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The Establishment of Ontario's Local Health Integration Networks: A Conflation of Regionalization with Integration of Health Services

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Abstract

In 2006, Ontario became the last Canadian province to implement health services regionalization with the establishment of Local Health Integration Networks (LHINs). Facing a large health reform agenda to be implemented in a "system" of disconnected health service silos, the Ontario government created the LHINs as a recognition of the need for system change to achieve health reform. As a component of greater provincial health reform goals, the LHINs were specifically designed to integrate health services; however, they may have been implicitly created to shift accountability away from the central government. While some stakeholders supported reform goals of increased health system integration and responsiveness, others opposed the reform stating concern about increased bureaucracy and lack of stakeholder input. Nevertheless, the reform was achieved with the policy framework developed by a government-mandated team and the creation of legislation called the *Local Health System Integration Act*. To date, no robust evaluations have assessed the causal impact of the LHINs on the integration of the health system in Ontario. The lack of primary care integration and the retention of local health organization boards may have prevented the LHINs from realizing their potential. The decade long experience of the LHINs is a lesson for the *Patients First Act* enacted in 2016, the next phase of Ontario health care reform involving LHINs as key players.

L'Ontario est devenue en 2006 la dernière province canadienne à régionaliser ses services de santé avec la mise en place des Réseaux Locaux d'Intégration des Services de Santé (RLISS). Souhaitant mettre en œuvre un programme ambitieux de réformes dans un « système » fractionné de services de santé travaillant séparément, le gouvernement de l'Ontario a créé les RLISS, reconnaissant que la réforme passait par une refonte du système. Le rôle des RLISS comme composante de la réforme de la santé de la province était spécifiquement de faire collaborer les services de santé entre eux; cependant, il est aussi possible qu'ils aient été implicitement créés pour détourner la responsabilité du gouvernement central. La réforme a été bien accueillie par certaines parties prenantes, qui soutenaient les objectifs d'intégration du système et de plus grande flexibilité, mais des voix se sont élevées pour dénoncer le poids accru de la bureaucratie et le manque de consultations des acteurs. Quoiqu'il en soit, la réforme a abouti au développement d'un cadre législatif par une équipe mandatée par le gouvernement et la création d'une législation, la Loi sur l'Intégration du Système de Santé. *À ce jour, aucune évaluation de l'effet des RLISS sur l'intégration du système de santé en Ontario n'a été tentée. Le fait que la santé primaire n'ait pas été incluse dans le mandat d'intégration, et le maintien des conseils des organisations sanitaires locales ont sans doute empêché les RLISS de réaliser pleinement leur mission. La loi de 2016 donnant la priorité*

au patient, prochaine étape de la réforme sanitaire en Ontario, dans laquelle les RLISS jouent un rôle central, peut tirer les leçons des dix ans d'expérience des RLISS.

Key Messages

- In 2006, Ontario was the last province to implement health services regionalization with the establishment of 14 regional organizations called Local Health Integration Networks (LHINs), existing in a three-tier regionalization model alongside local health care organization boards and the ministry.
- Regionalization aspires to achieve health system integration; but regionalization alone does not ensure integration and is not necessary to improve integration.
- Lack of primary care integration and parallel existence of powerful local health organization boards (i.e., hospital boards) in Ontario's three-tier system may have impeded LHINs in achieving their purported mandate.

Messages-clés

- *En 2006, l'Ontario a été la dernière province à régionaliser les services de santé avec la mise en place de 14 organisations régionales, appelées Réseaux Locaux d'Intégration des Services de Santé (RLISS), au sein d'un modèle de régionalisation à trois niveaux, à côté des organisations sanitaires locales et du ministère.*
- *L'objectif de la régionalisation est l'intégration des services de santé; mais la régionalisation ne peut garantir à elle seule cette intégration, et n'est pas non plus une condition nécessaire pour y accéder.*
- *L'absence des soins primaires et le maintien en parallèle de conseils d'organisations locales de santé dotés de beaucoup de pouvoir (c'est-à-dire les conseils des hôpitaux) dans le système à trois étages de l'Ontario a sans doute empêché les RLISS d'accomplir leur mission.*

