Local Health Integration Networks:
The Arrival of Regional Health Authorities in Ontario

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In the fall of 2004, the Liberal government of Ontario announced an important change in the province's health care system. The government would begin the process of introducing a new structure for health care. Regional health boards called Local Health Integration Networks (LHINs) would be set up throughout the province in order to assume responsibility for the delivery of major health services. Up to this point, the province had depended on the ministry of health (and regional advisory and administrative bodies) to look after the funding and operation of health care in Ontario. However, the province could no longer afford to run health care from Queen's Park; a more efficient, effective, and fair health care system, said the government, required bringing the system closer to local communities. This approach would also mean a new role for the Ministry of Health and Long-Term Care, one that centered on giving greater direction to the development of health care in Ontario. Over the next two and a half years, the government worked with health care providers and other interested parties to give shape to the new arrangement, and on April 1st of 2007 the local health networks took on the task of financing and coordinating many of the province's health services.

The intent of this paper is in part to explore the origins of the LHINs and the new system of providing and planning for health care in Ontario. For students of health care, Ontario has been a puzzle because of its reluctance to embrace regional health authorities; the other provinces had all accepted the necessity of these structures (though PEI has recently dismantled their authorities). An attempt is made here to solve the puzzle and to offer an explanation for Ontario acceding to the accepted wisdom of devolving authority to community-based health structures. The paper also outlines the operation of the LHINs and the revamped provincial ministry of health. This is done to give the reader some idea of the workings of the new system, but also to supply the necessary background for the final objective of paper: namely, to provide a preliminary assessment of Ontario's recent venture in health-care reform. Such an assessment relies on an examination of the relevant legislation and the experience of other provinces with regional health authorities. It also considers organizational theory linked to the LHINs arrangement.

ORIGINS OF LOCAL HEALTH INTEGRATION NETWORKS

The explanation for the emergence of LHINs largely appears as a replay of events in Ontario and elsewhere. A decade earlier, the Ontario government faced large deficits and health expenditures which represented a significant portion of government program spending; cost control thus fixated the minds of senior Ontario decision-makers. At this time, other provinces wrestled with the same challenge. In the 1990s, provincial ministries of health also sought to develop a more integrated or coordinated health care system; in this new system, hospitals, doctors, home care providers, long term care homes and others would combine their efforts so that patients could move easily from one provider to another. This new system would also focus more on prevention and community based care and less on institutional services. Another factor influencing public authorities was the absence of local input into the making of health policy. A more participatory decision-making process would enrich the democratic process and possibly make for better decisions; it might also act to dilute the political influence of health-care providers.

These forces (and some others) would cause nearly all provinces to adopt a regional approach to health care. Responsibility for the funding and operation of many health care

services would be devolved to newly developed health authorities at the regional level. In Ontario, the reaction was different. Like other provinces, Ontario had given careful consideration to regional health authorities; it then elected to establish an arm's length body (named the Health Services Restructuring Commission) with authority to effect major changes to the hospital sector and to recommend an overhaul of the province's health care system.[1] With this action, the Ontario government had in truth followed other provinces in transferring power to a new structure, but this structure constituted a single body and not a set of regional health authorities.[2] (The province seemed less impressed than other provinces with the argument for local participation.) Ontario had also made only a temporary commitment to devolution – the commission would cease operations in 2000. These differences between Ontario and the other provinces, however, would be largely erased with the emergence of a similar set of forces which had prevailed in the early part of the 1990s. In the first years of the new millennium, the Conservative government of Ontario suddenly faced rising expenditures and stagnant revenues; the Conservatives a few years earlier had ended frightening budget deficits only to set the grounds for new ones. On being elected in October of 2003, the Liberal Party of Ontario discovered that surpluses of the preceding years had transformed into a shortfall of over $5 billion. Almost immediately, the new government committed itself to eliminating the deficit by the fiscal year 2007/08. In light of the fact that health expenditures represented almost one-half of program expenditures, this commitment meant that health services would have to be given special treatment; part of this treatment was the introduction of the LHINs and complementary changes in the province's health ministry.

A second force pushing for change in Ontario revolved around the efficacy of health services. For many years, provincial governments had thought that the return on health expenditures fell short of what was possible. Too much focus on hospitals, too few community-based health services, and too little emphasis on integrating or knitting together the various health services. In the early years of the new century, one consequence of these connected failures became evident: unacceptably long waiting lists for health care. In Ontario (and elsewhere), the immediate reaction was to concentrate on hospital procedures with especially long wait times. Another action was a much more aggressive attempt to bind family physicians with other health care providers in order to establish primary health-care teams; the teams would relieve pressure on emergency departments and offer a continuity of care heretofore unavailable to patients. Eventually, decision-makers understood that regional health care arrangements had to be a component of any attempt to integrate and reform the health care system; there needed to be a forum which would allow for the integration of health services. "The LHINs were not so much a solution in themselves, as a means for others to find a solution," wrote a participant in the construction of the new regional bodies.[3]

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[1] For more on health care and regionalization in Ontario, see Joel Davison Harden, "The rhetoric of community control in a neo-liberal era," in Daniel Drache and Terry Sullivan, eds., *Market Limits in Health Reform: Public Success, Private Failure* (London: Routledge, 1999).

[2] Duncan Sinclair, Mark Rochon, and Peggy Leatt, *Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996-2000* (Montreal: IRPP, 2005), 251.

[3] W. Michael Fenn, "Reinvigorating publicly funded medicare in Ontario: new public policy and public administration techniques," *Canadian Public Administration* 49:4 (Winter 2006), 540.

The perceived benefits of 'local control' also played part in the emergence of LHINs. An alleged benefit of localization was that people closer to the ground could better appreciate the actual health needs of the population and address them fairly. As the Ontario minister of health said, the community is "in a much better position than government, however well-intentioned, from Queen's Park to solve every challenge, and to do so in an equitable way."[4] Local control also spoke to the wish for greater accountability in government; LHINs presented a locus of responsibility which was easily accessible to those wishing for answers about health care.[5] The transfer of operational responsibility for health care to regional authorities also denoted that the health ministry could spend more time on health planning; to use terminology popular with many, the Ministry of Health and Long-Term Care would 'steer' more and 'row' less.[6] The concentration on local control also represented part of the long-held wish to escape the politics of health care. At the centre, in Queen's Park, powerful interest groups often distorted decision-making, but in the regions this sort of dynamic could supposedly be avoided as local community groups would assume responsibility for the provision of health.

