

# **COLLABORATING FOR CHANGE:**

## **OPTIMIZING THE EFFECTIVENESS OF LOCAL HEALTH INTEGRATION NETWORKS IN ONTARIO**

**Ontario Hospital Association  
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## Summary

In October 2004, the Honourable George Smitherman, Minister of Health and Long-Term Care, released the first of a series of bulletins to provide the public and stakeholders with additional information on the creation of Local Health Integration Networks (LHINs). LHINs are a key component shaping the government's transformation agenda.

The Ontario Hospital Association (OHA) is supportive of the government's transformation plan, which is intended to achieve:

- An integrated system that is easier for patients, clients and residents to navigate;
- Reduced wait times for critical services, starting with cardiac care, cancer care, hip and knee replacements, cataracts and MRIs;
- Better access to comprehensive, around-the-clock health care for people in their own communities; and
- Expanded access to home care and long-term care to alleviate pressures on hospitals, and to treat people more quickly.

The hospitals of Ontario and the OHA are strong supporters of increased integration of the health care system and believe that efforts to improve integration should build on current system strengths and successes. Hospitals also support the establishment of LHINs that will focus on engaging communities in health system transformation by enhancing and supporting local capacity to plan, coordinate and integrate the delivery of health services at the community level.<sup>1</sup> In addition, the OHA fully endorses the government's commitment to maintaining local independent governance including the voluntary role of hospital trustees.

The announcement to establish LHINs across the province has precipitated considerable discussion and feedback on the most effective ways of implementing LHINs in the province. The key question that government and stakeholders face together is how best to implement LHINs to optimize their effectiveness.

As part of the government's consulting process with the public and providers, LHIN planning workshops were held across the province in late 2004. To help coordinate hospital input and feedback, the OHA attended these workshops and consulted with attending members. In addition, a LHIN Working Group (see Appendix B for members) was established to help coordinate hospital input in support of the government's consultation process.

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<sup>1</sup> See LHIN Bulletin No. 1/October 6, 2004, Ontario Ministry of Health and Long-Term Care

## Key Recommendations

The Working Group has prepared a broad policy framework to help facilitate the development and implementation of LHINs in Ontario. This work was guided by nine principles developed by the *Health System Integration Task Force*,<sup>2</sup> which have been adopted by the province. The Working Group believes that the implementation of LHINs will be successful with:

- ***A clear and well-articulated vision and context for the implementation of LHINs.*** To help define a broader context for the establishment of LHINs, the Working Group recommends that the government prepare a White Paper clearly defining a shared vision and context for the implementation of LHINs. The White Paper should include the government's accountability and governance structures; their role and mandate; and their inter-dependent relationship to providers, other LHINs and provincially-based programs and services, such as Cancer Care Ontario, academic health science centres and leading-edge research centres.
- ***A clearly defined role and mandate for LHINs.*** The Working Group believes that uncertainty regarding the role and mandate of LHINs could undermine their effectiveness. The Working Group also considers the functions of Britain's Strategic Health Authorities (StHAs) as being closely aligned with the goals the Ontario government has established for LHINs. The establishment of StHAs was a key element of the British government's plan to redefine the National Health Service (NHS) by transferring the balance of power away from government and towards patients and front-line providers. The Working Group recommends that LHINs be modeled after StHAs within the Ontario context. The key functions of StHAs are to (see Appendix A for details):
  - ✓ Create a coherent strategic framework for the delivery of services across all local organizations;
  - ✓ Build capacity and supporting performance improvement;
  - ✓ Support providers in delivering care; and
  - ✓ Agree to annual performance agreements and performance management.
- ***A strong commitment to maintain the independent nature of community governance, including the local voluntary character of hospital trustees.*** With increasing complexity and sophistication in the delivery of care, independent governance will allow each organization to optimize its role in the delivery of health care services (e.g., centres of excellence). Local independent governance will also ensure that the voice of communities is not marginalized through greater centralization of health service delivery and decision-making at the regional level. The Working Group expressed concern regarding the degree of independence LHIN boards will have given that the directors will be order-in-council appointments and will receive, for the first time, remuneration from the province. The Working Group believes that the ultimate success of LHINs will hinge on their ability to act in the best interests of their communities.

