution of health care in Ontario. They represent an understanding that community-based care, reflecting the needs of that community, is best planned, coordinated and funded in an integrated manner within that community.”¹⁵

¹³ The detailed individual local reports can be found at http://www.health.gov.on.ca/transformation/lhin/reports/integ_reports.html accessed August 24, 2005.

¹⁴ MOHLTC, *Summary Analysis of 14 Integration Priority Reports*. http://www.health.gov.on.ca/transformation/lhin/051605/integ_reports_summary.pdf accessed August 23, 2005.

¹⁵ LHINs Bulletin # 11, May 2005” summarizes the local priority reports http://www.health.gov.on.ca/transformation/lhin/050205/lhin_bul_11_050205.html accessed August 23, 2005.

Goals

Four goals were set out:

Manage health system planning, coordination and funding at the local level.

Engage the community in local health system planning and setting of priorities, including establishing formal channels for citizen input and community consultation.

Through greater integration of services, improve the accessibility of health services to allow people to move more easily through the health system.

Bring economic efficiencies to delivery of health services, promoting service innovation, improving quality of care, and making the health care system more sustainable and accountable.

Scope

The Ministry plans that the LHINs would eventually fund hospitals, CCACs, long-term care facilities and various community service delivery agencies. They would not fund physicians, ambulances, laboratories, provincial drug programmes or individualized care. Legislation will be needed.

Phases

The LHINs will be implemented gradually with planning and community engagement first, then service coordination and system integration, and finally funding and resource allocation.

The LHINs will be responsible for the following functions by 2007/08:

(a) Local health system planning

- Developing a local Integrated Health Services Plan in accordance with MOHLTC strategic directions

(b) Local health system integration and service coordination

- Working with health care providers to adapt and customize services to address local health needs
- Collaborating and integrating with other LHINs and the ministry to develop and implement provincial strategies

(c) Accountability and performance management

- Developing local area accountability and performance frameworks and agreements with health service providers that would be funded by the LHINs

- Setting performance baselines, priorities and improvement targets in accordance with provincial framework with health service providers

(d) Local community engagement

- Developing and carrying out community engagement strategies
- Developing mechanisms and channels for community dialogue
- Responding directly to unique local concerns and requirements

(e) Evaluation and reporting

- Evaluating and reporting on local system performance to ministry and/or LHIN community
- Contributing to provincial system-level evaluation and reporting activities
- Evaluating and reporting on best practices in service integration and coordination

(f) Funding

- Providing funds to health service providers within the scope of the LHINs' mandate and within the available LHINs funding envelope
- Providing advice on capital needs to the MOHLTC

Relationship to the Ministry

The Ministry stated that the government “intends to devolve a good deal of power and authority to the LHINs, leaving the Ministry of Health and Long-Term Care to function as a head office, providing more strategic direction.”¹⁶

The relationship between the Ministry and each LHIN will be governed by a Memorandum of Understanding and annual performance agreements. The Ministry would determine overall priorities and the funds to be allocated to each LHIN. The LHINs would then enter into performance agreements directly with health service providers.

The LHINs were established as non-profit corporations until the necessary legislation is passed.

LHINs Governance

LHINs will be governed by Boards of Directors appointed by the government.¹⁷ Board members will be remunerated according to per diem rates established by the Government Appointees Directives.

In June 2005, the Chairs and two Members were appointed for each LHIN. The founding board members and CEOs subsequently participated in orientation and training session sponsored by the Ministry and were to have organized various ‘meet and greet’ activities in their areas.

¹⁶ LHINs Bulletin #11, May 2005.

¹⁷ They are Order-in-Council (OIC) appointments by the Lieutenant Governor in Council (the cabinet). They can be reviewed by the Standing Committee on Government Agencies and several of the initial board appointments were reviewed in June 2005.

The Boards will:

- implement provincial strategic direction, objectives and standards;
- manage local strategies, plans and performance indicators;
- set and monitor planning goals for the LHIN geographical area;
- monitor use of funds;
- enter into performance agreements with LHIN-funded provider organizations;
- enter into performance agreements with MOHLTC; and
- hire and hold CEO accountable.

The Chairs will:

- provide leadership to the Board;
- provide regular progress updates to the Minister;
- manage board and ensure members are aware of legal and fiduciary obligations;
- act as key spokesperson and principal interface with other LHIN boards; and
- inform Minister of critical issues/events.

At the same time as the Chair and first Board members were announced, as their first official duty, the Chairs announced the CEOs for each LHIN. Whatever the formal role of the Board in appointing and supervising the CEO in the future, this means, of course, that the Ministry appointed these crucial first CEOs.

The Ministry also appointed a further three members to each LHIN board by the fall. Public calls for nominations were issued for the final three positions: those who applied will go through the Public Appointment Secretariat process, a nominating committee with some form of community representation will make recommendations to the Boards, the Boards will recommend candidates to the government, and the government will appoint the final three members. The plan remains that the full complement of nine members will be in place by the end of 2005.

Bill 36

Bill 36, the *Local Health Integration Act 2005* was introduced for first reading in the Legislature Nov. 24, 2005, second reading on Dec. 7, 2005, and referred to the Standing Committee on Social Policy.

This Bill provides the overall legislative framework for the LHINs model outlined above. Key provisions are summarized in its *Compendium*:

- it sets out the purposes and powers of the LHINs – including integrated planning, community engagement, working with others to improve access and coordination, allocating funding to health care providers, improving the efficiency of the system, setting performance standards, and other objectives as determined by the Minister through regulations;

- the Minister is required to prepare a provincial strategic plan for the health care system, and each LHIN would prepare an integrated health service plan;
- each LHIN must engage with the community on an ongoing basis, including about its integrated plan;
- health care service providers would also be required to engage with the community in areas where they provide services;
- the Ministry determines funding for each LHIN; and the LHINs would be allowed to reinvest portions of savings realized through efficiencies in patient services the following year;
- the LHINs have the authority to fund service providers and would enter into service accountability agreements with providers;
- the LHINs “could seek to integrate the local health system through its funding allocations, through negotiating and facilitating the integration of services and organizations (with health service providers and others), and through written decisions that require health service providers that it funds to proceed with an integration of services.” This includes requiring providers to provide or stop providing a service, provide a certain quantity of services, or transfer services to another location or institution;
- these decisions must be consistent with the LHINs’ integration plan, relate only to services they fund and could not force a provider to “change its fundamental corporate structure,” for example, by calling for it to close or amalgamate;
- upon receiving advice from a LHIN, the Minister may order that a not-for-profit provider funded by the LHIN cease operations, amalgamate with or transfer operations to another not-for-profit LHIN funded provider;
- much of the detail of the LHINs model will be put forth in regulations. With some exceptions, there will be public consultations on these regulations.¹⁸

This legislation will give the LHINs broad powers: being able to require health care providers in their regions to deliver their services in certain ways means that they will have great influence over how services are provided and in what levels. The Ministry, upon advice of the LHINs, has even broader power to order providers to amalgamate or transfer services, or to cease providing them altogether.

The government released a list of prominent people who endorsed the LHINs, including Roy Romanow, presidents of the Ontario Hospital Association and Registered Nurses Association, and leading executives from hospitals and CHCs.¹⁹

Next Phases

As of December 2005, the LHINs were in early stages of implementation:

- CEOs and six of the nine board members had been selected;

¹⁸ MOHLTC, *Compendium: Local Health Integration Act, 2005*, November 2005.

¹⁹ MOHLTC, *Background: LHIN Endorsements*, Nov. 24, 2005.

- offices were being secured and other senior staff hired;
- CEOs and Chairs had conducted 37 meet and greet sessions in their regions;
- moving forward, they would be addressing the priorities identified in initial consultations, supporting the overall transformation agenda and building relationships with communities and providers in their regions.

As planned from the beginning, the LHINs would be phased in:

- community engagement and local planning in 2005-06;
- local health system integration and service coordination, evaluation and reporting, and accountability and performance management in 2006-07;
- funding in 2006-07 and 2007-08.

Three LHIN CEOs commented on their experience to date at the end of October, 2005. They identified focusing on results, breaking down boundaries, capturing and applying learnings, and creating new ways of thinking and acting within the health care field as key leadership challenges. They also stressed community engagement, building local relationships and open communication that “will be the foundation of long-term collaboration, communication and mutual accountability.”²⁰

The CEOs reported that they had seen:

- excitement to share successes and challenges;
- hesitation about sharing too much;
- scepticism about the changes and concern about their effects;
- readiness to move forward.

However, their presentation was very general and did not comment directly on a number of issues raised later in this paper or concerns being expressed by stakeholders:

- the limited community input to board appointments;
- specific plans for community engagement or participation in priority setting;
- how traditional reluctance of providers and institutional barriers to cooperation and coordination will concretely be addressed;
- how existing service and coordinating networks will be built upon;
- the implications of LHINs funding for-profit delivery of health care.

²⁰ Sandra Hanmer et al, *Local Health Integration Networks (LHINs), Building a True System: Views from the CEOs*, slide presentation notes, OHA Health Achieve conference, October 31, 2005 at <http://lhins.on.ca/english/main/OHA%20Convention%20-%20LHIN%20CEOS.ppt> accessed Dec. 9, 2005.

EXPERIENCE OF OTHER JURISDICTIONS

All other provinces have developed some form of regional health authorities (RHAs). This section survey the origins of these authorities, their mandates and powers, and their impact. The goal is to identify ‘lessons learned’ from the experience of these other provincial authorities that may be relevant for Ontario.

Regional Health Authorities

RHAs were first developed in Quebec in the 1970s and were established in all other provinces thorough the 1990s. Within a great deal of variation in structure and scope.²¹

- they are responsible for the funding and delivery of a range of health services in defined geographic areas;
- while the particular range of services can vary, it always includes hospital and institutional care and many community-based services;
- the RHAs are designed to have the autonomy and local connections to represent community viewpoints and interests in health planning and prioritization;
- they are also intended to integrate services and reduce duplication and inefficiency;
- there is an increased emphasis on prevention and health promotion;
- the overall funding envelop they allocate is determined by the province and the degree of real autonomy is always a key issue – and source of tension.

In terms of other overall patterns:

- RHAs in all provinces have been restructured at least once in their history. Generally, the number of RHAs has been reduced and their regions made larger.
- BC has two tiers of RHAs and then local delivery areas under them; all other provinces have single tiers. Many provinces also have local community councils or networks.
- Many have moved from appointed to fully or partially elected boards (although Saskatchewan moved back to appointed).
- BC, Alberta and Saskatchewan are funded on population-based per capita formulas. Others submit budgets or receive funding envelopes from the province.

²¹ The following draws upon research, reports, newsletter articles and other information from the site of the Canadian Centre for Analysis of Regionalization and Health, a national organization of RHAs, experts, researchers and policy makers based in Saskatoon <http://www.regionalization.org/Regionalization/Regionalization.html> accessed August 26, 2005. Unfortunately, funding for the Centre ran out and it is currently not operating.

Differences from Ontario LHINs

When the Minister first introduced LHINs he emphasized that they were a ‘made-in-Ontario’ solution. The main differences with RHAs in other provinces were seen to be that:

- patient choice of physicians or medical facilities will not be limited by LHINs’ boundaries – so a patient can continue to go to a physician or clinic in another LHIN;
- the LHINs will not provide direct services;
- they will not require consolidation of local governance structures -- hospital, long-term care facilities and other local organizations will keep their boards.²²

The Ministry noted that it had been drawing on national and international expertise by bringing experts together for think tanks. But it did not indicate its analyses of the strengths and weaknesses of RHAs in other provinces or what conclusions it had drawn from their experience.

Historians of Medicare have often argued that not bringing hospitals under public control as health insurance was first being established was a missed opportunity.²³ With the evolution of medical care and technology, hospitals, especially the largest tertiary and teaching hospitals, have become powerful institutions within the health care system. Analysts have argued that they have been very adept at protecting their own institutional interests, and have at times been a significant brake on system-wide cooperation, rationalization and reform. In addition, hospitals in the major cities especially have tended to be governed by powerful and well-established local interests. Is the province missing another opportunity to reduce the power of locally entrenched interests over health care reform and to rationalize the system of public health care institutions?

The Practice and Impact of Regionalization

There has not been definitive comprehensive research on the impact of regionalization: “The implications of regionalization for improving health effectiveness and efficiency and its broader social implications for community participation and understanding of health have yet to be fully assessed.”²⁴ On the other hand, research on specific issues, conferences and other analyzes from practitioners are starting to fill out some key patterns.

This section first clarifies the underlying goals of RHAs and then discusses their impact in terms of those goals.

²² LHINs Bulletin #11, May 2005.

²³ Stephen Tomblin, *Creating a More Democratic Health System: A Critical Review of Constraints and a New Approach to Health Restructuring* Discussion Paper No 3, Commission on the Future of Health Care in Canada, 2002.

²⁴ Canadian Centre for Analysis of Regionalization and Health, “Definition of Regionalization” accessed August 26, 2005

The RHAs have formal mandates and powers, varying in details but broadly similar. And there are also, of course, less explicitly stated purposes and goals. For example, the RHAs were first developed in a context of restructuring and cuts to health expenditure, and provincial governments saw the RHAs as buffers against community opposition.

