

Local Health Integration Networks: Build on their purpose

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Abstract

This article provides a high-level overview on the creation of Local Health Integration Networks (LHINs) and illustrates the complexities involved in their implementation. To understand regional structures such as LHINs, one must understand the context in which design and execution takes place. The article ends with a commentary on how Ontario is performing post-LHINs and discusses next steps.

The start of a conversation

An article about the creation of Local Health Integration Networks (LHINs) would be incomplete without referring to Severe Acute Respiratory Syndrome (SARS). In 2003, Ontario hospitals, community care access centres, community service providers, and public health units all discovered their individual silos could be dramatically affected by other silos.

During an emergency or crisis, people work hard to park self interest and work together. Maybe the energy required to respond systemically in day-to-day life is too daunting? Does strategy place the same emotional demands on people who impel them to react as they did with SARS?

At the time, there was optimism. Many people went through the experience with a “third” eye—an eye focused on the underlying systemic issues that SARS exposed. Health leaders were asking probing questions about system design, roles and responsibility, accountability and empowerment, independence and interdependence, and about the need for fundamental strategic changes.¹

The impetus for LHINs

Within months after defeating SARS, Ontario was into a provincial election. The newly-elected government focused on better access and improved system integration, design, and function. Under the heading of “increased access,” there was to be clear progress on five key priorities: cardiac, cancer, cataracts, hips-and-knees, computed tomography (CT) and magnetic resonance imaging (MRI). With respect to the goal of “system integration, design, and function,” Ontario built on learning from four different fronts: the experience of regionalization in other jurisdictions; Ontario’s own system design flaws surfaced through SARS; a made-in-Ontario expert panel model; and insights contained in a thought-provoking 2000 article titled “A Canadian model of integrated healthcare.”²

After thoughtful review of the aforementioned evidence, it was decided that creating a regionalized structure would not, in itself, be a major contributor to better healthcare delivery. In fact, beginning with a top-down central bureaucratic structure (eg, large regions), rather than with functional and process reforms, had appeared to slow and distract healthcare reform

efforts elsewhere in the country. Without viable local health-care planning and funding, reform processes appeared to bog down. Moreover, until the daily grind of “managing” local issues could be removed from the agenda of the government, there would be little time or energy to deal with the big, strategic issues at hand. Those strategic issues ultimately land at the local level, demanding service delivery change. The LHINs were not so much a solution in and of themselves, rather a means for others to accept ownership for system integration, design, and function and find performance improvement solutions that worked in their local context.³

The made-in-Ontario solution

Building on a history of successful Ontario “networks” such as the Cardiac Care Network, LHINs were designed with the understanding that community-based care, reflecting the needs of the community, is best planned, coordinated, and funded in an integrated manner within and by that community.

The Minister of Health framed LHINs this way . . . “Our vision is of a system where all providers speak to one another in the same language, where there are no longer impenetrable and artificial walls between stakeholders and services, a system driven by the needs of patients, not providers.” (note 1)

On March 28, 2006, the government of Ontario passed into law the *Local Health System Integration Act, 2006* (the “Act”, “Bill 36”). The purpose of the Act is stated as follows: “to provide for an integrated health system to improve the health of Ontarians through better access to high-quality health services, coordinated healthcare in local health systems and across the province, and effective and efficient management of the health system at the local level by local health integration networks.”

With the creation of LHINs, a shift in mindset and behaviour was to take place. The role of government was to determine the

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playing field through the creation of sound healthcare policy so as to enable the various providers and communities to play on it. The delivery system was to be an “accountable” operator and innovator within the policy architecture set-up by the government. The LHINs were intended to become the catalyst, integrator and broker of health system improvement outcomes.

Policy and implications

What does the Ontario LHIN model suggest to us about the policy of regionalization generally in its many forms, structures, and processes? The most obvious notion is that regionalization, like any public policy measure, must be placed in context to be understood. Regionalization through structural change works differently province by province because of differences in size, community, plurality, economics, history, and political culture. Or to put it another way, there is no magic regionalization blueprint to guarantee health reform.