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1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

In a major speech in September 2004, the Ontario Minister of Health and Long-Term Care, the Honourable George Smitherman envisioned a more patient-focused and integrated health care system that effectively responds to local needs (Health Results Team 2005). A component of his transformation agenda included the creation of 14 regional organizations called Local Health Integration Networks (LHINs) to better manage local health care systems. In 2006, Ontario became the last province in Canada to implement regionalization with the establishment of LHINs designed to plan, coordinate, integrate, and fund local health services. The LHINs were described as a "made-in-Ontario solution," a regionalization model more specifically designed to facilitate the integration of local health services.

2 HISTORY AND CONTEXT

Regionalization is a structural process that involves the creation of "intermediary administrative and governance structures to carry out functions or exercise authority previously assigned to either central or local structures" (Church and Barker 1998). For provincial commissions and task forces of the 1980s whose main goal was to improve health services organization and implementation, health services regionalization appeared to offer an answer to contain health care costs, increase efficiency and effectiveness of health care, and enhance health care system responsiveness through decentralized decision-making (Black and Fierlback 2006; Church and Barker 1998). At the end of the 1990s, all provinces except Ontario were moving towards a two-tier governance system of regional health authorities (RHAs) and a ministry of health. Boards of local health organizations (e.g., hospitals, residential care programs) dissolved and regional health boards assumed responsibilities of local health organizations in the planning and delivery of health care services (Bergevin *et al.* 2016; Marchildon 2013; Simpson 2011). The ministry of health provides funding, overall governance, and oversight of provincial priorities.

In 2006, Ontario became the last province in Canada to implement regionalization with the establishment of 14 geographically-based Local Health Integration Networks (LHINs). Prior to the legislation of the *Patients First Act* in 2016 which expanded the scope of LHIN authority, the LHINs were responsible for hospitals, long-term care homes, Community Care Access Centres, Community Support Services, Community Health Centres, and Addictions and Mental Health Agencies within their geographical jurisdiction. Their responsibilities excluded physician care, public health, ambulance services, or provincial networks such as Cancer Care Ontario (Health Care Tomorrow 2014; MOHLTC 2017). The 14 LHINs allocate funds to these service providers and coordinate services but do not operate them (Barker 2007). Ontario's governance system is still "regionalization lite": it is characterized

as a three-tier system (local health care organizations, LHINs, and ministry) compared to the two-tier system (RHA, ministry) evolving in other provinces. Local health care organizations have retained their governance structures.

Essentially, regionalization was seen and conceptually designed as a vehicle for an organized or integrated health care delivery system. An integrated delivery system can be understood as a "network of organizations that provide or arrange to provide a coordinated continuum of services to a defined population and who are willing to be held clinically and fiscally accountable for the outcomes and health status of the populations being served" (Shortell, Gillies, Anderson 1994). The provision of heath care services moves away from silos of fragmented individual health care organizations towards a system of coordinated and seamless health care service delivery facilitated by a common regional organization (Simpson 2011). Through a population health approach at the regional level, improved knowledge of patient and community needs within the region can enable greater coordination and delivery of care around community needs and improved access to specialized care in rural areas of regions (Bergevin *et al.* 2016).

The LHINs were purported to be a "made-in-Ontario solution," a regionalization model more specifically designed to facilitate *health system integration* (Fierlbeck 2011; The Honorable George Smitherman 2004). Each LHIN is required to develop a three-year integrated health service plan including a vision, priorities, and strategic directions for the local health system and detailed strategies to integrate the local health system (*LHSIA* 2006). While multiple definitions of integration exist in literature, according to the *Local Heath System Integration Act* (*LHSIA*) that legislated the existence of LHINs, "integration" encompasses five dimensions: *coordinating*, *partnering*, *merging*, *ceasing*, and *starting*. Thus, integration could be implemented in multiple ways, varying by LHINs based on their regional health needs (Auditor General of Ontario 2015). Some LHINs *coordinated* services between different entities by developing referral systems across hospitals and *partnered* with a hospital to provide mobile support for seniors with greater needs. Other LHINs *merged* transportation services among community agencies, *ceased* funding to health service providers to avoid redundancy, or *started* a new model of care for high risk populations.

