

Can LHINs get there from here?

LHINs from a political perspective ... reflections on regionalization in light of the National Healthcare Leadership Conference (2008) Regionalization: Lessons Learned or Lessons Lost

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It is an established fact that Ontario has been a reluctant participant in the process of regionalization across Canada over the last 10-15 years. Ontario has been content to sit on the sidelines while other provinces have consolidated, restructured and regionalized their services. The most recent iteration of this process is the recent creation of a single Health Services Board for the entire province of Alberta¹ and the reduction to two RHAs in New Brunswick².

Meanwhile, Ontario has taken two small steps toward regionalization: one through the development of Regional Offices of the MOHLTC in 2000 (dissolved six years later); and the other through the introduction of 14 geographically defined, community governed³ LHINs (Local Health Integration Networks) in 2006. Enshrined and legitimized through legislation, LHINs in many ways reflect a marriage of former District Health Councils and regional offices of the MOHLTC, with an added bonus - decision-making power to approve and allocate resources to health services organizations, something regional MOHLTC offices had limited authority to do.

The most significant difference between what Ontario has done and the direction taken by other provinces is that in Ontario the MOHLTC has not dissolved or restructured service providing organizations through this process. What is also different in Ontario is the introduction of LHINs as a new layer of system planning and management. Where Ontario is similar to other provinces is that the Ministry has restructured and redefined its own focus and mandate.

To quote from the MOHLTC web site

¹ May 15, 2008 - One provincial governance board has replaced Alberta's nine regional health authority boards, the Alberta Mental Health Board, Alberta Cancer Board and Alberta Alcohol and Drug Abuse Commission (AADAC). This initiative is one part of the Alberta government's health action plan aimed at improving access to health services and making the province's health care system more efficient and effective. Source: Alberta Health and Wellness web site www.health.alberta.ca

² March 11, 2008 FREDERICTON (CNB) Transformational changes designed to put the needs of patients first were announced today by Health Minister Michael Murphy. The changes involve a transition, beginning immediately, from eight Regional Health Authorities to two. The transition will be complete by Sept. 1. The creation of the New Brunswick Health Council, with a dual mandate to provide residents with opportunities for meaningful input and dialogue on health matters, and to ensure that the health-care system is accountable to New Brunswickers; and the consolidation, under a new public sector company, of selected non-clinical services now carried out by the health authorities.

"These changes will result in a more effective, adaptive and accountable health care system - one that contributes to our goal of a self-sufficient New Brunswick," Murphy said. "We're removing barriers to patient care that have existed between regions; ensuring that residents are engaged in their health-care system and know how it is performing; and directing more of our health budget into patient care, with less into administrative and non-clinical functions. www.gnb.ca/news

³ Community governed in this case means members from the local LHIN area who are appointed by Order-in-Council by the provincial government.

The Ministry of Health and Long-Term Care is changing its focus and embracing a new direction. As staff continue to work towards better health care for Ontarians, stewardship will become the ministry's mission and mandate. This new stewardship role will mean that the ministry will provide overall direction and leadership for the system, focusing on planning, and on guiding resources to bring value to the health system. The ministry will be less involved when it comes to the actual delivery of health care and more involved in:

- Establishing overall strategic direction and provincial priorities for the health system;
- Developing legislation, regulations, standards, policies, and directives to support those strategic directions;
- Monitoring and reporting on the performance of the health system and the health of Ontarians;
- Planning for and establishing funding models and levels of funding for the health care system;
- Ensuring that ministry and system strategic directions and expectations are fulfilled.

As a corollary to this development, here is the description of the role of LHINs also taken from the MOHLTC web site.

LHINs are a critical part of the evolution of health care in Ontario from a collection of services to a true system that is patient-focused, results-driven, integrated, and sustainable. The legislation places significant decision-making power at the community level and focuses the local health system on the community's needs, improving health results for patients in every part of the province. The LHINs will facilitate the effective and efficient integration of health care services and make it easier for people to get the best care in the most appropriate setting, when they need it.