The LHINs satisfy network tenets of an inter-organizational network and are not hierarchical in structure. The LHINs were to encourage local delivery democratic governance and managerial leaders to see themselves through a lens in which they could put themselves and their organization in a relationship with the health service delivery system and their LHIN community partners in the delivery of care. The LHINs were intentionally designed to respect local governance of health delivery organizations, not provide direct service, build and work through community voices, and not have hard boundaries for patient access.

While called a “network,” the Ontario LHINs have features common to other regional structures. They, like regional authorities, have many functions that come from outside their purview and control, such as ministry policies, priorities, funding, and approvals; provincial ambulance services; pharmacare; physician fee schedules; public health, union negotiations; and so on. The list varies by province.

So what impact do these outside variables play? Unfortunately, the literature on regionalization has diminished considerably in the past 15 years, even as the policy itself has become commonplace. While policy-makers and policy analysts have more experience at this point to evaluate regionalization, there is less literature on the policy now than when regionalization was first being implemented. Part of the problem is that it is complicated, unwieldy and has often impeded reform by creating bigger bureaucracies to navigate. When applied to practical policy creation, the variables influencing any determination of how well regionalization works becomes even more complex.⁴ A significant and variable dynamic of regionalization is the tension between centralization and decentralization. Often this tension underlies most problems in the political execution of regionalization strategies.⁵

In a 2006 article by Casebeer et al. using Alberta as a case example, the authors concluded that the implications of regionalization have yet to be adequately assessed and reported. Using a beginning framework to capture stakeholder

perspectives 1994/1995 versus 2003/2004, they made the following observations:

- What we saw communicated by the government was the presumption of an orderly change process.
- What we heard from Regional Health Authorities was a mixed bag.
- What we observed from the frontlines was far more visceral and complicated involving struggles for dominance and feeling of loss of identity and value.
- The public remained hopeful and cynical.⁶

It is interesting to note that the political chatter at the time that LHINs were being designed is the same political chatter heard today across this country; health reform continues to be about structure, the super boss rhetoric. Unfortunately, there remains today an illusion of control implicit in regional structures and that healthcare, the most complex, organic, and adaptive living system, can be controlled like a machine. The rhetoric of democratic governance has infused much academic literature but not necessarily as one might expect. In the end, in most jurisdictions the idea of “democracy as financial accountability” trumped the concept of “democracy as citizen participation.” If anything, the strategy of regionalization has served, somewhat paradoxically, to solidify the centralization of power and to do so in a way that makes accountability very difficult to discern. This situation has resulted in an overall loss of accountability and a murky political space, which allows parties and policy-makers to act with less transparency and consistency than the theory of regionalization admits. This is notable, given that the theory within which regionalization developed attempted to achieve precisely the opposite.⁴ A 2016 Canadian regionalization research study would be a timely and fascinating case study.

Setting the table for LHINs through a new way of engagement: Expert panels

Expert panels have been widely used in healthcare as a way of bringing knowledgeable people together to examine issues and identify solutions in well-defined areas. The extent to which this advice results in tangible change depends on whether the advice influences policy, decision makers, and practitioners. To this end, Ontario took a new approach:

- Traditional “terms of references” were replaced with a “problem statement.”
- Panels reported to a “contracted” provincial Lead of Access to Services and Wait Times.
- The provincial Lead appointed the panel chairs, all of whom were regarded as leaders in their field.
- Panel members included clinicians, administrators, researchers, and other recognized healthcare leaders.
- The panel members were not advocacy or bargaining agent representatives acting on behalf of personal, professional, or organizational interests; rather, the panels were expected to provide their best advice for the benefit of patients.

- A common writer was retained.
- Ministry staff were not panel members. Ministry resources were used to support the work of expert panels.
- Panels advised the government through the Associate Deputy Minister-Executive Lead Premiers Health Results Team who had the authority to make final decisions.
- Expert panel reports were released on the Ministry of Health and Long-Term Care (MOHLTC) public web site within 2 weeks of being submitted to the office of the ADM-Health Results Team.⁷

Between 2004 and 2006, 336 panel members were recruited to 16 expert panels, charged with answering questions in key areas. Panel members had the credibility to say what is true, even when it was unwelcomed news, and peers were more likely to accept it. Moving from its traditional lynch-pin role and abandoning its “control” role, the MOHLTC opted to get out of the way by releasing the results on its web site within 10 days, without trying to alter the findings, or to mount bureaucratic resistance, or to engage in political spinning to explain system shortcomings and to find fault.