3 GOALS OF THE REFORM

3.1 Stated

The Honorable George Smitherman noted the creation of LHINs as a step to "make [the] health care system better integrated, and more responsive to patients" and to say "goodbye [to a] Patchwork Quilt" of health services in the province (The Honorable George Smitherman 2004). More exactly, the purpose of the Act enabling the LHINs was "to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care in local health systems and across the province, and effective and efficient management of the health system at the local level"

(*LHSIA* 2006).

3.2 Implicit

By explicitly stating integration as the goal of regionalization and creating a new local governance level, policymakers can avoid having to make the hard decisions (mergers, transfers, partnerships) at the central level. While regionalization can support integration, regionalization (consolidation of providers under regional governance) is neither necessary nor sufficient to ensure integration (organization of care around patient needs): these organizational processes are not mutually inclusive (Brown, Pisters, Naylor 2016). By highlighting a wide range of potential positive impacts of regionalization (despite limited empirical evidence), policymakers can market regionalization as a catchall solution to address public concerns about the systemic problems within health care including the absence of an integrated health system that responds to local needs. As Fierlbeck (2016) notes, since regionalization is a governance reform focusing on higher levels of health care administration, the reform is "invisible" to health care consumers. Regionalization can be used as a policy tool to diminish provincial accountability, by creating another level of bureaucracy (i.e., the LHINs) to be targets of public discontent rather than the central provincial government (CUPE 2005).

4 FACTORS THAT INFLUENCED HOW AND WHY

4.1 The issue came onto the government's agenda

Kingdon's agenda-setting theory proposes that successful agenda-setting requires the convergence of three streams—*problems*, *politics*, and *policies*—at a critical time, opening a "policy window" (Kingdon 2003). By the early 2000s, regionalization was a pan-Canadian policy as part of secular trends in public expenditure cuts and cost control (Barker 2007). Patients and governments alike were concerned about the responsiveness of Canada's health care system in the face of an aging population often with multiple, chronic medical conditions requiring coordination of health services at all levels and intensities of care. The 2003 Severe Acute Respiratory Syndrome (SARS) crisis exposed flaws in the design of Ontario's health care system. Both patients and health care providers encountered *problems* of service fragmentation, where hospitals, community care access centres, community service providers, and public health units acted as silos rather than an integrated system (MacLeod 2003).

Soon after overcoming the SARS epidemic, Ontario was busy with a provincial election. Monthly polls revealed that health care was the top area of *political* interest and concern for voters (Fenn 2006). With several health initiatives on their platform, the Liberal Party was successfully elected in 2003. Moreover, the new government was left with a fiscal deficit of over $5 billion from its Conservative predecessors (Barker 2007). Considering

that approximately 40% of the provincial budget was devoted to health care alone, health care reform was pushed to the top of the government's agenda.

The Ministry of Health and Long-Term Care (MOHLTC) was characterized by organizational divisions that were often closer to their own division stakeholders than to other parts of the system and the provincial government (Fenn 2006). In this context, the government recognized that implementing large-scale health reforms could not be effective or sustainable while the system was composed of autonomous actors and disconnected services (Health Results Team 2005). Regionalized health care arrangements were seen as necessary to plan and fund local health care so that centrally devised reform processes would not fail in local execution.

Within the *policies* stream, the government came to the conclusion that devolved regionalized structures had to be a component of health system integration and reform (Barker 2007). However, unlike the two-tier system (RHA, ministry) in other provinces, Ontario would retain governance structures of local providers in a regionalization lite, three-tier system (local health care organizations, LHINs, and ministry). The Honorable George Smitherman stated that regionalization in Ontario would continue with the Ontario tradition of community-based governance, referring to the evolution of locally represented and owned community care access centres (Ontario Legislature 2005). Additionally, the political capital of powerful, large tertiary and teaching hospitals proficient at protecting their own institutional and local interests may have influenced the decision of adopting a three- versus two-tier regionalization model (Barker 2007; Gardner 2006).