The policy context in which RHAs arose included:

- it was widely recognized that the health care system was too complex to be managed centrally and that more locally sensitive planning, as opposed to the blunt instruments of provincial budgets, would be more effective;
- similarly, fundamental reform and restructuring was needed, and it was hoped that regional authorities could play an effective coordinating or mobilizing role in such broader changes;
- an emerging emphasis on population health and the wider social determinants of health – and that it was harder for traditional institutions to adapt these new understandings;
- the need for better accountability – and an often unstated hope that RHAs would rely less on partisan considerations and more on research and evidence in making their decisions.²⁵

Experts and practitioners have highlighted four broad objectives:

- regionalization was seen, more or less explicitly, as part of broader health care reform and restructuring;
- community involvement in planning was seen as key to more effective priority setting;
- focusing on regional and local needs, and developing better planning processes, would lead to more effective allocation of resources and greater efficiency;
- enhanced integration of services would lead to better health care delivery.

Contribution to Wider Restructuring

RHAs were seen by their provincial governments as important parts of wider restructuring efforts from the beginning. The early phases of this restructuring through the 1990s focussed on consolidation of services and cutting costs.

RHAs proved useful to provincial governments in managing these cuts by buffering them from criticism. Community opposition to particular decisions was deflected to the RHAs that allocated the funds, rather than the central government that had cut back the level of funds available. Leading analysts have argued that there may be limits to this buffering role. If cuts are too deep, RHAs may not be

²⁵ Jonathon Lomas, “Devolving authority for health care in Canada’s provinces: 4. Emerging issues and prospects” *Canadian Medical Association Journal* March 15, 1997 156 (6); Steven Lewis, *Regionalization and Devolution: Transforming Health, Reshaping Politics*, Occasional Paper No. 2, Healnet Health Services Utilization and Research Commission, Saskatoon, October 1997.

able to defend them or may no longer be able to retain the support of local communities. RHAs could distance themselves from restructuring, or support or even mobilize community pressure against cuts.

While many board members recognized RHAs were created for these political purposes, they felt overall that the extensive reforms of the 1990s were necessary and that the health care system had been improved as a result. There was general satisfaction with the role that RHAs played in those reforms.²⁶

Another facet of this initial role for RHAs in restructuring was provincial governments' "hope to establish an alternative source of legitimate power over dominant interests that have historically prevailed."²⁷

However, the hope that RHAs would be more able to overcome provider or institutional opposition to change was not realized. RHAs have not been able to escape the tension between:

- rationalization or integration of services, and increased community involvement, on the one hand;
- health provider interests and opposition to fundamental reform on the other:
 - providers, especially physicians, tended to oppose reforms that would restrict their professional autonomy;
 - professionals were also able to ally with local community opposition to hospital closures in many cases.²⁸

The contradiction here may be that RHAs will only be able to play a major role in facilitating overall reform or pressing providers to accept change if they are seen as legitimate and effective by local communities; this legitimacy can be weakened if they are seen largely as supporting provincial cost cutting.²⁹

Primary Care Reform

More recently, there has been considerable discussion of how regionalization can be most effectively linked to primary care reform. The Canadian Centre for Analysis of Regionalization and Health saw many parallels in that comprehensive primary care reform would involve integrating different providers, delivering a comprehensive range of care, fostering community development and addressing non-medical determinants of health – all facets of effective regionalization.

The Centre conducted a survey of RHAs early in 2004 on their involvement in primary care reform:

²⁶ Denise Kouri, Kelly Chessie and Steven Lewis, *Regionalization: Where Has All the Power Gone? A Survey of Canadian Decision Makers in Health Care Regionalization*, Canadian Centre for Analysis of Regionalization and Health, December 2002.

²⁷ Lomas "Devolving authority" p. 819.

²⁸ Ibid: 821

²⁹ Steven Lewis et al, "Devolution to democratic health authorities in Saskatchewan: an interim report" *Canadian Medical Association Journal* February 6, 2001 164(3).

- almost ½ were conducting primary care initiatives;
 - almost all RHAs had multi-disciplinary teams;
 - the next frequently reported initiatives were chronic care management;
 - projects to improve access were reported by ½ the respondents;
- about 80% were involved or planning to work with sectors outside of health;
- 80% believed that regionalization contributed to the success of their primary care reform efforts through better collaboration and integrated planning.³⁰

Success factors and challenges were identified:

- governments needed to provide leadership and funds;
- funding mechanisms needed to be aligned with reform initiatives – e.g. appropriate incentives for providers to alter practice formats;
- provider resistance was frequently cited as a barrier to change; and
- involving providers in planning was seen to be essential.³¹

The theme of the CCARH 2003 annual conference was on the relationship between regionalization and primary care reform. Participants saw that RHAs could bring reforms down to a human scale. The community consultations, needs assessment and integrated planning that RHAs were constantly doing could also be the base for other reforms such as primary care. Similarly, RHAs are well placed to monitor performance and provide evidence about the impact of system reforms.³²

Community Involvement

the boards of RHAs are mandated to reprints broad community interests. However, it is also widely recognized that broader community participation in RHA planning and decision-making is critical. This can vary from:

- needs assessment to feed into planning;
- through community participation in the planning process:
 - at the minimum, as one source of input into priority setting;
 - or being directly involved in identifying and ranking priorities;
- to, most strongly, mechanisms whereby community representatives make decisions about resources to be allocated and services to be provided.

Some analysts see this latter sense of community empowerment as a goal of regionalization. It is clear that RHAs have not resulted in such community empowerment; nor would most board members see it as their goal.

However, RHAs definitely have increased public input and arguably influence in health care planning:

³⁰ Canadian Centre for Analysis of Regionalization and Health, *Newsletter* August 2004.

³¹ Ibid

³² Canadian Centre for Analysis of Regionalization and Health, *Newsletter* November 2003.

- some provinces mandate public consultation through structural measures such as networks or local advisory bodies underneath the RHAs;
- all increasingly use focus groups, public meetings and other forms of input;
- about $\frac{3}{4}$ of respondents to a recent national survey indicated that the main purpose of consultations was to help set goals and priorities;
- about $\frac{1}{4}$ involved the public in resource allocation decisions.³³

Planning and Priority Setting

Practitioners have generally felt that effective planning processes have been established and that, at least partially because of public input and more locally sensitive needs assessment, planning and priority setting is better. A 1997 survey of Saskatchewan board members found that they felt RHAs had been relatively successful in:

- increasing local control over health services;
- improving the quality of health care decisions;
- but that improved community needs assessment was needed.³⁴

In this latter regard, many practitioners have argued that more sophisticated consultation methods and increased information so the public can effectively participate are needed.

Lines of Authority

There has been considerable debate on the relationship between the RHAs and their provincial governments. The fundamental structural problem has been that overall funding and policy decisions are made by the provinces and the RHAs can operate within quite strict constraints. Recent national surveys found that:

- board members felt RHAs did not have the authority they needed or had expected;
- on the other hand, provincial officials did not agree RHAs' autonomy was too restricted, but did think that provider and other interests had too big an influence;
- board members felt that the division of authority was not clear enough – e.g. that residents sometimes bypassed the RHAs to take concerns directly to the provincial government.

It would appear that in the early 2000s provinces were taking back previously devolved authority by appointing board members where they were previously elected.³⁵

³³ Denise Kouri, "Is Devolution Working?" *Canadian Healthcare Manager*, October 1, 2002

³⁴ Lewis el, "Devolution."

³⁵ Kouri et al "Regionalization."

Governance

Survey and other analysis indicates that whether board members are elected or appointed has little effect on how boards worked. Given the very low turnout for elections, the representational effect would appear limited as well.

A more significant issue is whether and to what degree health care providers are represented on the boards. Provider members felt far more than others that providers should have more say in running the health care system. A leading analyst noted that: “One of the major challenges faced by regional boards is to confront provider interests, such as pay levels, working conditions and work location, when they conflict with community or provincial government objectives. Putting health care providers on boards provides opportunities for them to resist change when such inevitable confrontations arise.”³⁶

Integration of Services

The RHAs are seen to have been relatively successful in improving planning and coordination:

- most have been able to achieve some horizontal integration:
 - especially in fostering hospital integration or amalgamation, or by reducing inter-hospital rivalry and duplication;
 - experts argue that it is less contentious to address hospital and large institutions;
- vertical integration of hospital and community service providers had been more difficult;
- one objective of regionalization was to more effectively include prevention and health promotion in the continuum of care:
 - public health departments and health promotion programmes already existed;
 - regionalization allows for more joint planning and coordination across government departments and with community agencies that formerly worked in silos;
 - for example, while public health always offered immunization, it could now feed data back to the acute sector to help plan for outbreaks;
 - however, it is not clear that the coordination opportunities offered by regionalization have resulted in practical improvements in health promotion beyond what public health and other long-standing programmes were already doing;
- there have also been many interesting examples of effective local coordination:
 - Diabetes care was rationalized by Capital Health in Alberta. A single phone point of entry, standardized referral processes and a triage team were developed. Referrals and wait lists were monitored and adjusted. Specialists were concentrated in clinics, staff did more comprehensive

³⁶ Jonathon Lomas, “Past concerns and future roles for regional health boards,” *Canadian Medical Association Journal* February 6, 2001 164(3).

follow up and a community-based diabetes team was established. Wait times were reduced from 4-8 months to 2 weeks and the proportion of those with diabetes accessing services increased from 20 to 35%.

- A surgical care network was established in Saskatchewan to create a surgical registry, province-wide integrated pathways for procedures, transfer and referral protocols and better communication. These changes were put in place through RHA agreements and accountability measures.³⁷
- RHAs have been less able to affect broader determinants of health such as employment, poverty, education, etc. as these factors are both pervasive and beyond their particular mandates. On the other hand:
 - population health perspectives have been increasingly emphasized;
 - some RHAs work to share innovations not only to their counterparts and Health Ministries but to other sectors as well;
 - some address determinants by working in partnerships with other sectors;
 - some hope to go beyond networking and collaboration to community capacity building.³⁸

Key challenges to service integration have been:

- inadequate consultation, planning and implementation have often led to service provider and labour dissatisfaction;
- especially when regionalization was closely linked to provincial cost-cutting;
- human resources planning and change has been less flexible than expected.³⁹

Summary and Implications

Experts and practitioners emphasize that regionalization should not be seen as a single initiative; provinces had different objectives and the way in which they implemented regionalization varied considerably.

Analyses of the implications of regional health authorities in other provinces have focussed on the following broad themes or questions:

- how RHAs have been part of broader health care restructuring and reform;
- how community voices and interests have been incorporated into RHA planning and priority setting, and to what extent this has contributed to community empowerment;
- the kinds of planning processes, governance and relationships to the province, and their implications for system efficiency and responsiveness;
- whether and how more locally attuned needs assessment and priority setting, and more systematic planning in general, have contributed to better allocation of resources and overall efficiency;

³⁷ Canadian Centre for Analysis of Regionalization and Health *Newsletter* November 2004.

³⁸ Steven Lewis, Plenary Address to the 2004 annual conference of the Canadian Centre for Analysis of Regionalization and Health.

³⁹ Kouri "Is Regionalization Working?"

- whether and how regional planning and delivery has enhanced access to a full continuum of high quality care;
- whether and how regionalization has contributed to more effective and responsive integration of services; and
- to what extent all of this has contributed to better delivery, higher quality services and improved health outcomes.

Discussion of these issues has been extensive and detailed: the annual conferences of the Canadian Centre for Analysis of Regionalization and Health and its newsletter and web site were filled with assessments of programmes and projects, and of common planning issues the RHAs have faced. However, these assessments relied on programme specific or anecdotal evidence, and there has been very little systematic evaluation of the concrete results of regional planning and delivery. Nonetheless, practitioners and experts have come to similar overall conclusions on the impact of regionalization:

- communities have been more involved in planning and priority setting;
- divisions of authority with provinces remain contentious and complicated;
- a wide range of service integration initiatives have been promising;
- RHAs have been important elements of wider reforms such as primary care;
- other objectives – such as better system-wide management and more emphasis on population health -- have been harder to implement, but appear to have been moving in the right direction;
- barriers and challenges have included:
 - confusion over the division of authority with provinces;
 - provider opposition to increased cooperation or system change;
 - the role of RHAs getting conflated with opposition to cost-cutting and wider system reforms.

The Scope of Regionalization

The RHAs have faced tensions between competing objectives. For example:

- meeting provincial government pressures for restructuring, greater efficiency and more integrated delivery was seen to be incompatible with representing and empowering the community;
- it was difficult to push through significant reforms while maintaining service provider morale, and resistance from major health care provider groups has been a significant constraint;
- there has been considerable ongoing tension between provincial control of funds and overall priorities, and local/regional autonomy.⁴⁰

Faced with these tensions, most RHAs have focussed on more manageable tasks of rationalizing service planning and delivery.

⁴⁰ Lomas “Devolving authority” p. 821; Steven Lewis & Denise Kouri, “Regionalization: Making Sense of the Canadian Experience,” *Healthcare Papers* 5:1 2004; 12-31.

A study for the Romanow Royal Commission concluded that the impact of RHAs in overall system reform has been limited by their scope:

- they have not controlled their budgets and have to work within overall strategic directions set by the provinces;
- the arguably most important resources and drivers of the health care system – physicians, pharmaceuticals and payment/incentive schemes – are beyond their control;
- they have not been able to force structural change or overcome institutional opposition.⁴¹

This issue was highlighted by experienced policy makers and practitioners in a recent collection on regionalization. For example, arguing that Ontario should move to devolution as part of comprehensive reform, leading health law expert Colleen Flood and Duncan Sinclair, chair of the restructuring commission of the 1990s, stated that ...”fiscal responsibility for key elements, such as physician services and determining the rates of pay for all providers and employees (or the drug budget) has not been devolved to any regional health authority. Who can manage effectively without control of all the significant levers?”⁴² Colleagues from Nova Scotia largely attributed the inability of RHAs to drive “transformational change” to their limited powers:

- their control over funding and planning for the full range of institutions in the hospital, continuing care, public health and community sectors;
- more fundamentally, “a ‘best possible’ continuum would also include a comprehensive pharmaceuticals and equipment program, a thoughtful information management strategy and, most importantly, physicians and other healthcare providers” and RHAs have generally had very little authority or influence over these areas.