The concentration on local control and community input also gave a particular shape to the LHINs arrangement. In many of the provinces, regional health authorities had led to the end of traditional decision-making bodies at the lowest level of the community – hospital boards, long term care boards, mental health agencies, and the like. Regionalization had not only involved decentralization of authority downwards from provincial ministers, but also centralization of influence upwards from the aforementioned bodies. But regionalization in Ontario would have a "made in Ontario"[7] quality: the local bodies would remain intact and form an important part of the local decision arrangements for health care.[8] Of course, the political difficulty of eliminating these bodies played a role here; experience elsewhere suggested a great deal of valuable time and political capital had been expended on this effort. But it was not all power politics; senior public officials truly felt that the preservation of the traditional bodies would contribute to a more effective regionalization strategy and be more consistent with traditions in Ontario.[9]

Explanations of the beginnings of regional health authorities often give some importance to the short-run gains for the government in office. It is thus tempting to argue that the LHINs constituted an attempt to shift blame for any reductions or changes in health

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4 Ontario Legislature, *Debates*, November 29, 2005 (George Smitherman, Ontario health minister).

5 For this argument, see Colleen M. Flood, Duncan Sinclair and Joanne Erdman, "Steering and Rowing in Health Care: The Devolution Option," (2004) 30 Queen's L.J, 173.

6 Fenn, "Reinvigorating publicly funded medicare in Ontario," 546.

7 Ontario Legislature, *Debates*, November 29, 2005 (George Smitherman).

8 This is not quite true, for the number of Community Care Access Centres – which coordinate the delivery of major community health services – were reduced from 42 to 14. This was done with the approval of the organization which represents CCACs.

9 Ontario Legislature, *Debates*, November 29, 2005 (George Smitherman). To provide some corroboration for this sentiment, provider groups have played a large role helping the LHINs determine their initial priorities. There are, however, reports that this made in Ontario solution will disappear if hospital boards and other comparable bodies prove troublesome. See John Ronson, "Local Health Integration Networks: Will 'Made in Ontario' Work? *HealthCare Quarterly* 9:1 (2006), 46.

services to the new regional bodies.[10] But public attention paid to this policy development had been minimal. The major media outlets also had few stories on LHINs and the government itself has preferred to stress program initiatives such as wait list reductions and primary health care. If the electorate perceives controversial or unwanted changes in health-care services, the chances are that it will still place the responsibility with Queen's Park. The same kind of thinking might be applied to claims that the LHINs are an effort to generate political support for the government. If the Liberal government is indeed attempting to find votes in LHINs, it is doing so in an understated manner. Granted, the various LHINs in the provinces have spent much time meeting with local groups over the past few years, but most Ontarians remain unfamiliar with the local health integration networks. And admittedly the minister of health at times has engaged in rhetoric – he has said that LHINs represent "the most significant, far-reaching and enduring reform of all" – but this has been more the exception than the rule.[11] Perhaps the absence of overt political calculations with the LHINs arises from the very high stakes associated with health care reform. The government realizes that its fiscal structure and literally the lives of Ontarians rest on solving the heath care problems of the province.

STRUCTURE AND OPERATION OF LHINs

A central element of the Ontario decision to move toward a regional strategy for health care is the provision of the regional health authorities. The *Local Health System Integration Act* of 2006 establishes 14 local health integration networks, each of which is responsible for a designated geographical area in Ontario. The legislation specifies that all LHINs will have a board of directors consisting of up to nine members and whose terms will be for three years (with the possibility of being reappointed for an additional term); formally, cabinet makes all appointments to the board, but local communities may provide advice on some appointments through the health minister.[12] Board members "will be expected to possess relevant expertise, experience, leadership skills, and have an understanding of local health issues, needs and priorities";[13] and they will "receive … remuneration and reimbursement for reasonable expenses …."[14] Each LHIN shall also appoint a chief executive officer "responsible for the management and administration of the affairs of the network, subject to the supervision and direction of its board of directors."[15] The board may also hire additional employees necessary for the carrying out of the work of the network.[16] The legislation as well allows for committees of the board.

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[10] This is a theme which appears in discussions of regional health authorities in Canada. See, for example, Jonathan Lomas, "Devolving authority for health care in Canada's provinces: 4. Emerging issues and prospects," *Canadian Medical Association Journal* 156 (6), Mar. 15, 1997.

[11] Ontario Legislature, November 24, 2005 (George Smitherman).

[12] Ontario Ministry of Health and Long-Term Care, Local Health Integration Networks, Bulletin No. 17/November 15, 2005.

[13] Ontario Ministry of Health and Long-Term Care, Local Health Integration Networks, Bulletin No.1 /October 6, 2004, 3.

[14] *Local Health System Integration Act 2006,* S.O. 2006, ch. 4, s. 7 (5). It appears that this means the inclusion of fairly small per diem payments. See Ontario Ministry of Health and Long-Term Care, Local Health Integration Networks, Bulletin No. 11/May 2, 2005, 5.

[15] *Ibid*., 10 (3).

[16] The issue of LHIN staff is a delicate one because opposition parties have complained about the potential size and cost of the local health network organizations. At this point, it is appears that the staff will be quite

The legislation makes it clear that the board must establish a close partnership with the local community. Consultation with providers, patients, and other persons will take place on an "on-going basis" as well as form a central part of any planning exercises.[17] Forms of community engagement will include community meetings, focus groups, and the setting up of advisory groups. Special advisory committees or councils will be set up for the aboriginal and francophone communities, and input from health professionals will be arranged through an additional advisory body.

The duties and responsibilities of LHINs include the funding of selected health services in the designated area. These services encompass hospitals, community care access centres, community support service organizations, community mental health and addiction agencies, community health centres, and long term care facilities. The government has decided, however, that physician care and drug services (and a few additional services such as laboratories and ambulances) will stay with the ministry of health, a decision that reflects practices in the other provinces. The legislation also confirms that the LHINs will not follow the other provinces in assigning responsibility for the *delivery* of services to the regional health authority. This means that existing local bodies and entities – such as hospital boards, home care agencies, long term care boards – remain intact and keep their responsibility for the provision of their services; in other words, the LHINs will finance and coordinate services, but not operate them.[18] The major implication of the transfer of funding responsibility to the LHINs is that about 60 per cent of the health care budget in Ontario will now be dispensed by regional health authorities (amounting to about $21 billion).