With this legislation, the management of local health services has been devolved to the LHINs⁴. In fulfilling their mandates, the LHINs have taken on local health system planning and community engagement. As of April 1, 2007, they have also assumed responsibility for funding a wide range of health service providers, and for managing the majority of service agreements with health service providers. The government continues to provide stewardship of Ontario's health system,

⁴ Like the other provinces in Canada, Ontario has been selective in what it has devolved to the LHINs. Some services continue to be driven centrally, physician, drug and cancer services for example. Other health services in Ontario are provided through cost-sharing agreements with municipalities (Public Health and land ambulance services) and since it would be very complicated to disentangle these services, they have remained in place and are therefore outside the LHINs jurisdiction. It is interesting to note that while the LHINs have been given a system manager role by the MOHLTC, the MOHLTC did not embrace this role itself. The most consistent focus of the Ministry staff was on managing and directing specific sectors of service, not on how they worked together to support the continuum or integration of care.

setting direction, strategic policy, and system standards and delivering provincial programs and services. Together, all the system partners - government, LHINs, and providers – are accountable to the people of Ontario for quality and results.

This redefinition of the Ministry's role and the new one being assumed by the LHINs is still a work in progress. Neither the Ministry nor the LHINs have fully evolved in terms of realizing their intended future state.

By taking this approach, the MOHLTC has been able to avoid any serious confrontations with existing service provider groups and apart from initial opposition from some unions, has avoided any serious political flack.

The introduction of regionalization in every province in Canada has meant, at the outset, the dissolution of many organizations⁵ as legal, corporate entities. Literally hundreds of organizations ceased to exist. Employers disappeared and new management, staff and union relationships were established. Organizations that used to either collaborate or compete with each other now found themselves being divisions, programs and services of the same organization. The rationale for making these dramatic changes was multiple. Politically, the perception that the system was being over managed supported the expectation that administrative costs could be reduced and therefore money could be saved. In addition, elimination of unconstructive competition and parochial attitudes and behaviours was a strong motivator. Needless to say, the elimination of advocacy groups, both local and provincial, also reduced the profile and sheer volume of political 'noise' the government would receive.

The opportunity to reduce or eliminate service and program duplication through regionalization was also seen as an opportunity to reduce costs and increase efficiency⁶. The cost saving agenda made sense because regionalization was brought forward in the context of significant financial pressures being felt by provincial governments across the country. Additional reasons which were used to support regionalization were the opportunity to improve the integration and coordination of care and address population health issues. This softer side of marketing regionalization had its own following.

While regionalization was taking hold in many provinces in the early 1990s, Ontario had just elected its first NDP government, under the leadership of Bob Rae. This election surprised the NDP as much as it did the province a whole. It was a combination of factors that contributed to this election win – dissatisfaction with the new Liberal government that had decided to go the polls early in their mandate, combined with a lack of interest in going back to the Progressive Conservatives who, while having run the province for most of the 20th Century, were seen as stale and out-of-touch, especially with urban voters.

⁵ In Ontario, like in other provinces, Catholic-based organizations have successfully resisted attempts to be merged under direct RHA authority or with non-Catholic facilities. Rather, these organizations have maintained their own governance and enter into contractual agreements with RHAs for the provision of services.

⁶ See footnote 2 – New Brunswick for an example of how this rationale has continued to be used.

Although Ontario did not escape the recession that was being felt across the country at this time, the NDP was not in a political position to initiate actions within the health care system that would cause widespread disruptions and political heat. It was having enough trouble figuring out how to govern and therefore chose to simply ratchet down the system through budget allocations that forced significant staff lay-offs rather than entertain any notion of health system restructuring or regionalization. Simply put, it did not have the political capital to engage in the regionalization agenda⁷.

The election of the neo-conservative Progressive Conservative government of Mike Harris in 1995 brought with it a sustained interest in fiscal management and cost cutting, including across the board cuts to hospitals. In terms of the health care system, the Mike Harris government also took on health system restructuring through the establishment of the Health Services Restructuring Commission led by Dr. Duncan Sinclair. This Commission was in reality a hospital restructuring commission since it had a mandate to issue directives to hospitals but to only provide advice to the Ministry with respect to other components of the health care system. While in large measure the Ministry has not acted on the non-hospital components of the Commission's work, the HSRC made a significant impact on the hospital system in Ontario. The HSRC closed and merged facilities, redefined hospital mandates and facilitated the devolvement of provincial psychiatric hospitals from direct provincial operations to community based hospitals. In other words, it changed the face of the hospital system in the province. Its legacy also lives on through the continuing physical redevelopment of hospitals⁸.