4.2 The final decision was made or not made

The 3I framework suggests that the development of policies and choices are influenced by *institutions*, and by actors' *ideas* and *interests* (Lavis et al. 2012). *Institutions* had a great influence in MOHLTC's final decision to implement LHINs. Policy legacies such as the Ontario Health Services Restructuring Commission (HSRC 2000) and the District Health Councils (DHCs) instituted by the MOHLTC in 1975 support ideas of health care system integration and a system responsive to local needs. The HSRC was as an arms-length body that advised the Ontario government on hospital restructuring as well as changes required to create an integrated health care system; the 16 geographically based DHCs fulfilled an advisory role to the MOHLTC on the health needs of their geographic region (HSRC 2000; Mhatre and Deber 1992). Continuing these efforts, the LHINs preserved approximately the same geographic boundaries of the DHCs and were acknowledged as new and expanded versions of the DHCs with a specific mandate of system integration.

The *ideas* of New Public Management (NPM) trending internationally in the 1990s played a role in the development of the LHINs. The regionalization movement was based on an argument inherent in the NPM philosophy that inefficiency and unresponsiveness results from centralized control over management and delivery of services (Fierlbeck 2011). The division between policy-making and management of service delivery emphasized in

NPM is reflected in the attachment of a stewardship role to the MOHLTC and an operational management role devolved to peripheral units—the LHINs (Atun 2007). Following NPM philosophy, LHINs centre the citizen as the customer of service provision and promote citizen participation in planning. Integrated health services plans (focused on strategies of integrating the local health care system) produced by each LHIN are required to include community input (Barker 2007; Fierlbeck 2011). Furthermore, consistent with the NPM idea of encouraging performance measurements to drive accountability for results, performance as well as accountability agreements are made between LHINs and the MOHLTC as well as between LHINs and health service providers (Barker 2007).

The reaction from stakeholders was mixed (see Table 1: SWOT Analysis). Many *interest* groups such as the Ontario Hospital Association and Community Health Centres supported the LHIN reform, approving the goals of integration and increasing responsiveness of the system (Gardner 2006). However, other stakeholders including the Ontario Medical Association (OMA), Ontario Health Coalition (OHC), and the Canadian Union of Public Employees and the Ontario Public Service Employees Union (CUPE/OPSEU) actively opposed the LHINs (Gardner 2006). The OMA was concerned about negligible input from frontline physicians in the integration of health services and similarly, the OHC felt there was no public input in the development of LHINs, further worrying that LHINs would be dominated by the provincial government rather than the community (Gardner 2006). Unions were concerned about the loss of jobs through integration or centralization of services and competitive bidding to fund home care providers with LHINs as the purchaser of health services (CUPE 2005).

5 HOW THE REFORM WAS ACHIEVED (OR FAILED)

The policy foundation for the LHINs was established by the System Integration Team (SIT) within the Health Results Team that was responsible for the organizational and functional development of LHINs (Health Results Team 2005). Accompanying the official launch of 14 LHINs in October 2004, the SIT launched a regular series of monthly bulletins to keep the public updated on the progress of LHINs. In June 2005, the 14 LHINs were initially established as non-profit corporations under Ontario's *Corporations Act*. This Act enabled the LHINs to establish a board and initialize work planning in communities. However, to enable the LHINs to perform certain roles, the Honorable George Smitherman introduced Bill 36, the *Local Heath System Integration Act* (*LHSIA*), in November 2005. After passing the third and final reading and upon Royal Assent on 1 March 2006, the *LHSIA* gave the LHINs the power to plan, integrate, and fund local health services for their geographic area. By April 2007, all LHINs assumed their operational roles. Under the *LHSIA*, each LHIN is required to develop an integrated health service plan, detailing strategies to integrate the local health system.