These analysts concluded that “to expect any significant gains will be made in the regionalization process is unrealistic until all aspects of the continuum are under the control of a region.”⁴³

Along similar lines, an Institute for Research on Public Policy Task Force emphasized that:

The reallocation of responsibility and authority from provincial/territorial departments of health to regional health organizations for the management and operation of the healthcare services is a powerful and appropriate strategy

⁴¹ Jean-Louis Denis *Governance and Management of Change in Canada’s Health System*, Discussion Paper No 36, Commission on the Future of Health Care in Canada, 2002.

⁴² “Devolution – A Solution for Ontario: Could the Lone Wolf Lead the Pack? *Healthcare Papers* 5:1 2004: 66.

⁴³ Thomas Ward & Lewis Bedford, “Continuum of Care Must Be under Region’s Control,” *Healthcare Papers* 5:1 2004: 55-59.

to enable Medicare to meet the challenges of the 21st century. If we are to continue to meet the healthcare needs of Canadians, the myriad of individual services and programs available to patients must be integrated into a single local/regional health management body to enhance the efficiency and appropriateness of services provided.

It argued that results in terms of health outcomes, efficient allocation of resources, and public and provider satisfaction have been mixed so far, partly because provinces have not devolved authority for the full spectrum of care. The IRPP Task Force concluded that “reallocation of authority and responsibility for the management/operation of services must be all or nothing. Incomplete devolution of responsibility for common services perpetuates their duplication, sustains the incidence of patients falling through the cracks, and allows continued fragmentation of the continuum of care.”⁴⁴

Timing

Timing and phasing are always important. One analyst noted after the first five years or so of regional planning that “if experience to date is a guide to the future, in their first years boards will mainly be preoccupied with learning their business and riding herd on the system as it was – with the same or fewer resources. The propensity to innovate and stretch the bounds of the permissible will be low.”⁴⁵

RHAs were developed in the other provinces in a climate of fiscal constraint. In fact, in several, the province cut hospitals and services just as they were creating the Authorities. While this was never a formally stated objective, many observers and practitioners concluded that RHAs were seen as a buffer to insulate the province from community opposition to cutbacks and restructuring

The political context for the LHINs may be more favourable to reform and rationalization. For better or worse, the main hospital restructuring has taken place. While hospitals are under considerable pressure to balance their budgets and cost containment remains a significant constraint, there is new investment in these and other areas. The current drivers are more ensuring that all expenditure is efficient and coordinated, rather than simply cutting costs.

Implications for Ontario

Ontario has emphasized that its model is different from other provinces. But there is no reason to think that the kinds of tensions sketched above will not also be important in Ontario; and they were certainly evident in the reaction to LHINs so far.

⁴⁴ Institute for Research on Public Policy, Task Force on Health Policy, *Recommendations to First Ministers*, Montreal: the Institute, 2000: pp 15-16.

⁴⁵ Steven Lewis, *Regionalization and Devolution* p. 5.

One that may prove particularly complex in the coming years may be the decision to retain independent boards for hospitals and other institutions. The Ministry has not really said why it decided to retain these local governance structures. If it was seen as part of an effort to build on local community networks and forums to maximize community engagement, then that is one thing. How such community engagement and participation in LHINs priority setting can most effectively be facilitated is discussed below. However, if it was one more instance of not wanting to address the institutional power of hospitals and other entrenched provider interests, then that bodes less well for the possibilities of flexible and nimble reform. So, the first lesson for Ontario from the experience of other provinces may be that the structure and ethos of governance is going to be very important: if the processes chosen really do engage communities and put community interests and voices at the heart of health care planning, then there is real potential for significant change; on the other hand, if hospitals and the major professions continue to dominate the system as a whole, then the possibilities will be far less promising.

A related and equally fundamental issue was emphasized by the Institute for Research on Public Policy Task Force and many other experts. The impact of regionalization has been limited because of what it has not included: especially physicians, pharmaceuticals and the ability to control payment and incentive schemes. Ontario has chosen to limit the scope of the LHINs as well. The province should carefully watch to see if leaving doctors and drugs out of their scope restricts the potential of the LHINs to drive change and create a full continuum of care.

There are other critical governance issues that are highlighted by the experience of the other provinces:

- the first is that the division of authority between the province and the LHINs will need to be very clear; lack of strategic clarity from the provinces or too limited autonomy for the RHAs was constantly emphasized by practitioners.
- If Ontario really does want to devolve authority and responsibility for planning to the regional level, then the key financial incentives and levers have to follow: the LHINs will need to have real powers to allocate resources and to use these powers to drive reform. The test will likely come soon enough: the first time that a LHIN proposes to reallocate funds from a major hospital, and when the hospital goes to the Ministry to complain, will the Ministry back up the LHIN?
- all provinces developed means of more local level consultation and involvement to feed into regional planning. Effective community engagement will need to include innovative and responsive means of local engagement as well, and good transparent means to assess and balance the no doubt competing local priorities and demands.

The final lesson learned may be the most optimistic. There are countless examples of coordinating networks and projects that have contributed to more integrated and better quality care across the country. Early consultations for the

LHINs showed that this is also the case in Ontario. Identifying networks and planning that is already working well, building on these successes, filling gaps and encouraging local innovations has tremendous potential.

STAKEHOLDERS IN ONTARIO

Public reaction so far has been mixed – not surprising given the range of interests that will be affected – somewhat tentative – again, not surprising, given the early stage of this reform – but overall more positive than not. This is not meant as a comprehensive survey of all that has been said about LHINs. Rather it is a snapshot of the main issues that are being raised by key stakeholders.

Providers

Ontario Hospital Association

The OHA has generally supported the development of the LHINs. It sponsored a policy conference in December 2004, established a working group and developed a policy paper on LHINs.

The Association recommended:

- a clear vision and policy context for implementation;
- a clearly defined mandate for the LHINs – they worry that continued uncertainty will undermine effectiveness;
- a strong commitment to maintaining the independent nature of community governance, including of hospitals;
- they support the government’s phased-in approach;
- clear deliverables, performance objectives and evaluation criteria;
- public and stakeholder buy-in thorough comprehensive consultation.⁴⁶

The OHA has also asked whether the CEO of each LHIN will be accountable to the government or to the LHIN Board of Directors, and recommends that the recruitment and performance management of the CEO be delegated to the LHIN Board. They also expressed concern about the potential loss of autonomy in local decision-making if LHIN boards are remunerated and appointed through orders-in-council.

The OHA also agreed with the government that integration should be the driving force behind the creation of the LHINs. It pointed to various examples where integration has worked well: chronic disease management, centres of excellence, comprehensive community support PACE programmes for the elderly, voluntary coordinating networks and rural and northern care networks. However, it recommends that integration might not be advisable for all aspects of health care: “Experience in other jurisdictions shows that integrating all services for all patients may not be cost-effective given limited financial resources.”⁴⁷ They set

⁴⁶ Ontario Hospital Association, *Collaborating for Change: Optimizing the Effectiveness of Local Health Integration Networks in Ontario*, 16 February 2005.
[http://www.oha.com/Client/OHA/OHA_LP4W_LND_WebStation.nsf/resources/LHINsPaper/\\$file/OHALHINPolicyPaper.pdf](http://www.oha.com/Client/OHA/OHA_LP4W_LND_WebStation.nsf/resources/LHINsPaper/$file/OHALHINPolicyPaper.pdf), accessed August 22, 2005.

⁴⁷ OHA, *Collaborating for Change*, p. 3.

out a proposed funding formula and recommended that LHINs have special funds to support crucial integration projects.

The OHA highlighted key success factors:

- invest in evidence-based research to guide decision-making;
- work sensitively with local volunteer hospital and other boards;
- ensure the boundaries facilitate integrated delivery by paralleling catchment areas of all community agencies and providers in the region;
- an effective provincial health human resources strategy;
- invest in necessary enabling infrastructure – up-front costs, information infrastructure and management and training;
- a clear implementation strategy and critical path for rolling out the LHINs;
- recognizing specific needs of the North and rural areas;
- community consultation and buy-in;
- recognizing the continuing role for province-wide and academic health centres in complex cases, training and innovation.

The OHA played a leading role in creating an Integration Task Force of providers and stakeholders as a think tank on system integration. Its key principles called for an incentive-based rather than prescriptive approach to fostering system change. It emphasized the “coordinated engagement of citizens, health and community service providers and funders” and that “whatever form integrated initiatives and collaborations take within LHINs, the contribution of all health and community service providers must be valued equally.”⁴⁸

Physicians

The Ontario Medical Association has been far more hesitant. It was particularly concerned that physician input to early planning “has been negligible” and argued that “one of the recurring problems seen throughout Canada has been an attempt to integrate services without the engagement of front-line providers.”⁴⁹

The OMA foresaw a number of problems:

- very short timelines – regionalization took decades to complete in other jurisdictions;
- the Ministry sees the LHINs as distinct because volunteer boards will continue, but they will be bound by performance agreements – they seem like RHAs from other provinces in crucial respects;
- DHCs were wrapped up abruptly without transferring their knowledge;

⁴⁸ Health System Integration Task Force, *Key Principles for the Establishment of Local Health Integration Networks*, September 15, 2004
http://www.oha.com/Client/OHA/OHA_LP4W_LND_WebStation.nsf/CD0BBBE7B8237E1E85256482005B6998/3706300F17E30EA085256F2E00614164?OpenDocument accessed September 21, 2005

⁴⁹ Steven Harrison and Ted Boadway, “Local Health Integration Networks: Backgrounder” *Ontario Medical Review* April 2005; 18.

- primary care reform has not been closely connected to the LHINs initiative.

They called for a clear and transparent planning process with physicians at the design table. To that end the OMA has established an integration committee.

Community Health Centres

The Association of Community Health Centres supports the goals of integration and making the system more responsive. CHCs have long been involved in local integration efforts and multi-sectoral partnerships. Key success factors for the LHINs initiative were identified:

- they must have responsibility for all components of primary care, including physician and other health professional services;
- there must be binding provincial standards for primary care:
 - they called for a broad-based Primary Care Action Group with the power to set these standards;
 - payments schemes must allow the necessary flexibility – e.g. eliminating barriers to those physicians who want to work both in independent practice and in CHCs;
- there must be appropriate support for specific populations facing barriers in access to health services;
- the LHINs must engage community-based providers and groups at the local level and build on existing networks;
- for profit primary care delivery must be forbidden;
- accountability to communities must be one of the guiding principles of reform. This could include set number of board positions for community and sector representatives;
- whatever re-allocation of resources that takes place once the LHINs are established should incorporate a ‘one-way valve’ -- so that funds can only be diverted from acute care to community services, not the other way around.⁵⁰

Mental Health Service Providers

The Canadian Mental Health Association, the Centre for Addiction and Mental Health and the Ontario Federation of Community Mental Health and Addiction Programs issued a joint statement. They argued that mental health and addiction “has long been the orphan of the health care system” but that it must be integral to the transformed system. They also emphasized that consumers and families must be central to the transformation agenda and that access to housing, income, employment and social supports is crucial for mental health treatment and recovery.⁵¹

⁵⁰ http://www.aohc.org/app/DocRepository/2/Current_Issues/AOHC_Position_LHINS.pdf accessed October 29, 2005.

⁵¹ *Mental Health and Addiction Sector Responds to Ontario’s Transformation Agenda*, released October 8, 2004 http://www.camh.net/news_events/LHINs_support_statement10_04.html accessed November 9, 2005. In fact, mental health and addictions services were mentioned more than any other topic and in every workshop during the integration priority consultations: *Complete Findings*.

One concern was policy development. They argued that regionalization in other jurisdictions has led to a draining of resources and capacity from the health ministry to the regions. They stressed that a strong provincial government and Ministry was essential to leading reforms of the scale envisioned in the transformation agenda. They proposed a concrete mechanism in their field: a network or authority of mental health providers and experts to provide cross-regional policy leadership with a formal mandate from the government.⁵²

Unions

The Canadian Union of Public Employees and the Ontario Public Service Employees Union oppose LHINs. They argued that they will allow provincial politicians to avoid responsibility for their decisions as concerns or opposition to health care funding or service changes are deflected to the LHINs. They were both concerned that integration or centralization of services will result in jobs and services being lost and that health care services will be increasingly privatized.⁵³

CUPE also developed a more extensive discussion document. It argued that the LHINs and other reforms did not deal with the most significant cost drivers: pharmaceuticals and medial technology/equipment. It highlighted problems in the UK split purchaser-provider model favoured by the government for the LHINs: administration costs are higher because all services have to be costed; the system became more not less fragmented – services cut by hospitals became costs for some other providers; the focus become contract performance not meeting patient need; hospitals who could not provide particular services at the defined cost had to drop them or purchase them from others; and private clinics and hospitals grew.⁵⁴

Union opposition intensified after the LHINs legislation was introduced. CUPE, OPSEU and the Ontario Nurses Association (ONA) issued a joint press statement reiterating these themes and expressing further concerns:

- there has been no comprehensive plan for employee security and no front-line input;
- the initiative ignores the role of doctors as ‘gatekeepers’;
- the LHINs have the potential to extend the “disastrous competitive bidding” now used in home care to the entire health care system.⁵⁵

⁵² *A Strong Provincial Focus for the Addictions and Mental Health Sector in Ontario*, July 5, 2005.