Those who were involved and participated in this process will remember that the HSRC was continually embroiled in controversy and conflict as it directly challenged the significant and deeply rooted vested interests of hospitals in Ontario, especially urban hospitals. Rural hospitals, for the most part escaped the attention of the HSRC for a variety of reasons, including political ones⁹.

Somewhat like the financial rationale for regionalization, hospital restructuring in Ontario was also seen, at least from a political perspective, as a cost cutting measure - reducing or eliminating duplication (especially in multi-hospital communities) thereby reducing overhead etc. The quid-

⁷ In addition to the circumstances of the time, the entrenched influence of the Ontario Hospital Association and the Ontario Medical Association are significant enough to give any government in Ontario pause before unsettling the status quo of the health care system.

⁸ <http://www.health.gov.on.ca/hsrc/HSRC.pdf> This references the final report of the HSRC, **Looking Back, Looking Forward:** The Health Services Restructuring Commission, 1996-2000, a Legacy Report, March 2000. .

⁹ By setting up the HSRC as an independent commission, at arm's length from the MOHLTC, the government was able to deflect any political flack to the HSRC itself, which happened with great regularity. By taking this approach, it was the HSRC and not the government itself that 'took the political heat' from organizations such as the OHA and the Catholic Health Corporation of Ontario. Here is a quote from McGill University Press that published the book, "In the face of fierce resistance to change, especially by hospitals, courageous local leaders created workable strategies for information management, the re-engineering of primary care, and the integration of primary, home, and long-term care with hospital care that resulted in the establishment of acute-care hospitals and the elimination of 9,000-10,000 empty beds. The authors describe the commission's frustration with the slow pace of change caused by powerful interests groups, prolonged legal jousting, a policy vacuum, and political timidity."

pro-quo for hospitals, in part, was that in exchange for accepting the directives of the HSRC, they got significant capital resources to enable the building of new infrastructures (i.e. buildings) that they would otherwise not have been able to afford.¹⁰ This provided an important incentive for hospitals and their communities, as many hospitals in the province were coming to the end of their physical life cycle.

While the restructuring of hospitals and their physical redevelopment is the continuing legacy of the HSRC, its work from a health system integration perspective was largely left undone or incomplete. The HSRC did what it could with the mandate and tools it was given, and it briefly looked beyond hospitals into primary health care and other sectors of the health care system. Dr. Duncan Sinclair, Chair of the HSRC has been open about saying that primary care reform should have come first¹¹. But that wasn't the job the HSRC was given.

The reason for spending this much time talking about the HSRC is that in the history of the health care system in Ontario it serves as the most significant health system restructuring exercise the province has ever undertaken.

LHINs represent a refocusing and reorientation of the system from an integration planning perspective in that they have specific geographic catchment area and therefore specific populations to consider. Even though their mandate does not include population health per se, they do have a mandate to plan for the health care needs of specific service populations within their jurisdiction. This modified population health perspective is narrower than the one usually given to RHAs, but it is a modest move in the same direction.

There are many within Ontario who dismiss system-wide restructuring and regionalization in particular as a waste of time, effort and especially resources. They point to the drop in productivity during the transition process, the lack of evidence that regionalization either saves money or integrates care. The "Made in Ontario" mantra often translates into – it might work there but we can achieve the same outcomes without structural change; it doesn't save money so why bother; we're different; etc.

Yes, Ontario is different but perhaps not for the reasons outlined above. The history in Ontario is different partly because of its wealth but also because very influential organizations such as the Ontario Medical Association and the Ontario Hospital Association, has been able to mobilize significant resources to resist and oppose government actions that threaten the collective interests of its members. One example of smaller community organizations mobilizing to resist changes to their independent governance was their response to the NDP proposal to centralize community

¹⁰ The government, through the HSRC agreed to cover 70% of capital development costs whereas traditionally the government contributed 50%. This has now risen to 90% in light of the significant costs involved and the inability of local hospitals to fundraise the local share of the capital costs through their foundations.