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<sup>2</sup> The Health System Integration Task Force (ITF), Chaired by Joseph Mapa, President & CEO, Mount Sinai Hospital, represents a cross section of health care and social service providers in Ontario. It was established in June 2004 to support the government's transformation agenda, including the creation of proposed Local Health Integration Networks. See: [www.oha.com/itf](http://www.oha.com/itf)

- ***A phased-in approach to divesting clearly defined funding responsibilities to LHINs.*** The Working Group acknowledges and supports the government's phased-in approach to divesting funding responsibilities to LHINs. To maximize the effectiveness of LHINs, while not undermining hospital efficiency gains achieved over the years, the Working Group recommends that not all funding responsibilities be divested to LHINs. For example, the Working Group believes that the setting of hospital funding rates for major services should continue to be set provincially to ensure fair and equitable funding, to prevent cost shifting between LHINs, and to help estimate fair reimbursement policies for patients being treated outside their home LHIN. The Working Group also recommends the creation of a provincial specialized services agency to monitor, fund, and evaluate provincially based programs and services. Given the complexities and implications of funding divestment to LHINs, the OHA is preparing a separate policy paper in consultation with hospitals, other community stakeholders and government.
- ***The establishment of clear deliverables, performance objectives and evaluation criteria.*** The Working Group recognizes that there are some factors that are outside the control of LHINs that could ultimately hamper their effectiveness. For example, the lack of a common patient electronic record and information technology standards as well as a chronic shortage of health care professionals could seriously impede the overall effectiveness of LHINs. The Working Group is concerned that the failure of these system enablers may be viewed as a failure of LHINs. The Working Group therefore recommends that the province clearly set out the deliverables and results that LHINs are to achieve as well as an independent process to evaluate their effectiveness.
- ***Public and stakeholder buy-in through comprehensive and meaningful consultation.*** By developing a shared vision for LHINs, the government can play a leadership role in harnessing the experience and expertise in the system to affect positive change while avoiding or minimizing the impact of unintended consequences. Success in building buy-in with the public and stakeholders will be essential if LHINs are to be effective over time.

The Working Group hopes that the following paper, which explores these recommendations in greater detail, will assist the government in its transformation agenda. The OHA recognizes the challenges posed by change of this magnitude. However, with an open and transparent process and a strong commitment to collaboration, the Working Group believes that government, stakeholders and the public can successfully bring about effective change, which will ultimately deliver better care and contribute to a healthier Ontario.

## Introduction

On December 17, 2003, the OHA held a policy forum in support of the government's transformation agenda. OHA members approved several key initiatives to advance system change and to ensure the long-term sustainability of Ontario's health care system:

- The establishment of the *Governance Leadership Council* to continue the advancement of health care governance in Ontario;
- The *Hospital Efficiency Task Force* to recommend provincial strategies to ensure that Ontario hospitals continue to lead the country in efficiency; and
- The *Health System Integration Task Force* to bring hospitals and other service providers together as a "think tank" to offer constructive advice to government on its health care integration agenda.

These and other initiatives have been established to promote health care reform in Ontario, ensuring the needs of patients, clients and residents in all parts of the province – from large urban centres to the most remote regions of the North – are met.

On July 26, 2004, the Ontario government announced a key component of how the provincial health care system would be transformed, namely the establishment of "*Local Health Integration Networks*" (LHINs), which are intended to enhance the planning, coordination and integration of health care delivery in 14 regions throughout the province. Further details were communicated through the release of a series of bulletins providing additional details on LHINs.

As part of the government's consultation process with the public and providers, LHIN planning workshops were held across the province in late 2004. To help coordinate hospital input and feedback, the OHA attended these workshops and consulted with members.

In addition, a *LHIN Working Group*, chaired by Bruce Harber, President and CEO of York Central Hospital, was established by the OHA to coordinate and consolidate hospital feedback and advice provided to the government. The Working Group, guided by the nine principles developed by the multi-stakeholder *Health System Integration Task Force*, has prepared this initial broad policy framework to help guide the development of LHINs in Ontario and ensure that they are effective in improving health and wellness in the province.

To facilitate this input, the Working Group has summarized its comments under three overarching themes:

- Creating a shared vision of change
- Accountability, governance, roles and responsibilities
- Critical success factors for optimizing the effectiveness of LHINs.

## Creating a Shared Vision of LHINs

The OHA believes a key to successful health system integration is the development of a shared vision for change. It will take considerable leadership in ensuring that the public, patients, providers and government share a common vision for system integration and change.

To date, the government has shown considerable interest in hearing from the public and stakeholders as part of its consultation process for LHINs. For example, the government has conducted extensive workshops across the province and has adopted the nine key principles

established by an independent multi-stakeholder *Health System Integration Task Force*, which were released in LHM Bulletin 2.<sup>3</sup>

These nine principles provide a solid foundation for developing a shared vision for the development and implementation of LHINs.