⁵³ Canadian Union of Public Employees (CUPE), “Local Health Integration Networks: Report on Information to Date—May 4, 2005.” http://www.cupe.ca/updir/LHINs_-_Information_Report_-_May_10_2005_pdf_format.pdf, accessed August 18, 2005; OPSEU Online, *LHIN Emergency: Health Care Chaos*, accessed August 18, 2005.

⁵⁴ Local Health Integration Networks: CUPE Discussion Document September 2005 http://www.cupe.ca/www/Regionalization_and_/18083 accessed November 9, 2005.

⁵⁵ “Unions say flawed Liberal plan will create health care chaos,” December 9, 2005.

Local newspapers and news services carried stories of unions and their supporters picketing MPP offices.⁵⁶

Other Community Perspectives

The Ontario Health Coalition expressed significant concerns early in the LHINs process:

- they worried that the LHINs will be dominated by the provincial government rather than the local community;
- they noted that initial consultations were facilitated discussions on set topics rather than public hearings, and were more geared to agency representatives than residents.⁵⁷

They followed up with a discussion paper in May 2005 which highlighted both the potential and challenges of key facets of the LHINs:

- the UK-type purchaser-provider funding model:
 - can set concrete targets – although it is crucial that consumers be part of setting the targets;
 - but allows for greater privatization, with consequences such as:
 - increased administrative costs as every procedure and process now has to be priced and tracked;
 - in a competitive environment, there are real disincentives for providers to cooperate or share information;
- similarly, integration:
 - could be a positive development if it leads to a better continuum of care;
 - on the other hand, it could also lead to forced amalgamations, increased privatization, and resulting poorer quality of care;
- they pointed to potential conflicts over resource allocation:
 - when CCAC board members became government appointed the Centres no longer voiced public opposition to funding and service cuts;
 - it may also be difficult for providers to speak out if the LHINs control their funding.⁵⁸

The OHC developed a response to the introduction of Bill 36. It concluded the LHIN initiative centralized rather than devolved power and saw it as essentially health care restructuring. The Coalition was specifically concerned that:

- provisions for democratic input and community control are not specified, and there was no real public input to developing the LHINs concept;
- the legislation will facilitate privatization:

⁵⁶ Guelph *Mercury*, Dec. 3, 2005; Canada News Wire, Dec 1, 2005.

⁵⁷ Ontario Health Coalition *Backgrounder* November 2004 <http://www.web.net/ohc/LHINs.PDF> accessed September 25, 2005.

⁵⁸ Ontario Health Coalition, *Analysis of Ontario's Health Restructuring Under Local Health Integration Networks*, May 11, 2005.

- the Ministry's current trend is to support competitive bidding and specialization within hospitals → patients will have to travel more;
- the legislation provides broad powers to force the closure or amalgamation of non-profit service providers – but not for-profit providers;
- a competitive bidding process requires a pricing system, which entails additional administrative costs and provides the tools and data for private insurance to be established;
- the principles underlying the initiative are unclear and inadequate;
- an expensive administrative tier is created with no clear benefit.⁵⁹

There has been some concern from outside the main cities that the LHINs will be dominated by large urban institutions. A related concern has been expressed in the large cities themselves: that reform and planning will come to be dominated by the major hospitals and doctors. A challenge of the urban LHINs will be representing and reflecting the ethnic, cultural and social diversity of their communities.

⁵⁹ Ontario Health Coalition, Bill 36 LHINs Legislation Analysis January 2006
<http://www.web.net/~ohc/lhins/LHINsLegislationAnalysis2.pdf>

POLICY CHALLENGES

The following sections analyze a number of pressing issues and questions in implementing the LHINs initiative. What is needed for the reforms to be successful. What would success mean to different stakeholders and how can we assess it? The next section starts by identifying the most productive and progressive goals for the LHINs initiative.

Clarifying Goals

Part of the debate so far on LHINs has been the need to specify very concrete goals, and develop realistic indicators and measures to measure progress against those goals.

This section begins from the goals set out by the Ministry, but also builds upon the experience of other provinces and adds community interests and perspectives. It differentiates key goals and breaks them down into concrete or operational components. The most important pre-conditions or success factors for each goal are identified. Finally, the implications and impact of these goals are illustrated by analyzing them not only from the points of view of the government as the major funder, policy setter and as ultimately responsible for the health care system; but also from the standpoint of local communities and individuals.

Adding Community to Ontario Goals

The Ministry set out four basic goals for the LHINs: planning and delivering services locally, engaging communities, improving accessibility, and increasing system efficiency. One criticism has been that these goals are still too general. The Ministry could reasonably respond that it is for the LHINs to flesh out these goals more concretely as the reforms unfold.

To contribute to this clarification, this section amplifies the Ministry's goals to consider what successful LHINs would look like from the point of view of local communities and individual users of the health care system. These fuller goals could include:

- community interests and values will drive local and regional health care planning, resource allocation and delivery;
 - this will require creative forums and mechanisms to tap into community needs, experience and insight, and sustained resources to build community capacity to meaningfully engage in systemic planning;
- more effective planning will ensure that:
 - the key priorities for particular communities are identified;
 - resources are allocated to the issues and programmes that will have the greatest impact;
 - services will be effectively linked and coordinated so that these resources are most effectively used in service delivery;
- in a broader sense, integrated planning and delivery means:

- not just better treatment when people get ill or the most effective transition between institutional and community care settings;
- but better chronic condition management;
- more effective prevention and health promotion;
- services that take into account the broader social determinants of health;
- the outcome will be equitable access to all needed services – when needed;
- these services will be organized and delivered as a seamless continuum of care:
 - with easy entry and movement between services for users;
 - with acute, chronic, institutional, community and health promotion effectively coordinated;
- care will be high-quality:
 - not just in the technical and medical sense;
 - but care that takes into account the preferences, culture and lived experience of particular communities and individual service users.

Restated Goals

Building upon this re-orientation, we see five over-arching goals for LHINs:

1. contributing to the overall transformation of the health care system and working effectively in tandem with other reform initiatives;
2. priority setting and resource allocation that is driven by community input and interests;
3. more efficient and responsive planning, organization and governance of health care;
4. integrated planning and coordination of the full spectrum of health care programmes, providers and institutions to enhance efficiency and innovation in health care delivery;
5. as a result of integrated and community-driven planning, the LHINs will create a seamless continuum of care and ensure all have equitable access to the high-quality care they need, when they need it.

Each of these goals is discussed in a section to follow.

LHINs and Broader Health Care Reform

The province clearly sees the LHINs as an important element of its overall transformation agenda. It is certainly not alone in this. Commission after commission at the provincial and national levels have analyzed the need for fundamental change and come to broadly similar conclusions.⁶⁰ The Ontario transformation agenda echoes common themes of regionalization, primary care

⁶⁰ For an overview of these commissions see Cathy Fooks and Steven Lewis, *Romanow and Beyond: A Primer on Health Reform Issues in Canada* Discussion Paper No. H/05 Health Network, Canadian Policy Research Networks, November 2002.

reform, integrated resource and infrastructure planning, and quality improvements.⁶¹

There are three main policy challenges in ensuring that the LHINs become a productive element of overall health care reform:

- first of all, ensuring that the LHINs initiative is implemented effectively so that coordinated planning and delivery is enhanced. Arguably, integrated planning and delivery is the foundation of the other key reforms. How to achieve this is the focus of most of the remaining sections of this paper.
- secondly, the new LHINs must be well coordinated with primary care, information technology and other reform efforts. While the Ministry has established various task forces to lead reform efforts, it has not entirely clarified how the various elements will fit together and how LHINs will support other reform initiatives.
- thirdly, all of these reforms cannot be seen in isolation, but must address poverty, inequality, homelessness, social exclusion and other fundamental social determinants of health that have been shown to have such a powerful impact on ill health.

Coordinating Reform Initiatives

There are important lessons to be learned from the experience of other provinces with regional planning. For example, practitioners and experts have argued that RHAs have played a key role in supporting and facilitating primary care reform. While it may be too early to specify exactly what this role should be, the LHINs should consider how multi-disciplinary teams, innovative practice forms and other components of primary care reform can be linked into their community consultations and planning from the outset. They can also identify supporting innovations in primary care as one of their main strategic priorities. The province also has to carefully consider existing policy or institutional barriers to reform. For example, will the Family Health Teams fall under the LHINs' planning mandate? Will FHTs, CHCs, OHIP and other regulatory schemes allow doctors to practice in these different formats without financial disincentives?

⁶¹ Other commissions more explicitly emphasized population health perspectives, pharmaceutical policy and financing the system. In terms of the latter, Ontario reforms, as with all other jurisdictions, are very much part of ongoing federal-provincial-territorial financial deliberations.

Policy Action Recommendation	Expected Outcomes
<p>The province should publish a discussion paper in January 2006 setting out how the development of LHINs, primary care reform, information systems and other reforms will complement each other.</p> <p>The province should convene a stakeholder conference by March 2006 to discuss how the various reform initiatives can most effectively be coordinated and implemented.</p>	<p>More effective coordination of various reform efforts;</p> <p>As the reforms are better understood and supported by communities and individuals, community engagement in these reforms will be enhanced;</p> <p>A first step to supporting broad community engagement → broader support for health care reform.</p>

Beyond Health Care Reform: Tackling the Social Determinants of Health

A wide and solid range of health care research and practice has demonstrated that poverty, inequality, early childhood development, housing, social inclusion and many other social and economic factors have a pervasive impact on health.⁶² If the ultimate goal is improving the health of all Ontarians, then these broader determinants must be addressed at the same time as health care delivery and planning is being reformed.

One problem in addressing the social determinants of health is the structure of government itself. Policies and programmes dealing with income, housing, racism or supporting community building are scattered throughout many Ministries and agencies, often working in isolation of each other. In addition, the new Ministry of Health Promotion has focussed solely on promoting healthier and more active individual lifestyles; an important challenge, but one that does not address more fundamental structural determinants. In important ways, the health system is charged with fixing the adverse health impacts of public policy elsewhere.

There are three implications that follow. First of all, the provincial government must take overall responsibility for developing cohesive policies and programmes to address inequality, homelessness and other determinants that have such an adverse impact on the health of so many.⁶³ This means addressing the cross-sectoral disincentives to addressing broad issues such as the social determinants

⁶² See Richard Wilkinson and Michael Marmot, eds, *Social Determinants of Health, The Solid Facts* World Health Organization, Europe, 2nd edition, 2003; Richard Wilkinson, *The Impact of Inequality How to Make Sick Societies Healthier* New York, The New Press: 2005; Dennis Raphael, ed, *Social Determinants of Health, Canadian Perspectives* Toronto, Canadian Scholars Press: 2004; and Canadian Population Health Initiative, *Improving the Health of Canadians*, Ottawa: the Institute, 2004.

⁶³ Many of these issues are in fact in the jurisdiction of other governments or are shared with the federal and municipal levels. How all levels of government could work together to address the social determinants of health is a crucial issue, but beyond the scope of this analysis.

of health. A good current example is the controversy over special diet provisions for people on social assistance. The underlying issue is that research has solidly demonstrated that social assistance levels do not allow people to buy a nutritious diet, and that the resulting poor nutrition contributes directly to ill health. However, policy solutions – such as increasing the basic level of social assistance – are a cost to the Ministry of Community and Social Services, even while this could potentially lower preventable costs of ill health incurred by MOHLTC. The silo structure of contemporary government can create unfortunate disincentives to making expenditures whose benefits – and political credit -- are felt elsewhere.

Secondly, the most effective way for health care providers and institutions to address the social determinants at a front-line level is to work in partnerships and joint initiatives with community groups working in poverty reduction, immigrant settlement, employment support, homelessness and addressing other social and economic inequality. For example, CHCs, hospitals and others who deal with the health problems homeless people have should work with housing providers and advocates. A national survey found that 80% of RHAs in other provinces were working or planning to work with agencies from outside the health sector.⁶⁴

Thirdly, health care providers must provide innovative programmes that address the impact of social and economic inequality; that provide better care for marginalized communities and people. For example, as primary care is being restructured, what would effective and responsive primary care for homeless people look like? What kinds of cultural and language competencies must be integrated into delivery to adequately support isolated immigrant seniors with little English? What about when these particularly vulnerable people are scattered across large suburbs with poor public transport?

So, can the LHINs be accountable for reducing homelessness? Broadly no. But should LHINs build analyzing the impact of homelessness and other determinants into their health planning and build partnerships with front-line housing agencies into the fabric of their service delivery? Absolutely. Can the LHINs be accountable for developing innovative and responsive programmes that ensure that homeless and ill-housed people have adequate access to the health care services they need. Absolutely.

⁶⁴ CCARH, *Newsletter*, August 2004.

Policy Action Recommendation	Expected Outcomes
The province should report on how its health care transformation will address poverty, inequality, exclusion, homelessness and other broader social determinants of health, ideally as part of the reform discussion paper noted above.	Health care reform will be more comprehensive and systematic, and service and planning links will be made between the health care sector and others addressing the social determinants of health.
The province should also mandate each LHIN to build analysis of the social determinants of health into its planning framework.	Local health care reform and planning can also be more comprehensive and can build links to local efforts already underway in addressing the social determinants of health.

Success Factors

For the current transformation project to have a significant impact on improving overall health care delivery and health of Ontarians:

- overall government policy and programmes, and each reform initiative, will need to address the broader social determinants of health;
- reform initiatives, whether LHINs, primary care or information technology, will need to be well coordinated and be driven by a cohesive overall vision and goals.