6 EVALUATION

A value-for-money audit of the LHINs was included in the Auditor General of Ontario's 2015 Annual Report, eight years after the operationalization of LHINs (Auditor General of Ontario 2015). Between 2007 and 2015, performance declined provincially in three of four performance areas measuring the LHINs' activities in integrating health services through effective coordination of hospital and community health care settings (e.g., readmission of selected groups of acute hospital patients to any facility for inpatient care within 30 days of discharge). In sum, the report stated that the LHINs fall short of achieving their mandate of an integrated health system in Ontario. The MOHLTC lacked oversight and the LHINs did not consistently monitor nor evaluate whether their integrated health service plans were effective in achieving an integrated local health system. Inadequately measured targets and performance of LHINs to plan, fund, and integrate health care hamper progress towards system integration and evidence-based reinvestment into further system improvements.

Beyond its direct and measurable effect on health system performance, it can be argued that regionalization is a "means for others to find a solution" (Fenn 2006). In that sense, LHINs have allowed an arena for local health care providers (e.g., hospitals, home care, and community sector) to work together and integrate. Various committee and working groups have been established to address common local health system priority areas such as mental health and palliative care. On the other hand, integration efforts of LHINs have been limited by the exclusion of physicians and primary care, crucial components in the coordination and continuum of patient care. Physicians are not under LHIN authority as they retain their independence through fee-for-service contracts with the provincial government (Marchildon 2017). Physicians, the main deliverers of primary care, are then outside of LHIN control and do not have accountability for patient outcomes back to LHINs.

Meanwhile, integration efforts could have occurred organically without the existence of LHINs. The merger of Credit Valley and Trillium Health Centre in the Greater Toronto Area developed from a three-year close partnership between the two entities outside LHIN control (Falk 2011; Howlett 2018). Additionally, Ontario's choice to retain local health care organization boards may have, in fact, created barriers to health system integration. The parallel existence of two governance structures (local health care organization boards responsible for organizational oversight and LHIN boards responsible for overall regional oversight) can create opportunities to reach an impasse, preventing quick decision-making by the LHINs to improve patient care in the region. The LHINs must make tough decisions about system integration in the face of powerful hospital boards who can sometimes work against LHIN efforts in order to protect their own institutional interests. A notable case was a deep disagreement between the Kingston General Hospital, a tertiary teaching hospital, and the South East LHIN over the Hospital Service Accountability Agreement (a signed planning and funding framework between the hospital and the LHIN) that compelleded the ministry to send an external reviewer to intervene (Scott 2008).

In 2016 and after a decade of experience with LHINs under the *LHSIA*, the *Patients*

First Act was implemented in Ontario to augment momentum towards a more regionalized and integrated health care system (MOHLTC 2017). This Act expanded the responsibility of LHINs to include home care (which was previously the function of Community Care Access Centres) and primary care planning. As this Act is the next phase of health system integration in Ontario, it will be necessary to assess if the LHINs have evolved to better measure outcomes of integration initiatives and set timelines towards a clearer vision of an integrated health system.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1 summarizes the strengths, weaknesses, opportunities, and threats related to the establishment of LHINs from various stakeholder perspectives (MOHLTC, OMA, Wellesley Institute, OHC, the public, CUPE/OPSEU).

Table 1: SWOT Analysis

Strengths	Weaknesses
• Specifically stating a mandate of integrating services into a health system (MOHLTC) • Establishment of accountability agreements and performance goals and objectives for the local health system: creation of a layer of data to track issues in the system and better understand integration processes (MOHLTC)	• Absence of some health sectors including primary health care into the LHINs initiative (OMA) • No engagement of frontline providers (OMA) • Parallel existence of strongly governed local boards (i.e., hospital boards) guarding their own institutional interests and LHINs hinders LHINs from making important decisions about integrating care (public) • Perceived as another layer of bureaucracy resulting in additional administrative costs (public)

Opportunities	Threats
• Increased continuum of care through integrated health care delivery (MOHLTC) • Increased local input into health planning and decision-making: care around patient needs (MOHLTC) • Focus on population health and social determinants of health (Wellesley Institute)	• Provincial politicians can avoid responsibility for their decisions, problem deflected to LHINs (CUPE/OPSEU) • No real local input—domination of LHINs by provincial government rather than community (OHC) • Integrating by centralization of services (e.g., closure and merger of hospitals in rural communities) can cut jobs and services, meaning decreased access to health care services for some and increased inequality (CUPE/OPSEU)

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