¹¹ For a detailed review and analysis of the work of the HSRC see, **Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996-2000**, Duncan Sinclair, Mark Rochon, Peggy Leatt, 2006 Institute of Research on Public Policy, McGill University Press.

health services in the early '90s through the establishment of Multi-Service Agencies¹². The PCs used the backlash to this proposal as part of their election platform in 1995. Their alternative model, not unlike LHINs, was to establish Community Care Access Centres as brokers and centralized access agencies to community services, while maintaining the status quo of independent governing community agencies. Another, more recent example is that part of the 'buy-in' that the OHA was able to 'negotiate' with the Liberal government around the development of LHINs was the promise to stay away from interfering with the voluntary governance of hospitals. Thousands of other health care organizations in Ontario supported this position as well, but it was the OHA that led the charge and it was the OHA's support that the MOHLTC needed to maintain political peace.

A key asset of the current hospital system in Ontario in the current context is its ability to leverage its community presence, goodwill and stature to attract influential community and business leaders to its boards and through its foundations, raise significant funds to support capital and equipment purchases. Hundreds of millions of dollars are raised annually through hospital foundations in Ontario. Disruption or removal of this talent and capacity is seen as a significant liability for the hospitals. It could produce a significant financial burden that could threaten the voluntary leadership and contributions – both personal and financial – that are made without any direct cost to the health care system. The value of these tangible and intangible assets to the hospitals have been major 'speaking points' in their conversations with the MOHLTC around the impact of any challenge to either continued voluntary governance or threats to their voluntary capital fundraising capacity.

At the present time, organizations like the OHA continue to support LHINs, at least tacitly, but it is a conditional support¹³. The relationship between LHINs and hospitals, in large measure reflects the historical relationship it has had with MOHLTC wherein the primary focus of attention is budget negotiations and approvals. There are other elements to the relationship but this is the one that CEOs and Boards pay attention to most consistently. There are tensions but nothing that is dissimilar to the minor skirmishes that hospitals have always had with the MOHLTC. While the LHINs are now the party with which the hospitals negotiate, the dynamics remain largely the same. One difference is that with 14 new organizations being put in place, LHINs have not consistently carried forward the complex insider knowledge and experience of the MOHLTC in the intricate politics and bureaucracy of financial allocations and negotiations.

One footnote to this dynamic is that in parallel with the devolution of financial responsibilities to the LHINs the MOHLTC developed an accountability framework with hospitals that tied funding to specific deliverables and volumes of services. This was something the MOHLTC began under

¹² The NDP proposal was to establish "Multi-Service Agencies" to provide homecare as local public entities across the province, governed by local elected boards that would directly provide services, with 20% of services left to non-profit or for-profit agencies or companies. The funding mechanism for the 20% was unclear. The scope of services covered by public funding was broadly envisioned to cover the range from short term homecare to long term home support services for the frail elderly. Homecare was envisioned primarily as an alternative to institutional long term care. <http://www.web.net/~ohc/discussion%20paper080820.pdf>

¹³ The OMA is also watching LHIN developments closely although it's financial negotiations on behalf of physicians in the province continue to be take place directly with the MOHLTC.

its watch that has now been devolved to the LHINs. This trend is expected to both continue and expand. In similar fashion, each LHIN in Ontario has signed off on a three year accountability agreement with the MOHLTC¹⁴. These agreements spell out the respective responsibilities of the Ministry and LHINs in system management and sets out LHIN specific performance measures that are linked directly to provincial initiatives such as wait times. While the LHINs are being asked to reflect provincial performance measures in their agreements with the Ministry, service providing organizations are being contracted to deliver on volumes of service. It is interesting to note that the development of performance or accountability agreements have also been used by Ministries of Health in other provinces to define the deliverables of regional health authorities. For example British Columbia, from whom Ontario has borrowed or adapted a number of innovations, has developed and evolved a formal accountability system with its six RHAs¹⁵.