Community-Driven Planning and Priority Setting

Ontario has emphasised community input and consultation in rolling out the LHINs initiative and LHIN CEOs have identified community engagement as a key success factor. One challenge that was clear in the experience of other provinces is that community involvement in health care planning can mean very different things.

- a modest formulation would see that community input and consultation makes for more effective planning;
- a more comprehensive vision would emphasize creating forums and mechanisms where people can come together to assess what health services their communities need, balance and determine delivery priorities, allocate resources to services and providers according to those priorities, and evaluate how effectively the resulting services have met community health needs.

Problems can arise when the meaning of community involvement is not made clear from the outset; or when the different meanings for different groups are not explicitly recognized or worked out. An early task for the LHINs will be consulting with their communities and working out what scale and forms of

participation will work best in their regions. Wellesley Central believes that an expansive goal of community engagement has great potential to ensure:

- needs assessment that more reliably captures the complexities and nuances of community health care needs;
- more effective planning and priority setting because the fullest range of partners and stakeholders are involved;
- more effective reform and implementation – again because the widest range of community partners have ‘bought in.’

Community-Driven Planning

Being able to identify priorities that reflect the needs, preferences and expectations of local communities and building these priorities into service planning and resource allocation will require:

- involving large numbers of people and community groups, which represent the full diversity and complexity of local populations;
- plans and priorities that are seen by local communities as reflecting their needs;
- forums that will create plans that are practical and effective;
- community involvement in monitoring impact and implementation.

The Minister has long emphasized community engagement, and it is mandated as a principle in the legislation. However, Bill 36 does not specify how such engagement will be achieved. A number of concrete suggestions are made below on how efficient, systematic and responsive planning could be organized. Whether it is these or other specific options that are eventually implemented is less important than ensuring that effective mechanisms for real community participation in planning and priority setting are developed.

Clear expectations for engaging local communities in planning and priority setting should be set out for all LHINs. All would be expected to establish efficient and responsive mechanisms for community participation. These expectations should include clear success indicators – these should only be developed with community participation, of course, but could include the number of individuals and community groups involved in consultations and planning forums, how this input reflects community diversity and demography, the % of community recommendations that are acted on, research on how community members feel their voices are being heard, etc. And there should be clear requirements that LHINs regularly report back to their communities on progress against these community engagement objectives.⁶⁵

There should be an explicit organized process early on for the LHINs to engage local communities in their planning and priority setting. This should include:

⁶⁵ In fact, such accountability principles should be built into other issues as well; for example, how this could be done for knowledge exchange and innovation is discussed further in a later section.

- community conferences early in 2006 to help the LHINs get going in all 14 regions;
- these could build on the working groups established to set initial integration priorities;
- in a sense, these conferences could be seen as the first reports back to the working groups on the impact of their recommendations on LHINs' planning – each LHIN should present a clear response to its integration report:
 - not in great operational detail, but indicating how the major themes in the workshop reports will be taken up;
 - with specific plans for how community engagement in ongoing planning will be ensured;
- these conferences and ongoing consultations will need to find creative ways to include wider representation and unaligned individuals as well as the usual organized service providing and institutional stakeholders;
- one of the most important outputs of these early consultations can be concrete proposals to take to the provincial government on the forms of community participation in LHINs planning and resource allocation.

Policy Action Recommendation	Expected Outcomes
Action conferences should be held by all LHINs by March 2006 to begin to engage local partners, service providers and community groups in planning and priority setting.	The first crucial step in a long process for community engagement.

These planning conferences could best be seen as an annual process, in which broad community planning conferences are held to assess progress against last year's priorities and determine priorities for the coming year.

A major theme in subsequent sections is the need for LHINs to continually share insights and experience. Management level methods are already being developed, with the CEOs and boards in touch regularly. But sharing experience must also involve community partners and stakeholders as well. One mechanism could be for the conferences above to each select 3-4 community representatives who then go to a province-wide community conference.

Tools for Effective Community Involvement

Creative and responsive forums, consultations and other means of involving communities in health care planning will be needed. It will be important that the government not narrow these discussions too much. For example, the issues that arose in response to the first bulletins in the fall of 2004 were quite broad. Responses seem to have narrowed through the workshops and priority setting processes completed in early 2005. Was this a function of facilitating style, focussing discussion on defined administrative and service areas, and being able

to only identify only five integration priorities for each? Some stakeholders were critical of the pre-determined focus of these consultations.

Consultation methods are going to have to be designed to reflect the diversities of populations, neighbourhoods and cultures across the province, and within each LHIN. The LHINs should be as flexible as possible in letting communities work out for themselves the most innovative and reliable means of participating in planning and priority setting. Community-based consultation and research methods can be very effective in identifying needs and issues within diverse and complex communities, and a wide range of creative methods have evolved. There are also many skilled facilitators and considerable experience within community agencies and groups able to do this work.

There must also be a proactive responsibility on all LHINs and the Ministry to provide communities and citizens with the information, tools and resources they need to be able to effectively and meaningfully participate in planning and priority setting. This will require:

- access to reliable and understandable information on LHIN operations and health care delivery;
- this must not just be masses of service statistics and raw data, but well-organized information in terms of defined objectives and indicators;
- and, of course, significant community involvement in establishing appropriate indicators and measurements in the first place.

The LHINs will be systematically collecting and analyzing a great deal of information for their own programme monitoring purposes. They will need to ‘translate’ and adapt this analysis in meaningful ways for community stakeholders.

They should take this necessary analysis a step further and make the widest possible information readily available to their communities. For example, publishing the following kinds of information on their Web sites could be an invaluable aide to citizens and providers both as they navigate the complex health care system:

- details on CHCs, CCACs, walk-in clinics and other facilities;
- list of primary care physicians who are taking new patients;
- list of specialists taking referrals to help both doctors and consumers;
- pharmacies that waive specific fees;
- community services and providers in areas covering the broader social determinants of health;
- they could extend these web sites to provide interactive forums for community members to exchange ideas and views and pass them on to the LHINs.

Community groups will also need funding and support to build up their own capacities to analyze health delivery information and provide independent input to planning and evaluation.

- governments and the LHINs must recognize that there are real costs to community agencies participating in planning;
- ironically, given the government's commitment and community demands to play a key role, one danger is over-consultation:
 - community agencies are extensively consulted on many things and this can be a real strain on groups with few staff, and even harder on volunteer groups;
 - the result is that an important proportion of an agency ED's time can be taken up on policy and consultation work that is not covered in any operational grant;
- one way to concretely recognize this cost and to facilitate meaningful participation is to explicitly fund community groups to be able to take part in policy discussions.
- this also means that governments and LHINs must be serious about community engagement and not consult unless they are prepared to act on its results;
- communities will need to see that their work in providing input and in suggesting priorities has an impact if they are to continue to make the effort – the community will need to see its voices and interests reflected in the plans and priorities eventually adopted.

However these challenges are worked out, making community consultation work will require:

- forums and mechanisms for communities to collectively discuss and determine the most important health issues;
- then effective and locally sensitive means of needs assessment;
- then forums and mechanisms to determine local and community priorities arising out of the needs assessment and community discussions; and
- effective processes for the LHINs to incorporate these community recommendations into their planning.

Policy Action Recommendation	Expected Outcomes
The province should develop a concrete plan by March 2006 on the resources and support it will provide LHINs and local community groups so that effective community participation in planning and priority setting will take place.	Community driven planning; Significant and ongoing participation and support for the planning process from a wide range of community health service providers and partners.
To facilitate action on community engagement the province should: <ul style="list-style-type: none"> • create a specific line or envelope in LHINs' financial allocations to support community participation and engagement; • develop specific indicators for community engagement and build action on these indicators into MOUs and funding formulas with all LHINs. 	This will create a proactive responsibility on all LHINs to engage their local community in planning and priority setting, backed up with concrete incentives and evaluation.

Integrating Local and Regional Planning

A major challenge will not just be providing the most effective forums and tools, but figuring out which level is best for planning and prioritizing which kinds of issues. The assumption of the LHINs structure is that they will be identifying region-wide priorities and needs and allocating resources accordingly. This in turn requires more locally-based planning and consultation for two reasons:

- the particular health care needs, interests and preferences of local neighbourhoods and communities vary a great deal, and planning and needs assessment has to start at this concrete level;
- service delivery takes place at these local levels as well, so performance management and programme evaluation also need to be centred at sub-regional levels.

Ways are going to have to be found to ensure that the LHINs become well connected to local communities; so they can effectively represent their diversity of interests and perspectives in decision-making, and are accountable to their communities for their operations. Many other provinces developed various forms of local advisory committees or forums underneath the RHAs that fed local issues and interests back up into Authority planning. Ontario LHINs will also want to create effective and responsive means of local participation and engagement. The challenge then becomes how to best integrate local priorities and issues into region-wide planning, and how to build effective feedback loops between local evaluation and assessment back up to the regional level.

Policy Action Recommendation	Expected Outcomes
Each LHIN should create local neighbourhood or community advisory committees or planning forums, and ensure that local perspectives are fed into their region-wide planning. The province should require that such mechanisms be established, but be very flexible as to their exact form, which can vary between regions.	Increased local engagement in LHIN planning.

It is fairly clear that the province wants the consolidation of surgical, high-tech and other specialized services considered and that the LHINs will be the forum for such analysis:

- what kinds of planning criteria and consultation will go into such decisions – and their ripple consequences?
 - e.g. a particular hospital may have developed innovative pre-natal and maternal care programmes for immigrant women;
 - if ob-gyn specialists were all based in another hospital, such an innovative programme would not necessarily follow, and could be lost entirely;
- if high-level services are located in the larger hospitals and cities in each LHIN region could this weaken smaller community hospitals?
- will residents in rural areas have to travel further to obtain appropriate medical care?

These examples highlight a potential tension between decisions taken purely in institutional or fiscal terms versus those that strive for maximum efficiency while taking community interests and perspectives into account. For example, while it may make most sense in technical terms not to have many high-end services available in small hospitals, the result is that many people, especially the oldest and most ill, may have to travel long distances. A community may feel that the stress associated with such travel is not worth the immediate cost savings. LHINs will need to have the powers to make this kind of balancing, sometimes supporting what may not be the cheapest or most ‘rational’ allocation.

A further complexity will occur at the other end of the continuum. Specialized and high-tech care and treatment is concentrated in the large teaching hospitals, especially in Toronto and other major cities. These institutions provide this specialized care to residents of other regions as well. Their LHINs will need to balance providing excellent care and support for patients coming from other regions, while ensuring the full range of care is available to local residents. Funding formulas will need to recognize these patterns.

LHINs Boundaries and Regional Needs

The 14 LHIN boundaries were based upon hospital referral patterns, to reflect areas where people received healthcare. They were determined in collaboration with the Institute for Clinical Evaluative Sciences (ICES), and revised in response to feedback from the various consultations. All 14 LHINs contain at least one high volume hospital. Patients will still be able to choose a health care provider outside of their LHIN.

A number of questions and concerns have been expressed with these boundaries. The first has to do with effective integration and planning:

- some have argued that while the boundaries may reflect hospital discharge patterns this does not reflect the overall flow of health and other services;
- others have argued that the fact that the boundaries are not co-terminus with many other agencies will make planning and integration that much harder:
 - this may be easier for the Toronto Central LHIN than most as it is entirely within the City of Toronto;
 - however, from the opposite point of view, the City of Toronto, its public health department and the many community agencies aligned to it will be dealing with four LHINs;
 - the integration and coordination of institutional and community-based care will be crucial, yet the LHIN boundaries do not coincide with those of the CCACs;
 - nor do the LHINs correspond to the boundaries of the DHCs they replace, making interpretation of historical and comparable data more difficult;
- some of the LHINs, especially in the North, are enormous.

On the other hand, the LHINs are always going to contain more than one municipality; they are designed as regional not local bodies. There is some evidence from other provinces that larger RHAs are more effective; or at least, that they need to be a certain size to be effective.

One problem was addressed in the enabling legislation. Bill 36 will allow the Ministry to reduce the number of CCACs to 14 and align them with LHINs boundaries. The Bill would also allow the CCACs to appoint their own board members and Executive Directors and expand their mandate to a wider range of services.⁶⁶

Learning Their Own Lessons

How to create the most effective planning structures will be a very complex challenge. It will be important to monitor the impact of community participation and compare various planning forums and processes. Such systematic research is beyond the capacities of any single LHIN. One idea is to create a Centre for Excellence in Community Health Care Planning. It would focus academic and community-based research in a very practical and action-oriented way on

⁶⁶ Minister's statement at first reading; Legislative Assembly of Ontario, *Hansard Record of Debates*, Nov. 24, 2005.

identifying and testing the most effective mechanisms for community-driven planning. It could also play a central knowledge exchange function as a forum and facilitator for exchanging information and discussion on programme challenges, successes, innovations and lessons learned in front-line practice.

Earlier promising national efforts have not been sustained; the funding for the Canadian Centre for Analysis of Regionalization and Health ended recently. Ontario has a chance to be a national and international leader by creating such a centre for analyzing and promoting integrated planning.⁶⁷

Policy Action Recommendation	Expected Outcomes
The province should consider funding a Centre for Excellence in Community Health Care Planning. The Centre could work in partnership with existing academic, community and other research and practice efforts underway.	Systematic research and enhanced understanding of the potential of community participation in health system planning; Identification, sharing and elaboration of the most effective methods of community-driven planning.