## **Nine Guiding LHIN Principles<sup>4</sup>**

### 1. Patient/Client/Resident Focus

The overriding mandate of LHINs would be to improve population health and the citizen's experience; represent and engage patients'/clients'/residents' interests; and achieve better health outcomes while measurably improving quality of life and value in health. Wellness and disease prevention strategies are essential to this mandate.

### 2. Clarity of Roles

Success depends on the elucidation of the intersecting role and responsibilities of citizens, the Ministry (provincial priorities), LHINs and health and community service providers - in delivering timely, effective, efficient and equitably accessible care. This mapping of roles could include the cross-jurisdictional responsibilities of priority, specialty and academic programs.

### 3. Strategic Leadership Role

To best draw upon the strength and experience of providers, LHINs will assume a strategic leadership role with a particular focus on the long-term view (e.g., community-based system planning and integration; implementation of provincial priorities; performance standards and accountability; and collaborative modelling) as opposed to an operational one.

### 4. Voluntary Boards

In the best interests of the populations their organizations serve, community-based volunteer boards will continue to govern but, in addition, will expand their responsibilities to engage in LHIN activities and initiatives.

### 5. Stakeholder Engagement

Experience tells us that improvement to health outcomes involves the coordinated engagement of citizens, health and community service providers and funders. Therefore, the engagement of these stakeholders from the outset of the LHINs building process will be of great benefit to

*These nine key principles provide a solid foundation for developing a shared vision for change as well as engaging in further discussions about clarifying outstanding issues with respect to the role and mandate of LHINs.*

<sup>3</sup> See LHM Bulletin No. 2/October 20, 2004 at <http://www.health.gov.on.ca/transformation/lhin/>, Ministry of Health and Long-Term Care.

<sup>4</sup> The *Health System Integration Task Force* (ITF), Chaired by Joseph Mapa, President & CEO, Mount Sinai Hospital, represents a cross section of health care and social service providers in Ontario. It was established in June 2004 to support the government's transformation agenda, including the creation of proposed Local Health Integration Networks. To learn more, visit: [www.oha.com/itf](http://www.oha.com/itf)

the long-term strength and sustainability of LHINs. Similarly, LHINs strategic planning, consultation and execution should be predicated on the same broad-based approach (to the extent possible).

#### 6. Evidence-Based Balanced Approach

LHINs will progressively evolve through a balanced use of evidence-based practice, continuous re-evaluation, together with flexibility for innovation and responsiveness to community, regional and provincial concerns.

#### 7. Transparency

Open communication, transparent and non-partisan decision-making by LHINs and health and community service providers will maximize stakeholder acceptance and commitment to common goals, respective responsibilities and mutual accountability.

#### 8. Fostering Changes Through An Incentive-Based Approach

An incentive-based approach rather than a prescriptive model will encourage integrative and creative solutions by health and community service providers to achieve LHINs objectives. LHINs should recognize and reward providers that remodel their organizations to work collaboratively and interactively with other providers with a view to providing cost-effective best outcomes. LHINs should foster these initiatives and, in turn, providers will commit to specific collaborative and performance measures.

#### 9. Partnership of Equals

Whatever form integrated initiatives and collaborations take within LHINs, the contribution of all health and community service providers must be valued equally.

### **Elements of a Vision and Mission for LHINs**

As the transformation proceeds, the OHA believes that an overarching shared vision of Ontario's health care system will ensure that LHINs are an intricate part of system transformation. The Working Group also supports the clear articulation of a mission statement for LHINs defining their role and mandate. Will LHINs be a vehicle for greater government influence over health care decision-making or will they be independent, autonomous community-based organizations designed to meet local community needs within a provincial context?

Much of the impetus for LHINs has been for greater service integration and rightly so. However the Working Group suggests that greater attention be given to determining which users of the health care system require integrated care. Experience in other jurisdictions shows that integrating all services for all patients may not be cost-effective given limited financial resources. Instead, targeting integration efforts to those with chronic conditions and to the frail elderly will result in significant improvements in quality of life as well as reduced health care costs through lower rates of hospitalization.