Given the large amounts of transferred monies, it should not be surprising to learn that the government has insisted on legislative provisions relating to accountability and performance management. The minister of health and each LHIN will agree to accountability agreements which specify performance goals for the networks and various targets and standards which make it possible to gauge the success of funding decisions.[19] The LHINS will sign similar agreements with each of the funded health providers.

The *Local Health System Integration Act* outlines many objects for the LHINS, but the integration of health care services "is at the core of the LHIN mandate."[20] Through integration decisions, a LHIN may provide additional funding for a particular service or halt or reduce funding for another service; it may also require that a certain service be offered "to a certain level, quantity or extent"; and it can arrange to "transfer all or part of a service or to receive all or part of services from another person or entity." [21] What the legal terminology seeks to convey is that each LHIN may adjust the funding and operation of health services

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small and limited largely to planning, finance, administrative, and community-engagement personnel. But it appears that the LHINs will rely heavily on health-care providers to assist them.

17 Ibid., s. 16 (1).

18 The legislation does, however, provide authority for a local network to provide services with the consent of cabinet.

19 The ministry and each LHIN will also agree to a Memorandum of Understanding which clearly outlines the roles of both parties and offers more details on the requirements and arrangements of the LHINs. See Ontario Ministry of Health and Long-Term Care, Local Health Integration Networks, Bulletin No. 11/May 2, 2005, 4.

20 Government of Ontario, LHIN Coordination Project, Bulletin No. 30/ March 20, 2007, 2.

21 *Local Health System Integration Act, 2006*, s. 26 (1).

in a way that provides a better coordinated and more effective regional health care system.[22] The minister of health, in his announcements, has complained about the absence of a true *system* of health care in Ontario and said repeatedly that the purpose of the LHINS arrangement was to fix this problem; as a ministry bulletin comments, "LHINS are an important part of the evolution of health care from a collection of services to a true health care system."[23] Just to ensure that this message is not missed, the legislation also provides for the minister – acting on the advice of LHINS – to make integration decisions affecting providers under the authority of the local networks (LHINs integration actions relate largely to *services* of providers).[24]

The government knew that the integration provisions would generate some uneasiness among health care providers. The possibility of reduced funding for a service would capture the attention of the affected organization; the same would possibly hold as well for new arrangements which deviated from standard practices. The legislation thus lays out an appeal process by which persons or other entities may make written submissions to a LHIN or health minister relating to a proposed integration decision; the only condition is that this must be done within 30 days of the public notification of the proposed decision to integrate a service or services. On considering the submissions, the LHIN or minister may adjust the proposed decision if it serves the public interest.

The LHINs legislation deals with matters other than structure, funding, and integration. It states that the ministry of health "shall develop a provincial strategic plan for the health system that includes a vision, priorities and strategic directions for the health system …."[25] The purpose is to give some overall direction to the LHINs; already, the government has participated in public consultations for the purpose of putting forward a ten year plan for health care in Ontario (and to be released shortly). Each LHIN will do basically the same for its area – these plans are called "integrated health service plans" – and here too substantial action has already been undertaken.[26] The legislation also speaks to entities called Community Care Access Centres (CCACs), which have been responsible for the coordination and funding of home-care services in the province. In other provinces, the relevant regional health authority eliminated comparable bodies; but in Ontario the government wants to make it evident that these entities will be an important part of the local health networks, acting as a kind of sub-committee of the LHIN with responsibility for many services existing outside of hospitals (more on this later). Finally, there are a number of provisions relating to labour relations and the treatment of government employees affected by integration decisions and the new LHINs arrangements.

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22 Some say the legislation is unclear about whether LHINS can adjust funding because a provision of the act authorizes cabinet to make regulations affecting the allocation decisions of the local networks. See Louise Shap, "An Overview of Bill 36: Has the Landscape Changed or Have the Sands Simply Shifted?" *Law and Governance,* 10:1 (January 2006).

23 Ontario Ministry of Health and Long-Term Care, Bulletin No. 1/October 6, 2004, 1.

24 The legislation also allows service providers to integrate their services with other providers.

25 *Local Health System Integration Act, 2006*, s. 14 (1).

26 Ibid., s. 15 (1).

MINISTRY OF HEALTH AND LONG-TERM CARE

The decision to introduce regional health authorities always has implications for the central ministries or departments of health; Ontario is no exception. In drafting the LHIN legislation, the government of Ontario tried to "craft a piece of legislation that would allow the Ministry of Heath and Long-Term Care to rise up to a more strategic level, plotting the overall direction of health care in this province …."[27] Responsibility for administering and managing health services had led to "doubt about the ability of the health ministry to lead a fundamental, strategic and long term reform of the existing health care system …."[28] What had to be done was to strip the ministry of many of its line duties – to establish something like a LHIN – and to provide the department with a structure equal to a steering mechanism. In the past couple of years, as the LHINs have been established, the ministry has centered on this very goal. The old structure of the Ministry of Health and Long-Term Care (MOHLTC) included divisions relating to the delivery of services (Acute Services, Health Services, Community Health) with only adequate support for planning and strategic thinking (Integrated Policy & Planning).[29] The new structure (Figure 1 on next page) presents a different form. [30] The new ministry focuses on evidence based planning and strategic thinking which in turn provides the foundation for the prudent investment of health dollars. The figure also reveals a division which reflects another dimension of the new conceptualization of the ministry: namely, the need to concentrate on the performance and accountability of the Ontario public health system.[31] Also evident is the connection between the new divisions (notice the arrows beneath the divisions) and the need to establish a form of horizontal management and to dispense with the old hierarchical or "stove-pipe approach" to departmental operations.[32] For the newly structured ministry, the key themes are strategy, planning, performance, stewardship, and efficient use of scarce dollars, all of which can be seen in the statement of the ministry's new "principal functions":

- Establish overall strategic directions and provincial priorities for the health system;
- Develop legislation, regulations, standards, policies, and directives to support those strategic directions;
- Monitor and report on the performance of the health system and the health of Ontarians; and
- Plan for and establish funding models and levels of funding for the health care system.[33]

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[27] Ontario Legislature, Committee Hearings on *Local Health System Integration Act*, January 30, 2006 (submission by George Smitherman).