In addition to its financial responsibilities, LHINs have also been given a mandate to integrate the delivery of services within its purview.¹⁶ The powers assigned to LHINs in legislation cover much of the same territory that was given to the HSRC in the 1990's. While the LHINs can move or close down programs, the MOHLTC and the Minister of Health and Long-Term Care has retained the power to shut down and merge organizations. While LHINs have yet to act on their program-based powers, its mandated reach is essentially "HSRC-lite".

Like other Ministries of Health, Ontario's MOHLTC has repositioned itself as the system overseer; serving a stewardship and strategic, policy making role and getting out of their traditional system manager role. What makes Ontario distinctly different is that while other provinces restructured their health system to simplify the system management function by creating RHAs, Ontario has not done this. By creating LHINs Ontario has separated system management from system operational accountability and responsibility.

From a structural perspective, therefore, other provinces created a two tier system while Ontario has created a three tier system. By dodging the "service provider organization dissolution bullet", Ontario has put itself in the position of making it extremely challenging for the LHINs to address their system integration role. For example, the South West LHIN has 225 transfer payment organizations with which it has a direct relationship. That's 225 boards, CEOs, infrastructures and at the end of the day, vested interests (small, medium and large) that can actively resist any attempt to remove, relocate or transfer programs without their consent, to say nothing of closing or merging organizations.

¹⁴ Each of the 14 LHIN three year Accountability Agreements are posted on the MOHLTC web site http://www.health.gov.on.ca/transformation/lhin/lhin_aa.html

¹⁵ See <http://www.healthservices.gov.bc.ca/socsec/performance.html> and <http://www.healthservices.gov.bc.ca/socsec/serviceplan.html> for more information on the BC situation.

¹⁶ It is important to note that not all health services have devolved to the LHINs. Physician and other direct professional payments, laboratory services outside of hospitals, publicly funded prescription payments remain outside LHINs as do pre-hospital emergency and public health services. This somewhat disjointed devolution is a legacy of two factors: the municipal: provincial "downloading" process undertaken by the Harris government in the mid 1990s and the historical management of physician and related direct payment programs by the MOHLTC.

The LHINs have been effective in engaging service providers in their integration agenda – to the tune of thousands of hours of ‘voluntary’ hours being contributed. Why? For two main reasons really. On an individual level, many health care service providers believe in the value of integration and what it has to offer clients/patients. On an organizational level, if the LHINs are ‘successful’ it will prevent the provincial government from questioning the merits of its three tier model. That’s why it’s not uncommon to hear CEOs say that it’s important that the LHINs are successful, in spite of their frustrations with the relationship from a financial perspective.

So the future dilemma facing the LHINs is whether they will be able to continue to solicit the cooperation of the agencies that report and are accountable to them. The more LHINs challenge the status quo or try to impose their own way of working on the system, the more unpopular they will be; the more unpopular they are, the more political their actions will become; the more political their actions, the more pressure there will be for the Minister of Health to step in and, ‘do something’. You can almost hear the catcalls and insults being traded across the central aisle in the legislature. This is not a speculative statement - just ask the RHAs.

For example, some of the reasons that there have been periodic redefinitions of the number of RHAs in most provinces has been because RHAs have publicly challenged the Ministry; have not been able to address ‘hot’ regional issues in politically important ridings; or, have not been able to collectively address ‘hot’ provincial health issues. LHINs in Ontario run the same risk.

At the present time LHINs are being asked to walk a very fine line between two interconnected but competing agendas – exercising fiscal responsibility by keeping within their assigned system budgets and having service provider organizations sign off on balanced budgets, accountability and performance agreements; and at the same time, fostering inter-organizational collaboration and system-wide service integration. The reason these two agendas are at odds with one another is that while service integration blends and blurs boundaries among organizations, putting the interests of clients/patients ahead of specific organizational interests, by focussing on the continuity of care from a systems perspective, organization specific accountability agreements move organizations in exactly the opposite direction - making them accountable for specific deliverables as organizations, regardless of what might be in the interests of others. If the focus of the accountability agreements shift and start to reflect system-wide rather than organization-specific outcomes, then this dynamic would change, assuming the financial accountability changes to reflect this shift as well¹⁷.