Success Factors

Successful community drive planning will depend upon both process and outcome factors:

- community engagement will need to be a high priority for all LHINs;
- good mechanisms to support significant and sustained community engagement in planning and priority setting;
- clearly understood and transparent planning processes, with specific junctures and access points for community and individual participation;
- showing results – plans and priorities that communities can see reflect their input and interests.
 - This will never mean that all community demands and needs are accepted; but it will need to mean that expressed priorities are taken into account and that the necessary balancing and accommodating of competing priorities and demands takes place in an open and transparent fashion.
- community groups and representatives have the tools and information to participate effectively.

Effective Governance and Management

Developing effective, responsive and flexible governance and management processes will be an essential foundation of integrated and coordinated planning and delivery.

⁶⁷ This is also in line with a recommendation made for a similar Centre for Quality and Research in Home Care to support the work of CCACs: Hon Elinor Caplan, *Realizing the Potential of Home Care: Competing for Excellence by Rewarding Results* Toronto: MOHLTC, 2005: Ch. 2.

Division of Authority: Regional Responsiveness and Provincial Strategy

Board members and staff from RHAs across the country have consistently argued that the provinces have not made the division of authority between the provincial government and the RHAs clear enough and have not given the RHAs enough authority to effectively work.

Ontario will face the same challenge of balancing LHIN authority and autonomy, and provincial standards, strategy and powers. For example, there will need to be

- regional flexibility that can recognize:
 - the particular challenges of huge distances, diverse populations and economic vulnerability in the North;
 - the very different, but no less daunting, challenges of greater concentrations of hard-to-serve people in the major cities and tremendous social and cultural diversity;
- while at the same time, guarding against:
 - inequitable disparities in resources, access and quality of services;
 - inefficient variations in practice and delivery;
 - overly local or parochial priorities.

Bill 36 emphasizes that the LHINs will operate within the province's strategic plan, but it does not indicate how this can most effectively be linked into local needs, expectations and conditions. There will also need to be an appropriate balance struck between the need for standard reporting, monitoring and planning criteria, with sufficient flexibility to take into account the specific and diverse needs of communities across the province. One size will not fit all.

The innovation Ontario could make is to have the process of finding the most appropriate balance between provincial and regional authority as open and transparent as possible. Developing this balance and the best governance structures should not solely be negotiated between the Ministry and LHINs, but should involve all stakeholders.

One lesson from other provinces is to be as clear as possible about the division of responsibility between the province and regional authorities. Important first steps to achieving this clarity can be the Ministry setting out its views concretely in the discussion paper we have recommended, to then be fully discussed at the community planning conferences we have called for.

On the other hand, it will be very difficult to get this balance exactly right first time, and situations do change. How the division of responsibility is actually working will need to be assessed and adjustments made periodically. For example, this question could be a standing component of LHINs' annual priority setting and budget processes, and community planning conferences. In addition, the LHINs will all be developing regular programme and outcome evaluation as part of their routine performance management (to be addressed more fully below).

How effectively provincial standards are being balanced with sufficient regional flexibility could be part of these routine assessments.

Policy Action Recommendation	Expected Outcomes
<p>How to develop the most appropriate balance between province-wide standards and objectives and regional and local flexibility should be addressed in the discussion paper from the province and conferences to be held by each LHIN early in 2006 recommended earlier. Assessing how effectively this balance has been working should be a standing item on annual planning conferences and an important outcome indicator for ongoing programme evaluation.</p>	<p>The most effective balance between provincial and regional planning and responsibilities; The ability to fine-tune this balance in the light of experience and changing conditions.</p>

Representativeness and Accountability

A crucial challenge for the LHINs will be effectively representing the diverse communities within their boundaries. Their Boards must include significant representation of community and neighbourhood groups, front-line community service providers, consumer groups and unaligned citizens. There has not been a good start. The Chairs, CEOs and five other Board members were appointed by the province. While the remaining 1/3 of positions was publicly advertised and will undergo some form of stakeholder review and nomination process, the final three appointments will still be recommended by the existing Board members and approved by the province.

The issue of Board appointments and representativeness should be explicitly put to the community conferences we have called for in each LHIN. The province should then build these community perspectives and demands into the process for future appointments to LHIN boards.

If significant concerns are expressed about the representativeness and legitimacy of the existing LHIN boards, the province and LHINs should consider a remedial plan. For example, the 2/3 appointed without a public application and nomination process could:

- step down before the end of their three-year term to be replaced by Members appointed under a more democratic and transparent system; or
- undergo some form of community-based confirmation at these planning conferences.

The question of whether remedial action is needed will need to recognize that the new boards – even if appointed with poor process – do need consistency and some

time to learn the job. The best result may be leaving the existing appointments in place, but developing a consensus on how the boards can operate in the most representative and accountable fashion, and how more democratic recruitment and appointment could take place in the future. The most important factor in ensuring that LHINs are governed in an accountable and democratic manner is ensuring the kinds of widespread and meaningful community participation in priority setting, strategic planning and resource allocation discussed earlier.

One challenge faced throughout the decade of regionalization in other provinces has been the power of hospitals and major health care professions. Practitioners have argued that lack of buy-in or resistance from major provider groups has limited the speed and scope of reform.

Ontario has arguably ‘side-stepped’ this problem by allowing hospitals to retain their independent boards and by not including physicians in the LHINs’ mandate. But the problem really cannot be avoided so simply. There is no doubt that successful LHINs or any other reforms require the active participation and support of the major providers who will be implementing the changes. This is why stakeholder relations is such an essential facet of change management and reform projects. However, while bringing the full range of hospitals, health care providers, community agencies and coalitions to the table, the province must use its ultimate power to ensure that provider and institutional interests do not dominate or derail innovative reform.

Health care reform has long proven to be a complex and fraught process. How stakeholder relations will evolve as the LHINs are being implemented and what the specific impact of allowing hospitals to retain their independent boards cannot be fully predicted. But these issues do need to be assessed and their impact addressed if proving problematic. The most effective way to ensure this assessment takes place may be to require a ‘sunset review’ of retaining independent boards for hospitals within the LHINs structures.

Should these same considerations apply to CHCs and other non-profit service providing agencies with community boards? The differences to hospitals are significant: they are far smaller and less complex organizationally; they do not have the same influence (and therefore could not become such significant constraints on reform); their front-line delivery connects them more directly to local neighbourhoods and communities; their boards tend to be more reflective of the full diversity of their local communities; and their origins and operating ethos are more community-orientated.⁶⁸ There is a stronger argument for retaining the independent boards of these large numbers of community groups.

⁶⁸ None of this is meant to impugn the motives or commitment of hospital management and boards. These are simply structural and historical factors that do need to be analyzed. The review we have called for would concretely assess all aspects of independent governance; for example, it could be argued that small hospitals in smaller communities have some structural factors more in common with community providers than major tertiary hospitals.

Policy Action Recommendation	Expected Outcomes
<p>The province should issue a policy paper on LHIN governance by the end of 2007 in which it addresses:</p> <ul style="list-style-type: none"> • how board members can be chosen in the most democratic, transparent and effective manner; • the effectiveness, costs and benefits of hospitals retaining their independent boards and powers. 	<p>Community input and an evidence-based decision on the best governance within the emerging LHINs structures.</p>

Evidence-Based Decision Making

There is considerable support for the idea that LHINs will be able to introduce more evidence-based decision-making into the system.

- the experience of other provinces indicates that RHAs have generally had a greater capacity to make evidence-based decisions;
- it may be that this is the result of being more insulated from direct partisan political pressures than provincial governments, rather than an inherent advantages of regional planning;
- regardless, experience in the other provinces has shown that there are key pre-conditions for effective EBDM:
 - access to good information, presented and analysed in ways that make decision-making effective;
 - clear priority setting and planning processes;
 - clear demarcations of authority with the central governments.

This indicates that to realize the potential of EBDM, the LHINs will need to have:

- in-house capacity to generate, analyze and present data in reliable and effective ways;
- time and funds to invest in research to answer key policy and programme questions as they arise;
- sufficient centralized and standardized information generation and management to yield comparative data.

Ontario has the chance to be innovative in expanding the kinds of evidence used and the ways in which it is deployed in LHINs' decision-making:

- community-based and action research can be used as well as more traditional statistical and institutional data;
- assessing and bringing insights from front-line service experience into planning and decision-making will be critical;
- as will involving community stakeholders and citizens in helping to assess available data from their different perspectives.

Performance Management

Ontario and all other governments have increasingly emphasized the need to set clear performance targets for the health care system and to carefully monitor performance against these goals.

Stakeholders have expressed concern that these performance goals for the LHINs are not yet clear. Given the newness of the reform and the fact that the LHINs are nowhere near operational, this is not surprising. However, the government does need to clarify how its high-level goals for the LHINs can be monitored and evaluated. Developing concrete performance measurement processes and success indicators will require extensive community and stakeholder discussion. How the goals of reform shape the evaluative framework and kinds of performance indicators chosen also needs to be carefully and openly analyzed. For example, if the driving goal is system efficiency then indicators focussing on the most cost-effective utilization and deployment of resources tend to be chosen. On the other hand, if the critical goal is creating a seamless continuum of care, then indicators measuring the scope and quality of services and access will be more important. We have argued above that both efficiency and continuum of care, as well as community-driven planning, innovation and front-line integration and coordination must be driving goals of the LHINs reforms. The indicators and performance management system developed must reflect these multi-dimensional and overlapping goals.

These discussions need to happen soon, but developing indicators and assessment processes too quickly without adequate consultation and community involvement would be far worse.

From a Community Perspective

As a contribution to this necessary discussion, this section outlines what responsive and effective performance measurement could look like from a community perspective:

- it would likely need to re-interpret common indicators such as wait times in hospital emergency rooms:
 - while this has become such a hot button issue, it is not necessarily the best indicator of the state of the hospital system;
 - for example, the basis of the problem – whether people inappropriately occupying beds when they should be in long-term care facilities or inadequate access to chronic care management – may be a long way from the emergency room;
 - a more nuanced analysis would assess what proportion of people seen in emergency rooms are there because of inadequate access to primary care or gaps in the continuum of care;
- more interesting measures would be the availability of the full range of services comprising the continuum of care:

- which means there will need to be clear standards and expectations of what the continuum consists of;
- this will require community involvement in defining the optimum continuum and the inevitable trade-offs that have to be made in real-world delivery;
- quality cannot solely be measured in technical outcome or morbidity terms:
 - a goal should be providing responsive and appropriate care from the patient's point of view;
 - one facet of this will be cultural competence – how care was provided that reflected the specific cultural expectations and backgrounds of diverse populations;
- overall satisfaction will need to be measured:
 - communities will need to be involved in developing a range of innovative research and assessment techniques;
 - these could range from the traditional focus groups and surveys to interviewing users at the point of care;
 - talking to service users will also yield many insights into different ways the best care could be delivered;
- inappropriate admissions to hospitals and LTC facilities may be another telling indicator:
 - for example, for diabetes when not properly managed;
 - the point will be to identify problems – in this example, possibly inadequate chronic care management – and then act to fill the gap in the continuum of care;
- the goal of performance measurement should always be remedial – to use the data and knowledge to improve care;
 - care has to be taken that this goal does not get confused with financial incentives and regulatory discipline;
 - experience in other jurisdictions shows that tying funding to performance indicators can lead to ineffective and destructive competition among providers;
- indicators that highlight broader social determinants of health should be developed:
 - fewer low-birth-weight babies would be one such goal;
 - better health status of children when they first enter school would be another;
 - these examples indicate the potential of longitudinal data;
 - the government, in consultation with academic experts, researchers, providers, other stakeholders and the community, should assess the longitudinal data it needs to collect and make a long-term commitment to doing so from the outset of the LHINs. The Centre for Excellence proposed earlier would be one effective forum for this kind of analysis.

While there will need to be some regional and local variation in the most effective indicators to monitor, there will need to be clear provincial standards and processes. The Ministry should initiate a process:

- of developing the most appropriate indicators and forms of performance monitoring;
- one result of which is ongoing processes and forums for this monitoring to take place:
 - part of this will be formal accountability mechanisms of LHINs reporting to the Ministry in terms of agreed indicators and objectives;
 - but the danger is that monitoring becomes a purely technical function performed by officials unconnected to communities and stakeholders;
- as with earlier challenges, Ontario can be innovative here by involving the full range of health care providers, community agencies and other stakeholders in this process.
 - the province could convene a broad consultation on accountability and planning to ensure that the indicators through which performance will be monitored and the evidence upon which decisions will be made are not purely institutionally or fiscally driven and statistical, but also reflect community values, needs and preferences.
- there will also need to be permanent forums for community participation in interpreting performance measurements and deciding what needs to be done about the results;
 - one means could be Community Accountability Forums to monitor how effectively the LHINs are taking up community-identified priorities and issues, and how effectively health care planning and delivery is meeting community needs.

Policy Action Recommendation	Expected Outcomes
The province should initiate a consultative process to develop effective indicators to measure and forums to monitor LHIN and system performance.	Systematic planning, evaluation and refinement of service delivery.

Success Factors

- boards and governance systems that are seen as legitimate and accountable by communities;
- clear divisions of authority between the province and LHINs, but with enough autonomy for the LHINs to develop plans that reflect their communities' needs;
- provincial standards and guidelines to ensure equitable access to the full continuum of care, but with enough flexibility to take regional variations and diversity into account;
- sufficient buy-in from all stakeholders, but without the major institutions and professions being able to derail reform or dominate community interests;
- a new kind of evidence-based decision making and performance management that integrates community-driven indicators and perspectives.

Integration I: Efficiency and Innovation

The government has identified the need to reduce inefficiency and duplication, and enhance the effectiveness of all operations as one of its four main goals for the LHINs initiative. One of the driving goals of integrated LHIN planning will be to coordinate the many hospitals, clinics, long-term care facilities and other institutions, and the myriad of community service providing agencies to ensure the most effective dovetailing of delivery and use of financial, human and other resources.