[28] Fenn, "Reinvigorating publicly funded medicare in Ontario," 531.

[29] The old structure also included regional offices, and these have been closed and their responsibilities transferred to the LHINS. For more on the old system, see Ontario Ministry of Health and Long-Term Care, *New Directions*, January 2006. *New Directions* is a ministry in-house publication which has attempted to keep MOHLTC employees posted on the structural reforms.

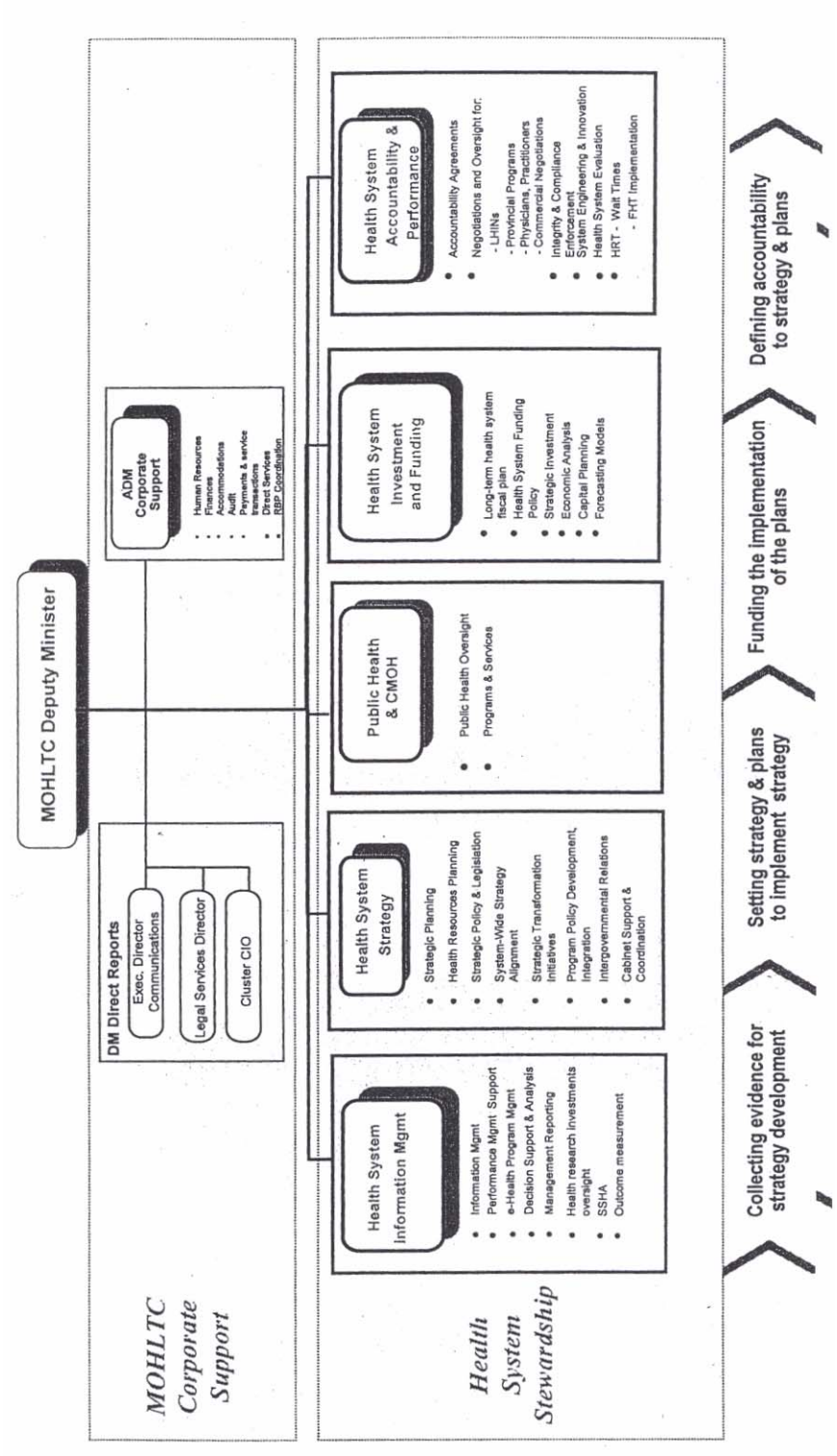
[30] Source for Figure 1 is Ontario, Ministry of Health and Long-Term Care, *New Directions*, January 2006.

[31] Public Health Division is a kind of anomaly, a result of a decision to maintain responsibility for some services at the ministry level.

[32] Ontario, Ministry of Health and Long-Term Care, *New Directions*, March 19, 2007, 2.

[33] Ontario, Ministry of Health and Long-Term Care, Letter from Deputy Minister to MOHLTC Stakeholders, January 18, 2006.

Figure 1


MOHLTC Deputy Minister
MOHLTC Corporate Support
DM Direct Reports
Exec. Director Communications
Legal Services Director
Cluster CIO
ADM Corporate Support
Human Resources
Finance
Accommodations
Audit
Payments & service transactions
Direct Services
RBP Coordination
Health System Stewardship
Health System Information Mgmt
Information Mgmt
Performance Mgmt Support
e-Health Program Mgmt
Decision Support & Analysis
Management Reporting
Health research investments oversight
SSHA
Outcome measurement
Health System Strategy
Strategic Planning
Health Resources Planning
Strategic Policy & Legislation
System-Wide Strategy Alignment
Strategic Transformation Initiatives
Program Policy Development, Integration
Intergovernmental Relations
Cabinet Support & Coordination
Public Health & CMOH
Public Health Oversight
Programs & Services
Health System Investment and Funding
Long-term health system fiscal plan
Health System Funding Policy
Strategic Investment
Economic Analysis
Capital Planning
Forecasting Models
Health System Accountability & Performance
Accountability Agreements
Negotiations and Oversight for:
- LHINs
- Provincial Programs
- Physicians, Practitioners
- Commercial Negotiations
Integrity & Compliance Enforcement
System Engineering & Innovation
Health System Evaluation
HRT - Wait Times
- FHT Implementation
Collecting evidence for strategy development
Setting strategy & plans to implement strategy
Funding the implementation of the plans
Defining accountability to strategy & plans