#### **VISION**

*What is the vision driving the change agenda? How can we best ensure it is a shared vision?*

*How will LHINs help improve quality and access to care from the patients' perspective?*

*What type(s) and degree of integration are LHINs expected to achieve?*

*What does success look like and how do we know when it is achieved?*

The Working Group supports the direction the government has taken to date to explicitly build on existing integration strengths and successes in the system. Further efforts to enhance integration under the LHIN initiative will need to leverage successful local integration initiatives currently underway in communities throughout Ontario (e.g., networks, chronic disease management strategies, etc.). Expanding these initiatives will contribute to cost containment and enhanced care and also meet a number of other specific goals including illness prevention and health promotion (see Figure 1).

<b>Figure 1: Existing Examples of Successful Integration Strategies</b>	
Chronic Disease Management (DM) Strategies	<u>Purpose:</u> To improve health outcomes and quality of life for high-risk populations and to help contain future cost increases in meeting the needs of these patients. <sup>5</sup> Examples include Cancer Care Ontario, Ontario Cardiac Care Network and Stroke Strategy.
Centres of Excellence	<u>Purpose:</u> To optimize quality of care and the use of resources (human and financial) at the regional level through development of strong centres of excellence networked with other hospitals and community facilities.
PACE Programs	<u>Purpose:</u> To help frail seniors remain in their homes by offering comprehensive and integrated community-based health services. Successful programs now exist in Quebec <sup>6</sup> and Alberta and are under development in other parts of Canada including Ontario.
Voluntary Networks	<u>Purpose:</u> To establish voluntary alliances between providers as a mechanism for achieving common goals through collaboration as has been the case with the Child Health Network, GTA Rehabilitation Network, Health Care Network of Southeastern Ontario and so on.
Rural and Northern Health Care Networks	<u>Purpose:</u> To promote a cooperative and collaborative approach to service delivery in health care in order to enhance access for residents of rural, remote and northern communities.

To achieve early results, the Working Group recommends that LHINs focus on areas in greater need, such as community-based needs assessments, and the planning and coordination of the delivery of health services to ensure equitable access for all Ontarians (Figure 2).

<sup>5</sup> The components of disease management often include: a) population identification processes; b) evidence-based practice guidelines; c) collaborative practice models to include physician and support service providers; d) patient self-management education; e) process and outcomes measurement, evaluation and management; and f) routine reporting/feedback loop.

<sup>6</sup> In 1995, for example, McGill University was funded by the Government of Quebec to develop a model for a system of integrated care for the frail elderly. The resulting program, SIPA (System of Integrated Care for the Frail Elderly), subsequently received funding from Health Canada for a demonstration project.

### **Figure 2: A Vision for LHINs Might Include the Following Components**

- Improved planning and program coordination at the local and regional levels.
- Greater investments in integration of service delivery (e.g., partnerships, strategic alliances and electronic health records).
- Enhanced local and regional strategies to recruit and retain health professionals, especially in under-serviced regions of the province.
- Implementation of local and regionally based disease management strategies to respond to chronic conditions (e.g., diabetes, congestive heart failure, asthma, arthritis, chronic obstructive pulmonary disease, dementia, disabling neurological conditions) and integrated programs for youth with disabilities.
- Integrated programs to support the care of the frail elderly in the community and reduce the rate of institutionalization and dependence on hospitals.
- Continued new investments in community-based care to reduce pressures on hospitals and prevent premature institutionalization of the frail elderly.

### **Realistic Expectations**

There may be practical limits to what LHINs can actually accomplish in the medium term due to factors outside their control, such as:

- *The inclusion or exclusion of specific services.* The scope of services falling under the purview of LHINs would, to a large extent, determine their effectiveness. For example, excluding primary care could impede the progress of improved integration and coordination of services as could the exclusion of public health and other health promotion initiatives, such as early childhood education.
- *The development and expansion of provincial-based programs and standards.* While LHINs can play a critical role in integrating health care on a local and regional basis, there will be a need for provincial standards as well as specific provincial programs exemplified by Cancer Care Ontario and the Ontario Cardiac Care Network. Clear and effective standards at the provincial level will enhance the effectiveness of LHINs whereas their absence could result in the balkanized delivery of provincial programs.
- *Overall system capacity in meeting the health needs of the community.* The most efficient and integrated health care system will not adequately meet the needs of the community if there is an inadequate supply of doctors, nurses and essential services. The effectiveness of LHINs and service providers will be significantly influenced by the availability of adequate federal and provincial health care funding; national, provincial and regional demand management strategies; and the availability of key system enablers (e.g., electronic health records).