Build On Existing Strengths

Work to integrate and coordinate diverse care providers and institutions has been going on for many years. The LHINs should build on the best of what is already taking place.

Networks

When launching the LHINs initiative, the Ministry asked for public input on several key questions, including examples of existing integration networks. The response indicated that a great deal of local planning designed to coordinate and integrate services is already taking place:

- 1,049 examples of health care integration were listed;
- the largest group -- 686 -- were service networks focused on elder abuse, stroke or other specific conditions;
- 178 health system planning committees were cited;
- York Region noted that it conducted integrated planning for all human services;

Respondents stressed that LHINs should “build on these successes.”⁶⁹

No doubt there is duplication, gaps and probable inefficiencies amongst all these networks. But they also indicate a clear front-line recognition that integration is important and commitment to doing the necessary coordinating and planning work. The challenge will be to incorporate the best of these efforts, help all planning processes become more effective and responsive, fill in the gaps and roll all of these local efforts up into efficient regional planning and integration.

At the same time, are these efforts necessarily local and uneven in their approach and impact or are there specific shortcomings or problems the LHINs will need to address? The Ministry has not said. The challenge will be for the LHINs to work closely with existing networks, local communities and stakeholders to build on this commitment, not bypass or bury it under new structures.

⁶⁹ MOHLTC, *Analysis of Responses to LHIN Bulletin #1*.

Policy Action Recommendation	Expected Outcomes
<p>To build on the knowledge, coordinating and service networks, and front-line insight already existing across the province, each LHIN should:</p> <ul style="list-style-type: none"> • beginning from the consultations and research done by the Ministry as LHINs were first being established, develop an inventory of coordinating and service networks in their region; • prepare a plan within its first year of operation on how the best of these networks will be incorporated into ongoing planning and delivery. 	<p>Already existing planning and coordinating forums and mechanisms will not be wasted;</p> <p>Already committed providers will buy-in to the new LHINs initiative if they see their coordinating efforts taken seriously.</p>

Transition from District Health Councils

One element of building on existing networks began badly. The LHINs replace and expand upon the functions of the District Health Councils (DHCs), the former province-wide network of 16 advisory health-planning boards. The initial plan was that the LHINs would be operational by the spring and that the DHCs would be wrapped up at the same time. LHINs' implementation has never been as fast as envisioned in early Bulletins, but the DHCs were still formally abolished April 1, 2005.

While the Ministry emphasized the valuable role the DHCs had played for 30 years it did not comment further.⁷⁰ For example, it did not explicitly set out how the LHINs will be an improvement on the DHCs. The main differences are that:

- the new bodies will not just be a planning mechanism or forum to encourage coordination;
- the LHINs will, in effect, be designed to enforce coordinated plans and priorities through performance agreements with providers;
- this power will become more significant when the LHINs allocate local funds among competing priorities and institutions.

The Ministry also did not indicate what problems or weaknesses in the DHC form of planning would be corrected by the LHINs. These problems could include:

- the extensive planning has not resulted in improved local integration or coordination of services;
- was this because the DHCs did not have the power to enforce or fund its priorities – a key goal of the LHINs?

⁷⁰ LHINs Bulletin #6, January, 2005.

- were the DHCs not seem to be well enough connected to their local communities – if so, how would the LHINs be different?
- broader health reform has not progressed (but to what extent did local planning contribute to this lack of progress?).

Regardless, the DHCs have done a great deal of needs assessment and planning work, and have built up considerable local knowledge and connections that should not be lost. It will be important for the new LHINs to draw on their work.

- an important first step was that many DHC representatives were involved in the initial consultations and priority setting exercises;
- will there be some process whereby the new LHINs Board and management could meet with their DHC counterparts?
- presumably some key staff and other players from the DHCs will end up with the LHINs;
- this, like many other local issues, is complicated by the boundaries of the new LHINs not matching those of the DHCs;
- the most important health planning data and strategic documents must be passed on in an orderly way.⁷¹

Efficient and innovative information sharing and knowledge management will be discussed below. Managing the transition from DHCs to the LHINs and ensuring the knowledge built up over the years is not lost can be the first major component – and first test -- of such a knowledge management strategy.

In fact, the chair of the provincial association of DHCs offered some advice to the new LHINs. Chris Carew, former ED of the Grand River DHC, argued that DHCs support the system integration envisioned in the LHINs and the broader transformation agenda. He identified critical success factors for the LHINs initiative:⁷²

- they will need good tools to support integration:
 - access to necessary data is the basis of sound planning – a challenge will be aligning boundaries to data sources;
 - population health needs analysis will be important to identifying best practices and service gaps;
 - common core services such as IT;
- the LHINs will need to be solidly connected:
 - engaging local leadership and consulting broadly;
 - building on existing collaborations;
 - developing clear and transparent processes for priority setting and resource allocation;

⁷¹Luckily, a great deal of planning and other material has been organized in the DHC Archives and is easily available on-line <http://www.dhcarehives.com/protected/home.asp?lang=en> accessed August 25, 2005.

⁷² *Countdown to LHINs: A District Health Council Perspective*, presentation notes, Ontario Health Achieve, November 2004.

- more flexible funding approaches to meet community needs;
- they can develop the strengths of existing networks, while recognizing that LHINs may alter established networks;
- regional recruitment and other HR strategies will be needed;
- the LHINs – and the government -- must recognize that fundamental change takes time and investment.

Fostering Innovation

Efficiency is not just about improved coordination and the most cost-effective use of finite human and financial resources. The Minister also emphasized "...a simple concept. If one hospital or long-term care home has a great idea, hundreds of patients benefit. But if that hospital shares that great idea with every hospital and health provider, millions of Ontarians reap the rewards of innovation."⁷³ To this end:

- the province will need to make innovation an explicit part of LHINs' mandate;
- there will need to be dedicated funding lines or envelopes to encourage experimentation:
 - not the rigid and excessively documented results demanded by most programme funding;
 - but encouraging all kinds of small-scale experiments that focus on innovations, implications and lessons;
 - they should not all be expected to yield immediately positive outcomes -- in fact, a 'glorious failure' may yield significant insights;
- the LHINs will also need sufficient organizational slack and capacity to be able to undertake and support experimental activities;
- this too could build on the local networks already active:
 - so, if there are several cardiac or diabetes treatment networks at work in a LHIN's area, it can assess what is working best and spread this approach;
- this can be the types of initiatives often mentioned in the health reform literature such as:
 - nurse practitioners following up patients with chronic conditions to help them manage their own care or new styles of team-based primary care;
 - regional authorities pioneering surgery registries, centralized waiting list management and other efficiency innovations;
 - it can address crucial gaps – how would chronic care management for homeless people work?
 - this is also the area where community-based research can yield valuable insights – what are the key barriers to homeless people getting the consistent primary care they need?
- LHINs will need in-house research and analytical expertise to design and assess potential innovations.

A background study for the Romanow Commission concluded that pilot projects can be an important way to foster system-wide change. It argued for venture

⁷³ Hon George Smitherman, "Speaking Notes", 2004, p. 18.

capital-type formations and careful attention to promoting, disseminating and then institutionalizing the successful experiments.⁷⁴

Each LHIN could be expected to undertake a defined number of pilot projects each year. The province would then need to create forums and mechanisms where these experiments and projects are assessed, their lessons and implications shared, and the best of them scaled up or replicated elsewhere.

Building on Local Innovations: Province-wide Knowledge Management

To build on successful pilot projects and innovations will require forums in which what experiments worked, what didn't and why can be analysed, and mechanisms by which these 'lessons learned' can be shared among LHINs from across the province. This is really knowledge management on a large scale:

- there could be many small-scale working conferences on particular types of innovations or service issues among the LHINs:
 - for example, the most effective ways to develop home-based chronic care management for people with diabetes;
 - these workshops could be hosted on a rotating basis by the different LHINs;
 - it is possible that some LHINs would become particularly expert at certain things – mini centres of excellence – and this would need to be explicitly encouraged and funded;
- effective and consistent knowledge exchange among the LHINs and beyond will need to be supported centrally by the province:
 - one means could be creating an independent association of LHINs – as opposed to a branch of the Ministry – that can provide secretariat type support on issues of common interest;
 - that there was a provincial association of DHCs before LHINs, and currently are associations of CCACs, CHCs and municipal public health departments demonstrates the need for such provincial forums;
 - it could have an explicit knowledge exchange mandate;
- the province will also need to provide the technical infrastructure to support knowledge exchange and information management. There has been considerable emphasis within LHINs implementation on information infrastructure and strategy:
 - e learning and sophisticated communications technologies to create an electronic forum where LHINs can easily and regularly share service and programme innovations and experience;
 - service and performance data for monitoring results;
 - service usage data to track trends and assess needs.

These alternatives and options are as concrete as possible. But, of course, they are suggestions only. The key thing will be that the LHINs develop effective means of sharing information, identifying key insights and innovation, and

⁷⁴ Denis, *Governance*, Part III.

sharing those insights so that innovations are spread through the whole system. Whether this is done through the specific suggestions for workshops, electronic forums and other mechanisms set out below is far less important.

Knowledge exchange and innovation should be built into the performance expectations and agreements between the province and each LHIN. For example, there could be clear expectations that LHINs would participate in conferences and workshops, initiate information sharing, provide input to collective discussions and problem solving, etc. Not participating in such activities should have funding and resource implications.

In effect, these recommendations are asking the province to facilitate and lead a comprehensive knowledge management strategy for the LHINs. This would necessarily be closely linked to other reform initiatives, especially information technology/management.

Policy Action Recommendation	Expected Outcomes
The province should develop policies and programmes that foster innovation and share best practices among all LHINS. It must provide the necessary infrastructure, resources and funding incentives for LHINs to be able to effectively share knowledge among themselves and with their wider communities.	A working culture of innovation and experimentation will be created and sustained → service innovations will be constantly developed and implemented; Innovations will be shared throughout the system.

The Most Effective Funding Model and Provider Mix

The LHINs will have broad powers to fund and enter into service agreements with health care providers. Some stakeholders have expressed concern that the government will move towards the type of split purchaser-provider model used in the UK, in which the government purchases services from a wide range of providers through competitive bidding and in which there is extensive for-profit provision. The recent history of for-profit provision of home care and other services through CCACs in Ontario is also seen as worrying in this regard. There have not yet been official plans on funding mix or statements on the role of for-profit provision from the Ministry.

Research indicates significant problems with the UK model in terms of higher overall administrative costs, quality of care and working conditions.⁷⁵ If the government does favour this model, it should set out its review of the pros and cons of British and other experience and its analysis of the relative cost-benefits of different funding models.

⁷⁵ Allyson Pollock, *NHS plc: The Privatization of Our Health Care*, London: Verso, 2004.

The Ministry should have sufficient programme data from the operations of CCACs and have done systematic evaluation of the impact of its funding and organizational model by now. The CCACs themselves collect evaluation data which could be analyzed. The government recently undertook an extensive review of the competitive bidding process used by CCACs, chaired by former Minister of Health Elinor Caplan. The review heard that certain features of non-profit agencies – such as providing extra (meaning non-mandated) services to meet specific needs and their connections to local communities -- were much valued by clients. However, it did not analyze in detail continuity of care, satisfaction, working conditions or other variables by type of provider.⁷⁶ There has also been some academic research indicating problematic effects of competitive bidding and for-profit contracting in home care which can be reviewed.⁷⁷ Here too, the government should explicitly address concerns raised regarding CCAC funding, analyse lessons learned from their operations and make a concrete case for the cost benefits of a purchaser-provider split model and for-profit provision if that is what it is considering.

At a time when LHINs are just beginning, it seems unwise to unnecessarily alienate significant stakeholders by moving to such a model without demonstrating its benefits. The LHINs will not actually be funding services for several years so there is plenty of time to fully consider the best funding options and service mix. More importantly, there is time to conduct this analysis and debate in a public and transparent fashion, in keeping with the government's emphasis on community engagement.

Another area of concern is the impact of competitive bidding among hospitals and other providers for LHINs service contracts. The danger is that low cost and/or high volume become the sole factors in determining service mix. But what of long-standing community agencies who have created distinctive niches by supporting particular cultural or language communities, which may be small or isolated, or by focussing on marginalized or hard-to-serve groups that no one else was supporting? While of irreplaceable value to the people and communities who depend upon them, such providers may not be the most 'cost-effective' in narrow technical terms. It is widely expected that competitive contracting could lead to centralization of specialized services in larger hospitals in the main cities. This would mean travel and dislocation for patients from outlying areas. How would these kinds of non-quantifiable or non-priced considerations be factored in to service decisions?

The most effective funding model and whether for-profit provision should be part of the mix can be considered in the various planning conferences, forums and

⁷⁶ Hon Elinor Caplan, *Realizing the Potential of Home Care*: Ch 8; however, it still concluded that there was no relationship between profit or non-profit provision and the quality of care and cost effectiveness.

⁷⁷ Julia Abeleson et al, "Managing under managed community care: the experiences of clients, providers and managers in Ontario's competitive home care sector," *Health Policy* 68, 2004: 359-372.

consultations we have been calling for over the next year. The Ministry should not allow or endorse for-profit provision until and unless it is able to demonstrate its superior programme effectiveness, quality of care, innovativeness, working conditions and other cost-benefits.