The restructuring of the ministry towards a "stewardship" role does not mean that it and the LHINs will operate in isolation.[34] The ministry will be involved in a number of important relationships with the local integration networks. A new LHIN Liaison Branch, located in the Health System Accountability and Performance Division, will serve as the inkage between the ministry and the LHINs. Specifically, the branch will be responsible for negotiating and monitoring the accountability agreements between the MOHLTC and each of the local health networks; it will also assist the LHINs in writing the accountability agreements between LHINs and service providers. The LHINs and a new ministry body – the Financial Management Branch – will work together in the funding of services, with the former taking the responsibility for making allocation decisions and latter arranging for the actual payment to health services providers. Another partnership between a new ministry branch (Compliance Branch) and the LHINs will handle matters relating to long term care facilities (former will maintain responsibility for standards and licensing and the latter will focus on funding and performance). Efforts will also be made (and already have been) to provide LHINs with easy access to the vast data bases in the ministry.[35] Finally, LHIN CEOs will meet regularly with the head of the performance division, and chairs of the LHINs will consult with the health minister.

CHALLENGES AND ISSUES

It is clearly impossible to provide a definitive assessment of the new health care reform in Ontario; however, it is possible to consider some of the challenges and issues that will emerge with the introduction of Ontario's regional health authorities. The *Local Health System Integration Act* and the literature on health-care regionalization offer a basis for deliberating the fate of the McGuinty government's attempt to provide better health care to Ontarians.

Citizen Engagement

One of the challenges confronting the LHINs system is ensuring that the citizenry are able to participate actively in the shaping of health priorities and the delivery of services ("citizen engagement" refers here largely to public input and not to governance arrangements[36]). There seems to be no doubt that the Ontario government sees citizen engagement as an integral part of the devolution of authority to regional authorities. The health minister spoke critically of the fact that health decisions 'were made behind closed doors … at Queen's Park"; he also said that it was "just common sense that we ask people from local communities, closer to the action, to help to determine which local priorities must be supported first …."[37] Also revealing, the *Local Health System Integration Act* states that the

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34 This is the term favored by the Ontario health ministry.

35 A number of publications for the LHINS have been published to facilitate use of and access to health care information that is available through MOHLTC.

36 Lomas and his colleagues comment on the confusion between the citizen as a member of the governing structure (in Ontario's case, the LHIN) and citizen as an interested member of the public wishing to comment on the activities of government. See Jonathan Lomas, John Woods, Gerry Veenstra, "Devolving authority for health care in Canada's provinces: 1. An introduction to the issues," *Canadian Medical Association Journal* 156 (3) Feb. 1, 1997.

37 Ontario Legislature, *Debates*, November 24, 2005 (George Smitherman).

LHINs will "engage the community of diverse persons and entities … on an on-going basis …", and amendments were made to the initial bill to give greater definition to the process of public participation.[38] The question, however, is whether the reach of the provincial government in relation to public participation exceeds its grasp.

The legislative committee hearings on the *Local Health System Integration Act* suggest that the government will face some difficulties. It was noted that the accountability agreements tie the boards not to the community, but rather to the minister; thus, the LHINs may have little incentive to confer with the public. The sheer size of the regions will also make it difficult for the public to participate, and the absence of a stipulated process of community engagement in the legislation lessens the chances of effective public input. The experience of regional health authorities elsewhere in Canada also gives cause for concern. Some citizens feel that little real attention is paid to their views and that the consultations amount to "window-dressing"; as well, information provided to support the consultation process is sometimes biased or too technical for the layperson.[39] In some provinces, formal advisory bodies were set up to facilitate public input into the decision-making of regional health authorities, but evidence indicates that these bodies performed below expectations.[40] There is also concern that the citizen-engagement process itself is flawed because it is "vulnerable to interest group capture" and because "the public may not be that willing to participate in time consuming, face-to-face processes …."[41] Others outside the field of health regionalization also ponder the wisdom of citizen engagement.[42]

However, there are also signs that the challenge of citizen participation may be surmounted. Some of the LHINs have already concluded some impressive exercises in community participation, [43] and publications relating to LHINs show that some serious thought has been given to the issue of community participation.[44] As well, citizen-engagement exercises in regional health authorities in Canada have experienced some success.[45] Arguably more important, research has uncovered principles (and consultation

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38 *Local Health System Integration Act,* s. 16 (1).

39 Julia Abelson et al., "Will it make a difference if I show up and share? A citizens' perspective on improving public involvement processes for health system decision-making," *Journal of Health Services Research and Policy* 9:4, 208.

40 Martha Black and Katherine Fierlbeck, "Whatever happened to regionalization? The curious case of Nova Scotia," *Canadian Public Administration* 49:4, 512-515.

41 Julia Abelson et al., "Deliberations about deliberative methods: issues in the design and evaluation of public participation processes," *Social Science & Medicine* 57 (2003), 247, 248.

42 Eric Montpetit, "Public Consultations in Public Network Environments: The Case of Assisted Reproductive Technology Policy in Canada," *Canadian Public Policy* xxxix: 1 (2003). A related theme is that the absence of citizen participation may reflect an "efficient" or satisfactory representative system – in other words, public consultation and participation is unnecessary. See Damien Contandriopoulos, "A sociological perspective on public participation in health care," *Social Science and Medicine* 58 (2004), 326.

43 The SouthWest LHIN, for instance, conducted a number of meetings with communities throughout the region. The purpose was to receive input on the network's initial planning document. The author attended four of these meetings and can report earnest attempts were made to incorporate the views of the public into the planning document.

44 See, for example, Government of Ontario, Ministry of Health and Long-Term Care, *The Health Planner's Toolkit: Community Engagement and Communication*, 2006 and Government of Ontario, *South West LHIN, Community Engagement Framework*, May 8, 2006.