If there is an increase in the financial pressures facing the healthcare system in Ontario¹⁸ the LHINs may find themselves doing battle on the financial rather than the integration front. If integration is not structurally imbedded, individual organizational and financial interests will tend to override system integration interests.

¹⁷ Some of the directives issued by the HSRC reflect this shift. The HSRC sometimes issued the same order to different organizations thereby compelling them to collaborate in order to comply.

¹⁸ The most likely scenario will be stimulated by moves by the Ontario government to contain the seemingly endless appetite of the health care system for more money in the face of an economic downturn in the provincial economy which is already underway.

Unfortunately, the economic climate into which the LHINs and the health care system as a whole may be moving is likely to be stormy at exactly the some time as the LHINs are just beginning to find their feet and their system financial management role is evolving and expanding. With literally thousands of organizations under their responsibility, the possibility of both large and small ‘fires’ breaking out are endless. It’s a scary thought. At the same time, not only locally but provincially LHINs are vulnerable. As mentioned earlier, the OHA continues to be a formidable organization, able to mobilize its resources to publicly challenge both LHINs and the MOHLTC should the financial interests of its member hospitals be seriously threatened, especially collectively. The current process that hospitals go through to sign off on their accountability agreements with LHINs has not been a smooth one. Both large and small ‘fires’ have broken out; but for the most part they have been contained within LHIN boundaries. They have not spilled over to become province-wide issues, yet. But the financial forecast for 2009-10 and 2010-11 is not a pretty one.

With this economic forecast in mind, it is extremely unlikely that the LHINs will make any serious effort to implement its integration agenda from a structural perspective – especially along the lines of moving programs or recommending the merger or closure of organizations to the Ministry. Unless it has the full backing and endorsement of the Ministry it would simply be too risky from a political perspective.

In fact, it is reasonable to suggest that only a Ministry orchestrated directive to structurally integrate programs or organizations would provide sufficient cause for action to take place. If the MOHLTC chooses to do this it would be acting like all the other Ministries of Health in the country and would therefore require a solid rationale that could be sold both financially and politically. In practical terms any action in this regard on the part of the Ministry is likely to depend in large measure on the financial pressure it faces in light of the expected downturn in the Ontario economy. If it can afford not to go in this direction, history tells us it will choose not to.

What is clear from the experience of RHAs is that while the initiation of regionalization is defined by the elimination of the myriad of local boards and is a necessary step toward system integration at an organizational level, it is not sufficient to deliver integrated services. That takes something different.

RHAs across Canada, having gone through the process of organizational integration, have been focussing their attention on service integration and in large measure it’s been tough slogging with varied successes. Some RHAs have been stellar in setting the course and direction, developing sound change management strategies, understanding the challenges and rewards of physician engagement and participation, recognizing the significance of e-health to support both process and outcome improvements. Others have not. The results are variable both within and among provinces.

In balance, structural regionalization can be seen as a necessary but not sufficient condition to deliver on the promise of system-wide health services integration. It does not have a direct impact on the front line delivery of health care, but it does establish the conditions that allows the more substantive and systemic work of integrating the delivery of care possible..

In conclusion, Ontario has historically had more choice than other provinces in deciding what it will or will not do; largely because of its strong financial position. At the moment this position is threatened as Canada's resource-based economies are on the ascent and manufacturing jobs are on the decline. Whether this will become the dominant face of Canada in the global economy remains to be seen. What is clear is that Ontario will face some very tough economic choices in the months and years ahead and with that will come some tough decisions for the provincial government. With health care system currently consuming nearly 48% of the program budget of the government, it's not going to escape.

So, is the health care system as it is currently structured in Ontario positioned to be able to cope with significant economic challenges? In a word, no. Could it? Maybe. But to do so the province may have to choose between two equally difficult options: to go down the structural integration route of the other provinces (i.e., the RHA model) or to use the full power of the LHIN legislation to impose integration directives at both the program and organizational level, on a province-wide basis, that will position service providing organizations to withstand the system shock of a significant downturn in resources. Either way, it may well be Ontario's turn to step up to the 'regionalization' plate. If it doesn't it may well find it won't be able to get there from here.

July 2, 2008