Policy Action Recommendation	Expected Outcomes
<p>The province should conduct public consultations on the most effective funding models for the LHINs and what, if any, role for-profit provision should play. These consultations should be well coordinated with the various planning conferences and other forums to be held by LHINs that we have been calling for.</p> <p>The province should issue a report with its proposed funding model or options by December 2006. It should not endorse or allow for-profit delivery of care until then.</p>	<p>A research-based and fully debated decision → more effective funding model and provision;</p> <p>Community engagement is furthered by public debate on a critical and contentious issue.</p>

Integration in Practice: The Right Care in the Right Place by the Right Providers

A critical element of overall system efficiency is to ensure that the most appropriate care takes place in the appropriate location, and in the appropriate way. The literature points to many types of examples:

- a greater proportion of chronic care management taking place in home and community settings;
- more appropriate use of providers other than specialists – e.g. midwives rather than obstetricians for routine births;
- elderly and other people requiring intensive support being cared for in their homes or community settings rather than hospitals;
- better prevention and health promotion programmes to cut down unnecessary hospitalization;
- innovative clinics and other practice forms to keep people out of emergency rooms for routine care.

There is no blueprint for the most appropriate mix of services or most effective inter-relationships among them, and the best mix will vary across the regions. But ensuring the most equitable access to the most effective range of care is the common goal that should drive planning and integration everywhere.

Success Factors

Key factors for developing integrated planning and organization, and improving overall efficiency will be:

- infrastructure, knowledge management and working cultures in every LHIN to foster innovation;
- means to continually reflect on what is working well and not so well, and integrate this learning into service improvements;
- provincial support to assess the wider applicability of local innovations and scale them up where appropriate.

Integration II: Continuum of Services and Enhanced Delivery

Integrated and coordinated services are a crucial lynch-pin of more efficient, flexible, adaptive and cost-effective delivery from a system point of view. But patients tend to be less concerned with the behind-the-scenes organizational facets of integration than with their results. From a community or individual point of view, integrated planning and delivery means a seamless continuum of high quality care that people can easily access and understand. The Minister highlighted the challenge:

Patients need a system which is easier to understand and navigate. But, in reality, health care is often difficult to navigate. The continuum of care is often more of a circuitous, poorly signed road. We all know that we don't have a true health care system. Health care in Ontario is more a loose collection of services – first rate services delivered by highly talented health professionals – but not a *true* system. That isn't good for patients, and it stifles the enormous potential locked inside our public health care system.⁷⁸

Creating a Seamless Continuum of Care

The concept is well known in health care theory and is widely accepted as a central goal of health care reform. Key elements are that:

- people have access to a full range of care, when they need it;
- care is effectively linked – so that, for example, a person is discharged from hospital with a community nurse or nurse practitioner to oversee follow-up home care;
- there are easy entry points – generally seen as the role of primary care providers -- and the range of services can be easily navigated by patients;
- the movement from primary to acute or chronic care is also easily navigated

⁷⁸ Hon. George Smitherman, "Speaking Notes, 2004," p. 15, his emphasis.

- at the simplest, patients do not ‘fall between the cracks’.

A seamless continuum of care has been notoriously difficult to achieve in practice. Obstacles have been:

- professional – physicians and other providers being responsible for only part of a person’s care or, at worst, jealously guarding their spheres so that collaboration with other providers is difficult;
- institutional – limited coordinating mechanisms between different institutions and settings to efficiently move patients between them, and a structure of funding that does not support such inter-sectoral mechanisms;
- infrastructural – health information systems that are incompatible and records that cannot easily follow the patients as they move between providers;
- systemic – not enough services of particular kinds or in particular places to ensure fast and equitable access for all patients, or not enough ‘surge capacity’ to efficiently handle variable demand.

Ontario has identified key elements in building an effective continuum of care: developing new types of team-based delivery, primary care reform, investing in services all along the continuum, information technology and management system that can facilitate easy movement for patients within the continuum, and regional coordination of services and providers through the LHINs.

Key questions and challenges that LHINs will be addressing in ensuring such a seamless continuum will be:

- determining the most appropriate range of services to reflect the specific and diverse needs of local populations and communities;
- ensuring qualitative elements such as cultural competence, patient-centred care and responsiveness are built into all services;
- ensuring there are no unintended consequences of the shift from hospital to community or home-based care – for example, drugs covered under OHIP when administered in hospitals are often not covered when provided in community settings;
- integrating prevention and health promotion into the range of services provided, working closely with public health departments and other front-line providers;
- there will necessarily be variations in the continuum’s specific components but there will also need to be common standards and expectations for the range covered in all communities;
- equitable access will be a central principle.

The LHINs will need to involve communities in defining exactly what kind of continuum is important to them and how it can be achieved. And they will need to work with providers and stakeholders to find creative and achievable ways to overcome the institutional obstacles that have limited a real continuum.

Policy Action Recommendation	Expected Outcomes
<p>One facet of the community planning we have recommended each LHIN should undertake should be defining what a continuum of care means to particular communities within their regions.</p> <p>This should then be fed into the province-wide planning conferences and other mechanisms recommended.</p> <p>By July 2006 the province should, working closely with the LHINs, providers and community partners, set out guidelines and standards for a continuum of care.</p>	<p>Critical elements and foundations of an appropriate continuum of care are identified and understood;</p> <p>Everyone has equitable access to the full continuum of care and support they may need.</p>

Success Factors

Achieving an effective, responsive and seamless continuum of care builds upon all the success factors already outlined for other LHINs goals:

- a good continuum of care will be the result of reforms in many areas as well as the LHINs, such as primary care reform, information management, team work in front-line provision, and restructuring the fundamental incentives and drivers of the overall system;
- getting sufficient community and individual input so that the continuum of services really does reflect community needs and preferences;
- fostering a transformed working culture of professional and institutional cooperation;
- fostering innovation all along the continuum and effectively sharing lessons learned to improve care throughout the province;
- integrated and effective planning, coordination and delivery.

From the point of view of the health care system as a whole and the provincial government, a continuum of care is successful if comprehensive care is delivered with the most effective use of resources. From the point of view of consumers or patients, the continuum of care is the ultimate success indicator; where efficiency, integrated planning and high-quality care all come together to meet – or not meet – their needs. The continuum is successful when patients can get equitable and timely access to all the care and support they need, and when health outcomes for all improve. These are different frames of reference, although clearly inter-connected. In the past, institutional and system needs and perspectives have too often trumped community and individual perspectives and expectations. Both need to be at the core of overall health care reform in Ontario and the development of the LHINs.

CONCLUSIONS

A number of specific goals have been outlined for the LHINs initiative, building on the Ministry's stated goals and adding insights from the experience of other provinces and from community interests and perspectives. Challenges, opportunities, key success factors and concrete policy actions were discussed for each goal.

The LHINs are seen to be a vital part of the government's overall health transformation plan. They are going to happen. The challenge for both the government and community-based stakeholders is to ensure that they are developed and implemented in the most effective, innovative and equitable fashion.

Moving Forward

Phasing

The Ministry has set out the broad stages through which LHINs will be developed; detailed implementation plans have yet to be released.

The first few years of the LHINs should be seen as a pilot phase. Experts and practitioners from other provinces emphasized that regionalization was not a unified coherent initiative, but rather a series of – hopefully well coordinated – change projects. The LHINs should be seen as a large and complex experiment, some parts of which will work effectively as planned, and some of which won't. The critical challenge will be to realistically assess what worked well and build on this foundation to continually improve the overall initiative.

Here again, Ontario will want to do this in a very different way: involving the community and stakeholders in all stages of monitoring and then continually adjusting service mix and organizational design on the basis of this ongoing evaluation.

Build in Milestones

Clear milestones should be built into the implementation plans. We have suggested timelines for the various planning conferences, discussion papers, planning structures and other specific recommendations we have made. The Ministry also has indicated timelines in its implementation plans. However, such a complex initiative as the LHINs cannot be expected to work out exactly as planned; adjustments and refinements to components and priorities will need to be made. Building in milestones where this assessment and adjustment will be done; and clear objectives and indicators to guide the assessment will be crucial. For example:

- some milestones and success indicators could be geared to the end of 2006:

- for example, the LHINs should have conducted extensive consultations and developed forums and processes to ensure significant participation of their local communities in planning and priority setting;
- assessing outcomes against these objectives can then be used to adjust plans and priorities to lead into fiscal 2007-08;
- other facets will take longer to implement and milestones could be set for the end of 2007 -- these too would be used to adjust and refine plans and priorities for fiscal 08-09;
- there will need to be extensive community and stakeholder consultation through all these stages:
 - at the outset to determine the most effective phasing and milestones;
 - to assess progress against objectives and expectations at each of these milestones;
 - and to adjust plans and priorities as necessary;
 - essentially this means developing systematic annual assessment and planning process, with community consultation and input at its core.

Policy Action Recommendation	Expected Outcomes
The province should develop clear milestones; concrete objectives that each LHIN is expected to achieve by the end of 2006 and at designated later dates.	These milestones will become part of annual planning processes and a key means of evaluating success against agreed objectives and indicators.

As always, there will need to be a judicious balance between:

- giving the LHINs enough time – many commentators have stressed that it took years for RHAs in other provinces to be solidly established and to have an impact;
- but without waiting forever -- right from the start, the LHINs should encourage and foster innovation and experimentation, and proceed within the kinds of community-driven values and commitment emphasized throughout this paper.

Building Momentum for Change

The Ministry has set up various action groups to lead reform efforts. An internal challenge will be ensuring these groups, with quite different mandates and professional/stakeholder composition, are effectively coordinated and directed to similar broad goals.

As with any major reform effort, stakeholder relations will be vital. A clear lesson from the history of health care reform in Canada, and the particular history of regionalization in other provinces, is that health care providers, especially the major professions and hospitals, can be a significant brake on structural change.

The Ministry will need to carefully analyze the levers and incentives for these stakeholders to embrace, or at least not oppose, change. The health professions and institutions will need to be extensively consulted and be included in the planning process from the beginning.

Obviously, such a complex change as the LHINs taking over the allocation of funds needs to be carefully phased in. But some functions may need to go together with others. The LHINs will first of all be assessing local needs and priorities and analyzing what services are needed to meet those priorities. There will then be a period in which the LHINs will be negotiating performance management agreements with hospitals, agencies and other service providers without controlling funding in these areas. However, the current plan is that LHINs would not get funding powers until later. Will providers pay attention to the LHINs and change their service provision without the indispensable incentive of actually controlling the funds? In other words, does negotiating performance and service agreements need to go together with the power to allocate funds?

More generally, and back to the divisions of power between the province and LHINs, will they be simply intermediaries in these negotiations? Will providers still be able to go the provincial officials if they don't like how these local negotiations are going? Practitioners in other provinces said that if such facets of the division of authority are not clear – and they generally were not – people or organizations did bypass the RHAs and go to the Ministries.

A critical component emphasized in this paper has been community mobilization.

- the government will need to create forums and mechanisms where the public can meaningfully contribute to overall thinking on health care reform;
- community representatives will also need to be 'at the table' – so that the experience and insights of front-line health care workers, individual citizens and community groups can be drawn upon for policy development and planning;
- the government and LHINs will need to work with local communities in building momentum for change within their own spheres and neighbourhoods;
- and ways of building public awareness and understanding of the direction of change will need to be found for the far larger numbers of people who will not be directly involved in planning or reform discussions.

Health care policy and reform is intensely political. It could be speculated that enhanced community involvement and engagement in policy development and priority setting can counter balance the inertia or explicit opposition to change from large institutions and providers. To whatever extent this is true, the LHINs may be the most important means of involving the public and communities in wider health care reform.

Realizing the Potential Of LHINs

There is an opportunity for the LHINs to:

- support more effective coordination and integration of all health care providers, institutions and community agencies:
 - so that a real continuum of care is created – with easy entry and navigation for patients between care providers and settings;
 - so that waste and duplication is reduced and resources can be most effectively utilized;
- better tap into community needs and interests:
 - to better identify service and investment priorities for particular regions and neighbourhoods;
 - to better allocate scarce resources where they will have the most impact;
- foster innovations within their regions and share these lessons across the system;
- by creating more integrated and responsive planning and delivery, the LHINS could make an important contribution to the overall reform of the health care system.

The challenges the province and individual LHINs will face are significant:

- having the imagination and commitment to stay focused on large and ambitious goals;
- finding creative, responsive and effective ways to ensure community participation in planning;
- balancing regional flexibility and provincial standards, provider and consumer interests, different types of practice, short-and long-term projects, health promotion and treatment, and all the other complexities of a modern health care system;
- coordinating resources and care across a complex and fragmented system and weaving together the myriad of practitioners, community providers, hospitals and other institutions into a coherent and integrated system;
- creating a new culture of innovation and cooperation among diverse providers and institutions.

The LHINs will be able to realize their potential only **if** they:

- are able to effectively represent the diversity of interests and communities in their regions and prove themselves accountable to those communities;
- develop planning, priority setting and resource allocation processes that reflect community interests and encourage wide participation;
- successfully build on the coordinating networks and other local initiatives that have been built up over the years, fill gaps, foster innovations and experiments in each and every LHIN, and share the insights and lessons gained in those innovations widely;
- really do create a seamless and responsive continuum of care for all; and

- address the pervasive social and economic inequality that has such an adverse impact on health at the same time as they are developing more integrated and responsive care.

The LHINs will not succeed if they:

- fail to establish clear and actionable priorities, priorities that have been determined with full community participation;
- fail to seriously engage with their local communities;
- allow wasteful competition among providers;
- cannot secure the active buy-in of physicians, nurses and other health care providers and hospitals and other major institutions;
- do not share knowledge and insight amongst themselves – if they come to operate as just another ‘silo’ in a still fragmented system.