45 Julia Abelson, "Examining the role of context in the implementation of a deliberative public participation experiment: Results from a Canadian comparative study," *Social Science & Medicine* 64 (2007).

modes) which might be used by regional health authorities to increase the chances of effective consultations with the public. The principles relate to *representation* (fair selection & representative group), *procedural rules* (known process and objects of consultation), *information* (accessible and unbiased), and *outcomes/decisions* (impact of consultation on final decisions).[46] If the LHINs can incorporate these kinds of principles into their efforts to consult the public, they might be able to keep their promise of citizen engagement.

Financial Relations

As noted, the government of Ontario will be transferring about 60 per cent of the health ministry budget to the local health care networks. An accountability agreement stipulating network goals and performance targets accompanies the transfer; each LHIN is also required to submit a plan to the ministry "for spending the funding that the network receives" and to ensure that this "spending shall be in accordance with the appropriation from which the Minister [of Health and Long-Term Care] has provided the funding to the network."[47] These specifications leave some questions unanswered. The LHIN legislation, for instance, provides no details on the funding formula for transferring monies to the local networks, a quality that perturbs service providers.[48] Another query is whether the local integration networks will have the flexibility to make significant adjustments to the usual allocations to service providers; the legal authority to do so is present in the legislation, but some fear the LHINs will become servants of ministerial wishes. In some provinces, the evidence suggests that regional authorities have been able to re-allocate monies in accordance with policy directives (e.g. more funding for community-based health services)[49] or possess the potential to do so (but remain content with incremental budgeting practices).[50] However, in most provinces the central health ministry kept a tight hold on spending for both new initiatives and existing services.[51] Flood and her colleagues report that at first regional health authorities "were restricted to line-by-line budgets negotiated with and set by the Ministry of Health" and it only has been in the past few years that authorities have been offered some leeway in the allocation of funds.[52] Recent reports do indicate that at a minimum the LHINs will be restricted in their first years, largely because accountability agreements for major service providers (e.g., hospitals, long term care institutions, and

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46 Abelson et al., "Deliberations about deliberative methods," 245.

47 *Local Health System Integration Act, 2006,* s. 18 (2) (d).

48 Hospitals, for instance, expressed this concern during committee hearings on the *Local Health System Integration Act*.

49 Gregory P. Marchildon, "Regionalization and Health Services Restructuring in Saskatchewan," in Charles M. Beach et al., eds., *Health Services Restructuring in Canada: New Evidence and New Directions* (Montreal & Kingston: McGill-Queen's University Press, 2006), 50; Damien Contandriopoulos et al., "Governance Structures and Political Processes in a Public System: Lessons from Quebec," *Public Administration* 82:3 (2004), 647.

50 Craig Mitton and Cam Donaldson, "Setting priorities in Canadian regional health authorities: a survey of key decision makers," *Health Policy* 60 (2002).

51 Doreen Neville et al., "Regionalization of health services in Newfoundland and Labrador: perceptions of the planning, implementation and consequences of regional governance," *Journal of Health Services Research and Policy* 10: Supplement 2 (October 2005), S2:18; Black and Fierlbeck, "Whatever happened to regionalization?" *Canadian Public Administration* 49:4 (Winter 2006), 517. Lewis and his colleagues also report frustration of board members in Saskatchewan with "restrictive rules" set by the provincial ministry, but don't relate this specifically to spending decisions. See Steven Lewis et al., "Devolution to democratic health authorities in Saskatchewan: an interim report," *Canadian Medical Association Journal* 164: 3, Feb. 6, 2001, 345. See also Steven Lewis and Denise Kouri, "Regionalization: Making Sense of the Canadian Experience," *HealthcarePapers* 5:1 (2004), 25.

52 Flood, Sinclair and Erdman, "Steering and Rowing in Health Care," 191-92.

community health services) have already been negotiated between the providers and ministry officials. This seemingly leaves the LHINs with little budget flexibility in the short run. However, experience with budget re-allocation in the Calgary Health Region imply that analytical techniques can facilitate successful budgetary allocations in the longer run (and the Calgary experience also provides a specific instrument that other authorities might use for re-allocation purposes).[53] Moreover, the commitment of the Ontario government to an integrated health system almost requires that funding flexibility be available to the local health networks.

An additional concern about funding arrangements relates to the belief that the real purpose of the local networks is to reduce overall health care funding and rely more on for-profit providers. If there is flexibility in the budgetary arrangements, some believe, it is only the ability of the local networks to effectively close hospitals and arrange for less expensive – and lower quality – methods of delivering clinical and non-clinical services. In the legislative committee hearings, the most-oft expressed criticism was that the LHINs constituted a cloak for the privatization of the Ontario health care system. Of particular concern was the possibility that a "competitive bidding" system would be used for all health services under the authority of the LHINs. At present, the CCACs employ such a system to arrange for home care services, and the system has spawned a fair amount of concern.[54] The worry in some minds is that this bidding practice will be extended to other LHINs services and will favour for-profit companies. The minister of MOHLTC has repeatedly denied this possibility, but at the same time he has made it clear that he expects the local health networks to achieve some efficiency gains; and the LHINs legislation says "savings from efficiencies that the local health system generated" will be taken into consideration when determining any adjustments in funding for the networks.[55]

Integration

A further challenge brings us to the core purpose of this reform process, which is to integrate the various health services (and providers) at the regional and provincial levels. A number of barriers put at risk this endeavor. The most obvious one is the absence of physicians in the list of providers responsible to the local networks. As the Ontario Nurses Association says, "the coordination of transitions between primary, community and acute care will be inadequate, because primary care physicians will have little incentive to become a part of integration decisions"; the goal of "seamless health care" will most likely remain elusive.[56] The fact that other health services – drug programs, independent health facilities, public health – are also beyond the reach of the LHINs only serves to aggravate this difficult

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[53] Craig Mitton et al., "Priority setting in health authorities: a novel approach to a historical activity," *Social Science & Medicine* 57 (2003) & San Patten, Craig Mitton, Cam Donaldson, "Using participatory action research to build a priority setting process in a Canadian Regional Health Authority," *Social Science & Medicine* 63 (2006). Hurley also provides some grounds for thinking optimistically about achieving more optimal allocations of resources. See Jeremiah Hurley, "Regionalization and the Allocation of Healthcare Resources to Meet Population Health Needs," *HealthcarePapers* 5:1 (2004).