Since the MOHLTC did not own the recommendations, it could act on them comprehensively or selectively, as if they were recommendations by the healthcare system, to the healthcare system. This left the MOHLTC free to play the role of monitor, facilitator, funder, and, ultimately, system “steward.” In this way, it avoided imposing significant changes directly on the healthcare system—the difficult and often frustrating pattern followed by previous governments in Ontario and elsewhere.

A key learning was the power of unleashing the talent in the system versus top-down driven edict. To say it another way, the answers to the most complex and perplexing issues facing Ontario’s system of healthcare services can be found within the system. To quote R. Quinn, author of *Deep Change: Discovering the Leader Within*, “Deep change requires more than the identification of the problem and a call to action. It requires looking beyond the scope of the problem and finding the actual source of trouble. The real problem is frequently located where we would least expect to find it—inside ourselves.”⁸

All the expert panels acknowledged the important role that LHINs could play in planning services regionally, monitoring and ensuring access to services in the future (note 2).⁹ The expert panels generated an impressive body of practical advice. More importantly, government and LHINs listened to and acted on many of the changes recommended by the panels. At a strategic level, the panels influenced policies, decisions, and practices; strengthened the working relationships between government, LHINs, and healthcare practitioners; developed wait time champions across the province; and highlighted the value of expert panels to support effective stewardship of the healthcare system. Ontario’s wait time strategy benefited substantially from the expert advice. Ontario moved from a national laggard position to a leader.

LHINs were designed but were they built to succeed?

From day one, design/build observations and questions surfaced. For example, on paper the LHINs were powerful, with over \$20 billion of funding authority and the power to issue integration orders compelling healthcare organizations to alter and even merge services to improve healthcare. Questions arose such as will LHINs be a funding conduit, perpetuating the status quo or will they simply do the MOHLTC’s bidding and add another layer of unnecessary bureaucracy.⁹⁻¹¹

Unfortunately, the political nature of healthcare often serves to solidify the centralization of power and, in doing so, has made accountability somewhat difficult to discern. To reverse this, the MOHLTC is being reinvented to do what governments do best in the 21st century—policy development, standard setting, and accountability assurance. In other words, steering, not rowing, in the parlance of reinventing modern government.¹² Five specific recommendations to advance reinvention were:

1. LHINs be provided with the commensurate authority to exercise their responsibilities and satisfy their local objectives.
2. Ensure a true devolution of authority to LHINs such that decisions about how healthcare services should be structured and delivered within a particular community can be made locally.
3. Re-balance intervention or zealous oversight from the government via the MOHLTC.
4. Give LHINs greater responsibility for managing the accountability for primary care and independent health facilities by expanding the list of health service providers under the *Local Health System Integration Act, 2006* (LHSIA).
5. Amend the “Act” to require all health service providers to develop plans and set priorities that are consistent with the LHIN integrated health services plan and reflect a shared responsibility for system performance.

Despite micromanaging and the inadequacies in how they’ve been allowed to develop, LHINs have figured out how to fit into the system. And people have figured out how to live with them. They are not top-down control centres, and sustainable local integration and transformation is taking place. In fact, Ontario has witnessed a number of voluntary organizational mergers. The fiscal situation has forced more effective collaboration than probably could have ever been forced from the top. A quote from a former LHIN Chief Executive Officer sums it up best “... All things considered, the LHINs have done an admirable job of engaging the health service providers, other interested players, and bystanders in rethinking and reshaping the way we do business with some positive outcomes. The politically naive lens would present a somewhat different picture, one that may well focus on not what LHINs have been doing, but what they have and have not been allowed to do.”¹³

How is Ontario's healthcare system performing?

Regionalization has been a key healthcare strategy for many provinces for well over two decades. In fact, the tension between centralization and decentralization has resulted in many provinces implementing multiple evolutions of regionalization. Much was expected of reform based upon regionalization: Efficient coordination and integration of services would contain costs, while an emphasis upon local participation would make healthcare more responsive and accountable.¹⁴

The goal established by the new government in 2003 was clear, "better access and improved system integration, design and function." Ontario has made great strides and that was what LHINs were created to do.