## Proposed Next Steps

The Working Group believes that the government can play a leadership role and be successful in developing a shared vision for LHINs by releasing a White Paper to:

- Articulate a shared vision for a transformed health care system to define what will be the role and mandate of LHINs;
- Describe the governance structure together with accountability protocols for LHINs, providers and government including details of how the inter-dependent relationships between LHINs, providers and funding ministries will relate to each other; and
- Set out the government’s strategic plan to support the implementation of LHINs including critical milestones, timelines, performance standards and evaluation protocol to monitor and evaluate implementation.

## Accountability, Governance, Role, Mandate and Funding of LHINs

A smooth and effective transition to a transformed health care system can best be achieved through the development of an overarching provincial context together with clearly articulated details of the following aspects of LHINs:

- Accountability
- Governance
- Role and Mandate
- Funding

### *JPPC Policy Statement on Accountability*

*A shared understanding of the government’s vision, goals and priorities concerning the role of hospitals and other providers, including the planning, legislative, policy and funding tools in place to achieve these goals and priorities.*

## Accountability

*By “accountable” I mean making sure that the government and our health partners clearly agree on what outcomes we need to achieve together.* – The Honourable George Smitherman

The OHA believes that there are multiple layers of accountability to be considered in the creation of LHINs. There are at least three basic levels of accountability:

**Government** is accountable for:

- In collaboration with providers and LHINs, create a strategic plan for provincial health services and provide adequate funding;<sup>7</sup>
- Maintain a policy and regulatory environment to facilitate the provision of services across organizational boundaries and promotes the delivery of services at the most efficient, appropriate, and accessible point of care; and
- Creating the necessary infrastructure (e.g., information technology) and mechanisms to measure, monitor and evaluate the effectiveness of the health care system (e.g., information management systems).

### *Accountability*

*How will accountabilities be defined? How will they be shared? (LHINs vs. health providers vs. elected officials).*

*What process will be established to determine joint accountabilities? Will they be negotiated?*

*How can LHINs support the creation of better ‘system’ accountability?*

<sup>7</sup> The Ontario Joint Policy and Planning Committee. “Policy Statement on Accountability”. December 2004.

**Provider** is accountable to:

- The public and government (or the funder in the case of WSIB or third-party insurers) for the cost-effective use of resources;
- The patient, client or resident for quality services and treatment; and
- Other providers to ensure the patient moves from one part of the system to another in a seamless fashion.

**Patient, client or resident** is accountable for:

- Practicing good health and wellness and for helping to manage his or her health where possible;
- Providing timely information to health care providers on symptoms and reactions to treatment; and
- Adequately following clinical advice when necessary (e.g., drug therapies).

The Working Group believes that LHINs will assume some of the government's accountabilities, but not all. For example, LHINs will be accountable for planning to ensure adequate system capacity to provide timely access to quality health services as close to home as possible, and for creating the necessary infrastructure (e.g., information technology) and mechanisms to measure, monitor and evaluate the effectiveness of the health care system (e.g., information management systems). LHINs will also assume some of the providers' accountabilities in determining the type and volume of services to be provided as well as ensure that patients move through the system in a seamless manner. The government, however, would continue to be accountable for adequate system funding and for providing an appropriate policy, legislative and regulatory environment to support population health and wellness, and the delivery of health and health care services.

In addition, it will be necessary for clear distinctions to be made between the roles and responsibilities of LHIN boards and provider boards. For example, roles of LHIN and provider boards for developing strategic directions and performance monitoring must be differentiated as will those of government and LHINs.

The Working Group believes that government should build on recent successes in promoting greater accountability, such as:

- The public reporting on hospital performance through the Hospital Report initiative, funded jointly by the Ministry of Health and Long-Term Care (MOHLTC) and the OHA with research conducted by the Joint Research Collaborative;<sup>8</sup>
- The Joint Planning and Policy Committee's (JPPC) efforts in advancing accountability through the Hospital Funding Formula, which rewards hospitals for efficiency and performance; and
- The JPPC work on joint accountability agreement frameworks and performance management tools.<sup>9</sup>

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<sup>8</sup> See Hospital Report [www.oha.com](http://www.oha.com) under programs.

<sup>9</sup> For further information on the Joint Planning and Policy Committee, see [www.jppc.org](http://www.jppc.org)

To the greatest extent possible, it is suggested that all accountability relationships be developed jointly between government and stakeholders utilizing:

- Incentives and performance management targets rather than directives and orders, as appropriate; and
- A proactive and collaborative approach to performance improvement that recognizes the mutual roles and responsibilities of government, LHINs, and providers for improved health services.