[54] See Elinor Caplan, *Realizing the Potential of Home Care: Competing for Excellence by Rewarding Results*, May 2005.

[55] *Local Health System Integration Act,* s. 17 (2). Moreover, the minister's legislative secretary conceded that competitive bidding might be employed to better allow the government to reach its wait-time targets for designated services.

[56] Ontario Legislature, Standing Committee on Social Policy, January 30, 2006.

situation. Another possible impediment arises from the decision to ignore the practice of other provinces and keep in place the various provider boards and agencies. It seems much easier to coordinate services when each is under the authority of one body. A third consideration is the perception of dual accountability mechanisms which may hinder integration exercises; this possibility can occur in various ways. For example, responsibility for long term care services is shared between the individual LHINs and the MOHLTC – the former manage the funding and the latter licensing and observance of province-wide standards. The association which represents long-term care facilities fears that this may produce confusion in the minds of operators of nursing homes, a condition which has the potential to hinder efforts at integration.[57]

A final point to consider in relation to integration is to appreciate the influence of preferences and standard procedures. The integration of health services implies changes which may hurt some health care providers; as a result, they may resist these changes. It needs to be appreciated that the attempt to integrate a health system is a political exercise if we define politics as the attempt to resolve differences. Also important is the truth that organizations become accustomed to doing things in a particular manner. For many, the fact that health care providers operate as separate entities or "silos" may be abhorrent, but to providers this might be satisfactory and any endeavor to adjust these procedures can run up against deeply-ingrained behaviors.

Notwithstanding these obstacles, there are grounds for believing that there are navigable. Integration plans may still include doctors even if they reside outside the ambit of local health networks. A major priority of one of the LHINs involves building up primary health services and tying them into other health services over which it has responsibility. Actions associated with this priority include locating ways in which family physician practices can integrate with other providers, and holding community engagement events in which physicians and other health professionals discuss ways of building up group practices and family health teams. In pursuing these actions, the network has persuaded physicians to become members of "priority action teams" which have been given the responsibility for pursuing the aforementioned actions; the network also hopes to locate physician "champions" who can talk to their colleagues and medical students about the benefits of practicing in interdisciplinary teams of health providers.[58] Physicians may, of course, defy such initiatives and approaches, but the LHINs appear to have built up a momentum which may be hard to resist. As well, the provincial government preceded the introduction of LHINs with policies which made physicians more accepting of LHIN-like initiatives.[59]

The decision to maintain the various boards and agencies may also prove to be less of a challenge that initially believed. It appears that the Community Care Access Centres may assume a role which turns them into entities responsible for the placement of persons into services under the authority of the LHINs; they will become the guides for residents wishing to secure the most appropriate type of health care. At present, the CCACs do

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57 Ibid., February 7, 2006.

58 South West Local Health Integration Network, *Working Together for Better Health: Our Integrated Health Service Plan, Appendix H: Detailed Priority Action Plans,* October 31, 2006.

59 Fenn, "Reinvigorating publicly funded medicare in Ontario," 544.

assessments and placements largely in relation to home care services, but the case management duties of the centres may extend to community health centres, hospital discharge practices, family health teams, and other community-based services.[60] One important implication of this possible development is that the individual LHINs will not be dealing with a great number of bodies and agencies; rather, the CCACs will become the primary contact point, which should enhance the chances of successfully integrating services. Interestingly, it also suggests that the Ontario experiment in regionalization – as with similar experiments in other provinces – includes an important centralizing element (and it should be recalled that the CCACs were re-structured to make them equivalent in number to the LHINs).

Theoretical Basis

A final issue to consider is the theoretical foundation for the reorganization of Ontario's health system. Sources indicate that the school of New Public Management (NPM) – and in particular the "reinventing government" member of this school – performed a large role in the building of the LHINs and the new MOHLTC.[61] NPM urges a clear division between policy making and management; elected officials handle the former, appointed officials the latter. It also recommends giving public servants greater flexibility in carrying out their managerial duties and achieving accountability through measurement of the results of their actions (and discarding performance though compliance with rules). The inclusion of citizens (or "clients" or "customers") in planning and setting of priorities is also emphasized, and so is the introduction of competitive relations in the administration of services.[62] Officials involved in the re-invention of the Ontario health care system say that a NPM-inspired approach "has much to recommend to it."[63] The problem, however, is that NPM can lead to the kind of failings which some have pointed out have already afflicted or will afflict the new health-care arrangement in Ontario.

The distinction between the restructured MOHLTC and the LHINs reflects the belief of NPM that policy and managerial duties should be separated. Under this arrangement, elected officials and their advisors will have the opportunity to centre on providing direction for government; appointed officials will be able to escape the sometimes intrusive nature of politicians and pursue the professional management of public services. But experience suggests that it is difficult to preserve this separation. Elected officials find political gain in immersing themselves in administration – votes are more likely to emerge from visits to hospitals than planning a new strategy.[64] These same politicians also worry

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[60] The CCACs already have some role in relation to these listed services, but the intention is to confer an almost an exclusive responsibility on them for these services. The LHINs legislation provides for an expansion of the duties of the CCACs. For a better idea of the expanded responsibilities of CCACs, see Ontario Association of Community Care Access Centres, *Addressing Health System Navigation Challenges in Ontario: A Position Paper*, June 2005.

[61] Fenn, "Reinvigorating publicly funded medicare in Ontario," 532, 546.

[62] For more NPM and "reinventing government," see Paul Barker, *Public Administration in Canada: Brief Edition* (Toronto: Thomson Nelson, 2008), ch. 4. The key text for "reinventing government" is David Osborne and Ted Gaebler, *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector from School House to State House, City Hall to Pentagon* (Reading, Mass: Addison-Wesley, 1992).

[63] Fenn., "Reinvigorating publicly funded medicare in Ontario," 546.