1. Ontario ranks well against international peers. In a study comparing how provinces rank against international peers by the Conference Board of Canada, Ontario received an "A" grade, the highest rating for Overall Health Care System Performance based on an evaluation of 47 indicators across system-relevant areas such as accessibility, effectiveness, and patient-centredness.¹⁵
2. Ontarians today have better access, shorter waits, and a better experience in how they receive care. According to the Wait Time Alliance, Ontario received an "A" grade regarding wait times for hip replacements, knee replacements, cancer (lung, prostate, and breast), and cardiac bypass surgery.¹⁶
3. Ontario is delivering better value for money without impacting access and quality. Ontario ranked second on a Fraser Institute evaluation of value for money in healthcare, based on availability, use, and access to resources; clinical performance; and provincial health expenditures.¹⁷
4. Ontario also ranks well in a study on national health expenditure trends covering the period 1975 to 2014 by the Canadian Institute for Health Information.¹⁸

LHINs exist: What next?

How can LHINs ensure that they can improve their leadership capacity in today's rapidly transforming healthcare environment?

Be driving influencers of 21st-century healthcare leadership

Little is uncertain, the tempo is quicker, the dynamics are more complex, feedback loops are intense, all within a hyper connected world, driven by a new informed customer. Leverage for LHINs lies in understanding dynamic complexity; seeing interrelationships rather than linear cause and effect chains. An opportunity exists to bring healthcare leadership to life through a new leadership framework called LEADS. The widely

adopted framework provides a tool and process to develop the capabilities required to accomplish healthcare transformation.¹⁹

Embrace the transition from transactional leadership to relationship leadership

We are now in the digital information era that is constantly creating informal as well as formal shared contexts for senior executives and employees to construct new meaning through their interactions. Moving from an old paradigm in which leadership resides in a person or role to a new one in which leadership is a collective process that is spread throughout the LHIN network of people.²⁰

Adopt practices consistent with the new age of transparency

A new era of leadership "under glass" within and beyond the organization has arrived. Health leaders will be under public and political scrutiny, 24 hours a day, seven days a week.

Facilitate a strategic "coming together" through a new adult conversation

On system alignment, using the citizen voice and experience as a focus can offer a humanistic and unifying theme. Now is the time to reframe the conversation from "what is the matter" to "what matters to you," redefine success in terms of health and wellness outcomes that are valued by a population, and put people in charge—shift the decision-making process from the "provider as expert" to the "person as expert."²¹

Conclusion

While control can achieve some degree of compliance or success, real and sustainable transformation emerges from healthy LHIN relationships and the intrinsic motivation that is rooted in truth and human values.

Ontario has leaders who recognize that change does not need to come from the top. With the right LHIN environment and enablers, effective change can continue. In fact, often the best ideas and solutions come from the very people and places you least expect.

As LHINs grapple with rising demands and limited resources, the need for creativity and innovation has also come into sharp focus. The challenges are significant but not insurmountable. The key lies in engaging the hearts and minds of the legions of people who work within the LHINs as well as those who intersect with the direct service providers. One does not need to be an expert on integration to have ideas about how the providers and patients in the LHINs can work together to improve performance and better meet the needs of the community served.²²

With clarity of purpose, alignment of effort, credibility of leadership, integrity in the system, and accountability for performance, Ontario can elevate performance improvement, become a world leader and build on the purpose statement set out in "Bill 36," the "Act" that created LHINs.

Author's note

At the time the LHINS were created, Hugh MacLeod was Associate Deputy Minister of Health and Executive Lead for the Premier's Health Results Team. The "Team" was responsible for the Ontario Wait Time Strategy, the creation of 150 Family Health Teams and the creation of LHINS. Today, Hugh is founder of Global Healthcare Knowledge Exchange.

Notes

1. Remarks made by the Minister of Health at the Empire Club of Canada on November 25, 2005.
2. Sixteen expert panel reports are available at www.ontariowaittimes.com

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