LHINtegration:
Can Ontario Leapfrog the Regionalized Provinces?

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Why Integration?

- Health care notoriously fragmented
- Seams in system between programs and sectors often look like canyons
- Authority is dispersed; autonomy is the practice norm, especially for physicians
  - Agendas collide or leave gaps
  - Major variations in practice
- Everyone is working hard but but the whole is often less than the sum of the parts

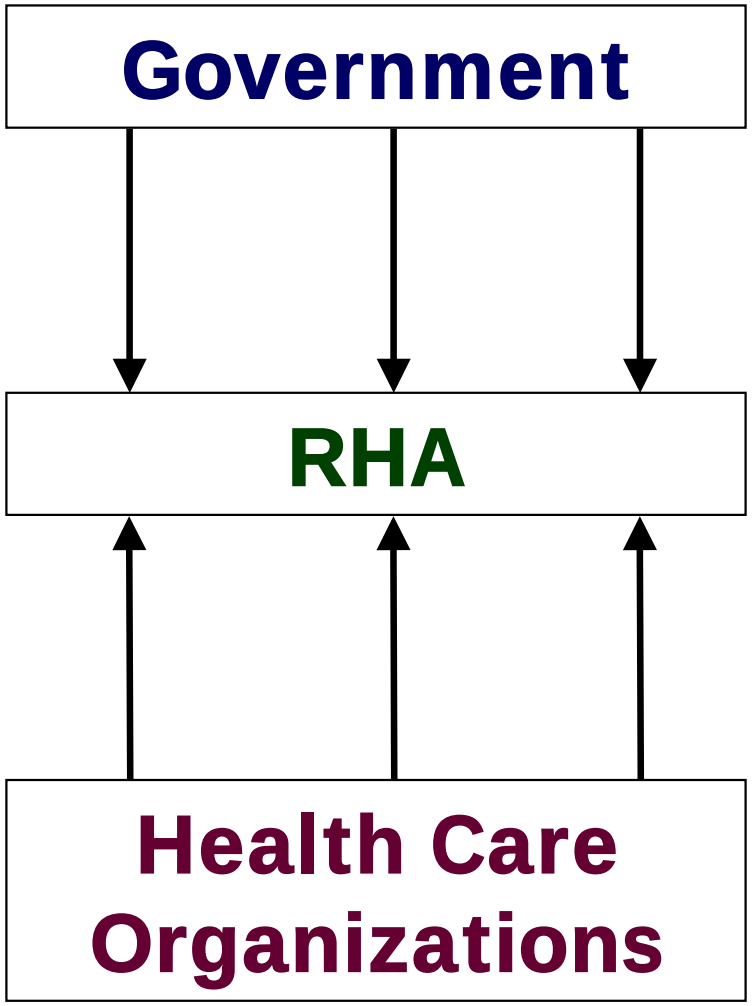
Results

- Confusion among public, patients, and often, providers
- Care is often uncoordinated
- System capacity poorly used
- Many groups vulnerable to harm:
  - People with chronic conditions
  - Frail elderly
  - People taking several medications
- Quality, efficiency, and people suffer

Enter the LHINs

- Not quite the same as health regions in other provinces
- Same general goals:
  - Make parts work together more smoothly
  - Make system easier to navigate
  - Promote quality and efficiency
  - Enhance accountability
  - Move resources to where the need is

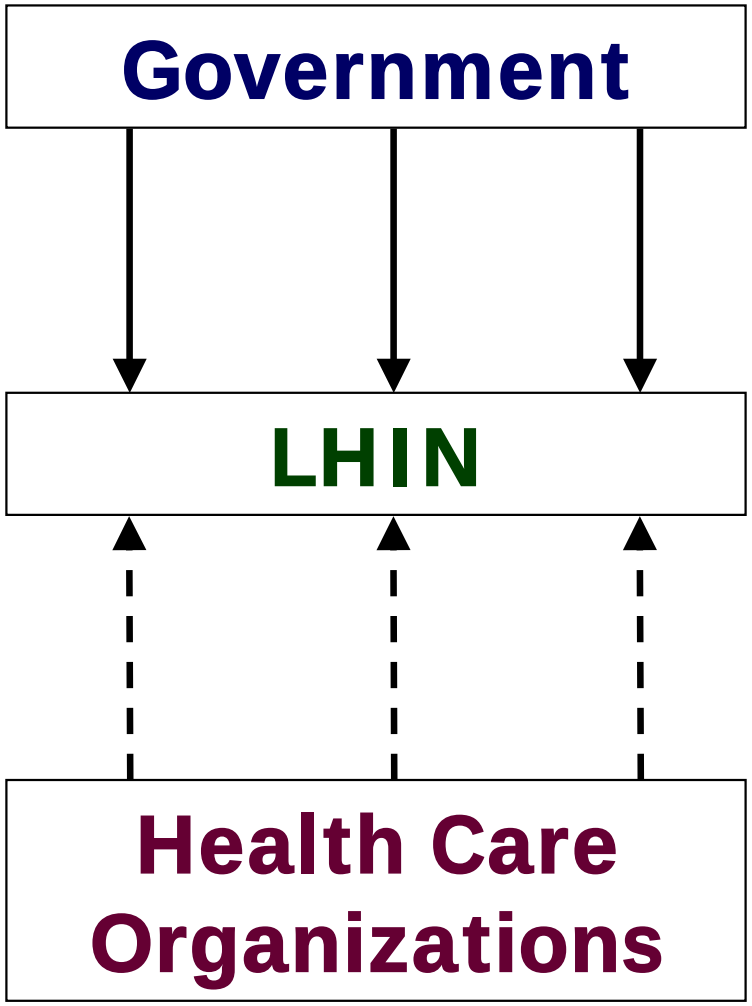
What Regionalization Was About



Devolution of authority

Centralization of authority

What LHINs Seem To Be About



Devolution of authority

Negotiation of authority

LHINs and Regions: Key Features

Feature of Model	LHINs	RHAs
Hold budgets for community care, hospitals, LTC, other	✓	✓
Boards appointed by MOH	✓	✓
Board/CEO have clear authority over services within area	?	✓
Mandate and capacity to manage (many) services and programs directly	X	✓
Ministry retains authority for some major decisions	✓	✓
Responsible for MDs, drugs	X	X
Fewer local boards with greatly reduced power	X	✓