[64] David Good, *The Politics of Public Management: The HRDC Audit of Grants and Contributions* (Toronto: University of Toronto Press, 2003), 198.

that autonomy leads to mistakes which reduce chances of re-election.[65] The public is also unlikely to observe the distinction and may pursue politicians on matters which properly belong in the realm of administration; community representatives, for example, might bypass LHINs in favour of the minister if they find actions of the networks unacceptable.[66]

Consistent with NPM, the new health reform in Ontario relies on performance agreements and results-based accountability. The old way of discerning performance had been to ensure that the rules and procedures were followed; but NPM emphasizes the need to look at the outputs – and not the inputs – of government action. But one of the problems with this philosophy lies in measuring outcomes. As two experts on performance management write, "governments tend to be left with the messy, complex and difficult jobs – and the messy, complex and difficult results are harder to define and measure."[67] In a review of regional authorities in BC, the province's Auditor General complains that performance agreements include "a long list of vague and open-ended compliance items" and urges greater "focus and clarity."[68] Yet, many public purposes resist easy measurement, and health care is no exception. Proponents of the NPM seem to think that government can discover the simple and straightforward performance measures found in the private sector – profit being the most obvious of these indictors – but this search can be frustrating.

The NPM also stresses the importance of setting clear objectives which can guide public servants (or decentralized authorities such as regional health authorities) and provide a basis for accountability. But sometimes it is in the interest of governments to keep objectives vague and quite general. Many groups commenting on first draft of the *Local Health System Integration Act* protested that its key provisions lacked the necessary clarity, but the government left most of them unchanged. The cause of this lies in part with the wish of government to pursue conflicting objectives for political purposes; clarity would reveal the contradiction all too clearly.[69] It also stems from the fact that sometimes the government is either not sure of what it is trying to accomplish or appreciates the political risks of being too precise (failure can be more easily determined with clear aims).

Arguably the most unsettling aspect of the NPM is its seeming inability to observe proper constitutional practices. In a parliamentary system, an important constitutional convention requires that the minister be ultimately responsible for the actions under his or her authority. The 'rowing' really cannot be separated from the 'steering' – the minister is accountable for both. The new LHINs arrangement sees this point with the insertion of performance agreements and memorandums of understanding; but at the same time its supporters highlight the need to give authority to the local networks and complain of any ministerial encroachment. Yet, encroachment in one form or another is what we expect of

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65 See Donald J. Savoie, "What is wrong with the new public management?" *Canadian Public Administration* 38:1 (Spring 1995).

66 For a case study of this possibility, see Government of British Columbia, Office of the Auditor General, *A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities*, 2003/2004 : Report 1, 19; also see Lewis and Kouri, "Regionalization: Making Sense of the Canadian Experience," 22-23.

67 Barbara Wake Carroll and David Dewar, "Performance Management: Panacea or Fools Gold?", in C. Dunn, ed., *The Handbook of Canadian Public Administration* (Toronto: Oxford University Press, 2002), 417.

68 Office of the Auditor General, *A Review of Performance Agreements,* 30

69 Donald J. Savoie, "Just another voice from the pulpit," *Canadian Public Administration* 38:1 (Spring 1995), 135.

ministers in a parliamentary system. The NPM rightly recognizes the dangers of intrusive ministers; however, in its eagerness to fix this problem it may be guilty of going too far the other way.

NPM has experienced problems in Canada and other countries, and the concerns with the LHINs arrangement suggest that NPM may again be misleading another government.[70] Yet, as with other concerns expressed in this paper, this one is less than fatal. NPM has its supporters, and some degree of success can be achieved if the limits of the NPM are understood.[71] The problems with NPM emerge with the attempt to adopt its various maxims without adjustment; for example, the list of features associated with the "reinventing government" literature is treated as a set of commandments. The preferred approach is to take what is sensible in the NPM and modify its features in light of prevailing constraints. For instance, the autonomy of the LHINs provides the basis for a serious attempt at integration; but it has to be understood that the minister and the central ministry will inevitably become involved. Lewis and Kouri advise that provincial governments "must decide … what regionalization should be, and then leave the regional health authorities to get on with the job, fully accountable for performance."[72] This sentiment is well-intentioned, but arguably too excessive; the responsible minister cannot (for constitutional reasons) and will not (for political reasons) "leave" any *major* public-administrative entity on its own.[73]

CONCLUSION

In the past decade or so, governments in Canada have seen fit to devolve influence and authority over health care. The federal government has given the provinces centre stage in order to address the shortcomings of medicare[74], and provincial governments in turn have looked to regional authorities to take the lead in the delivery of important health services. The basic reasons for this trend are straightforward. Those closer to the patient are better able to understand health needs and to respond to these needs. They are also able to appreciate that health-care needs may differ across space. One of the big questions facing Canadians now is whether this process of decentralization should move right down to the level of the individual and the market. In this environment of decentralizing power, the introduction of the LHINs appears logical and consistent with prevailing trends. There are, however, problems and issues which confront the new arrangement in Ontario and whose resolution is uncertain. The experience of health authorities in other provinces certainly supplies grounds for some concern, and it appears that the commitment of provincial governments to an effective devolution of influence can be questioned. For the odds to turn decisively in favour of success, it seems that those directly involved with regionalization in Ontario – the minister, senior ministry officials, and especially the LHINs boards and staff – will have to supplement the trend towards decentralization with political and organizational

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70 For a critical look at the performance of NPM in Canada, see Donald J. Savoie, *Breaking the Bargain: Public Servants, Ministers and Parliament* (Toronto: University of Toronto Press, 2003).

71 See, for example, Kenneth Kernaghan, Brian Marson, and Sandford Borins, *The New Public Organization* (Toronto: The Institute of Public Administration of Canada, 2000).

72 Lewis and Kouri, "Regionalization: Making Sense of the Canadian Experience," 30.

73 See Jack Davis, "Let Regionalization Continue to Evolve," *HealthcarePapers* 5:1 (2004), 51.

74 In recent accords, the federal government has sought to re-assert itself in health care, but the actions of the Harper government suggest that the trend towards decentralization will continue.

skills.[75] Among other things, they will need to recognize the principles behind successful community engagement, discover budgeting systems which are both fair and effective, and appreciate that the relations between the centre and region constitute a delicate – and continuous – balancing act.

[75] For an example of how this might be done, see Contandriopoulos et al., "Governance Structures and Political Processes in a Public System," 640-44.

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