Critical Differences

RHAs	LHINs
Funders, providers and managers of services	Purchasers/funders of services
Major employers	Only employ own staff
Authority both direct and via agreements with affiliates	Authority exclusively via service agreements

What Is There to Leapfrog Over?

- An inability to move important agendas forward
  - Primary health care transformation
  - Quality and safety revolution
- Provider skepticism about a systems approach
- Lingering divided loyalties and unconstructive competition among organizations
- Frequent RHA boundary changes
- Lack of comprehensive, valid, real-time performance indicators
- Unclear lines of authority

Local Boards: Essential Social Capital or Recipe for Conflict?

- Retention of local boards is generally a complication
- BC started out with Community Councils and then eliminated
- Divided loyalties and parochial affiliations make integration, consolidation, and reallocation more difficult
- LHINs will have to negotiate and persuade where RHAs are more able to act decisively
- Ontario hospital boards are famously powerful

Are RHAs As Powerful As They Seem?

- Originally conceived as holders of fully devolved authority
- General repatriation of authority by Ministries over time
- Proved very difficult to devolve both authority and accountability
- Long tradition of politicization of health care and looking to Ministry to address local problems
- Are RHAs operational units of the Ministry or do they have significant autonomy – or both?

Achievements of Regionalization

- Rationalization of specialized programs
  - Consolidation of surgical services
  - Streamlined, single-entry systems for LTC
- Closer cooperation among hospitals, long term care, and home care
- Greater understanding of and commitment to a population health, needs-based philosophy
- More equitable funding (fine-tuning of population-based, needs-based models)

The Ideal Government-LHIN Relationship

GOVERNMENT	LHINs
Make high-level policy	Implement high-level policy and make mid-level policy
Define performance and develop indicators	Perform
Govern	Manage resources
Decide *what* is to be done	Decide *how* to get it done
Macro-allocation of funds to LHINs	Micro-allocation of funds to services
Devolve accountability and tools to achieve it	Accept accountability

The Great Temptations of Government

- Reverse or put brakes on brave decisions
  - Proposed closure of a rural hospital in SK
  - Proposed role transformation of academic hospital in Saskatoon
- Participate directly in hiring/firing of CEOs
- Impose constraints on how to balance budgets
  - Vancouver Coastal told to solve $44 million deficit problem without cutting any services
- Announce plans, commitments, etc. without consulting with RHAs

Big Issues for LHINs to Address

- Physicians not fully integrated into system
- Primary health care movement has stalled
- Antiquated IT (Canada a laggard in OECD)
- Poor primary and secondary prevention performance
  - Chronic disease management
  - Reducing SES-related health disparities
- Distorted incentives resulting in unnecessary, wasteful, and even harmful care

What LHINs Can and Cannot Do

- Can't redesign physician and primary health care, payment mechanisms
- Can't close facilities (though can, it seems, change their roles)
- Can promote a modern and comprehensive IT agenda
- Can promote progressive change models and build public support
- Can identify the origins and costs of population health disparities and point to solutions

But It's Not All About the Structure

- LHINs are not what you would come up with if starting from square one on a blank canvas
- The problem is not lack of authority, but an unwillingness it use to to solve problems
- Ontario has recognized the importance of
  - Defining performance
  - Aligning incentives with performance
  - Measuring and reporting
- Health systems change when health care cultures change

How Will We Know If LHINs Are Failing?

- Bad things happen and LHINs and Ministry point fingers at each other
- Political decisions override careful and transparent LHIN consultation and planning
- Donation-driven initiatives are not linked to LHIN plans and priorities
- End runs by powerful constituencies trump LHIN vision and plans
- Government continues to be held accountable for decisions and actions that lie within the LHIN areas of authority

How Will We Know If LHINs Are Succeeding?

1. A LHIN butts heads against a powerful interest and lives to tell the tale
2. Budgets get reapportioned and disadvantaged populations get better care
3. Health philanthropic agendas fully support the LHIN strategic plan; there is less glitz and more effective investment
4. The system becomes more interdependent, communication improves, good practices spread rapidly
5. Quality and efficiency rise, and patients have better and smoother experiences

Promising Signs in Ontario

- Commitment to performance measurement, public reporting
- Willingness to examine policy and incentive barriers to improvement
- Examples of leading edge information technology implementation (e.g., UHN)
- Strong applied research sector (ICES, CHEPA, CHSPR – Queen's, HIRUs, etc.)

Strategies for Moving to the Head of the Pack

- Be firm and clear about system goals
- Do not be distracted by occasional hot buttons
- Be prepared to wait to see the fruits of long term initiatives
- Invest in public engagement and reporting – the only way to sustain difficult reform
- Communicate with the media and the public, honestly and often
- Government must master the art of standing by – the LHINs need time to grow and air to breathe

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