## Governance

Effective governance of the health care system is essential for continued performance improvement, innovation and effectiveness. The success of LHINs will be considerably enhanced through relationship building between LHIN boards and provider boards.

The Working Group strongly endorses the government's commitment to maintain the independent nature of local voluntary governance, including the voluntary role of hospital trustees. With increasing complexity and sophistication in the delivery of care, independent governance will allow each organization to optimize its role in the delivery of health care services.<sup>10</sup> Provider boards and government, however, will face new challenges in working interactively for greater integration.

Provider boards will determine their own values, vision and mission within the context of the LHIN, other providers and provincial agencies.

Hospitals can continue to play an important role in promoting effective governance in the delivery of health care services. To date, hospitals, through the OHA, have:

- Provided an informative and practical educational certificate program for new trustees with a more advanced program for existing trustees under development;
- With financial support from the MOHLTC, commissioned a report from Graham Scott and Maureen Quigley on hospital governance best practices in Ontario<sup>11</sup>; and

### *Governance*

*How will LHIN directors be nominated and appointed in the future to ensure greater autonomy and independence?*

*Who will the CEO be accountable to – the government or the LHIN Board of Directors?*

*What are the reporting relationships between health care providers and the government and LHINs?*

### *OHA's Governance Leadership Council*

- The LHIN Board will need to employ principles of good governance regarding:
- Size, Composition, Skill/Competency Mix, Selection Process & Criteria, Term Length;
- Development of position descriptions, by-laws, code of ethics;
- Relationship between CEO and Board and the Board with government;
- Capacity for strategy, visioning, goal setting, oversight and evaluation.

<sup>10</sup> Many countries have moved away from creating large geographic monopolies in the delivery of complex health care delivery systems and instead have opted to separate purchasers from providers to foster greater innovation and efficiency. See Mariott and Mable "Integration Update: An Overview of Progress and Potential in Health System Integration in Canada", November 2002, which recommends that consideration be given to the creation of comprehensive health organizations allowing consumers to roster in full service health care organizations.

<sup>11</sup> Maureen A. Quigley and Graham W.S. Scott. "Hospital Governance and Accountability in Ontario". Ontario Hospital Association April 2004. See [www.oha.com](http://www.oha.com) under communications/reports and studies.

- In the Fall of 2004, established the *Governance Leadership Council*<sup>12</sup> to provide advice to the OHA Board of Directors on opportunities and best practices in hospital governance.

The Working Group supports the government’s direction of appointing LHIN Boards of Directors from the communities they represent with the skills and expertise necessary to govern large complex organizations.

To ensure strong community representation, the Working Group recommends that government:

- Conduct a fair, open and transparent selection process when recruiting LHIN boards of directors; and
- Delegate the recruitment and performance management of the CEO to the LHIN board.

The Working Group believes that there should be one line of accountability between LHINs and government - through the LHIN board of directors. A report prepared by the British Columbia Auditor General found that dual accountability arrangements between board chairs and executive directors of BC Regional Authorities to the Minister and Deputy Minister respectively, defused governance responsibility and accountability as the executive director was accountable to both the board of directors and the Deputy.<sup>13</sup>

The Working Group is, however, concerned about the potential loss of autonomy or independence in local decision-making with LHIN board of directors being remunerated and appointed through government orders-in-council. Community volunteers and trustees have built the underlying foundation to our universal public health care system. Moving the governance structure of the health care system towards a commercial structure will need to be carefully implemented and closely monitored and assessed.

## **Role and Mandate**

To date, few details have been made public of how LHINs will function or how they will be structured. For this reason, the Working Group proposes a model to ensure that activities such as planning, coordinating, integrating care at the local level are carried out effectively without simply adding a whole new layer of bureaucracy.

The Working Group clearly supports the government’s decision to preclude LHINs from delivering health care services to ensure greater objectivity in planning for the delivery of health care services and for measuring and evaluating activity within the LHIN.

In recent years, Britain’s National Health Service (NHS) has attempted a number of approaches to reform including regional health authorities, an organizational and delivery model they have now rejected in favour of Strategic Health Authorities. Research into the United Kingdom (UK) experience suggests that the role and mandate of Strategic Health Authorities is intended to achieve very similar goals as those expressed by the government of Ontario related to LHINs.

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<sup>12</sup> The OHA struck a blue ribbon Governance Leadership Council, chaired by Virginia McLaughlin, Board Chair of Sunnybrook and Women’s College Health Sciences Centre, to advise the OHA Board of Directors on matters related to hospital governance.

<sup>13</sup> Auditor General of British Columbia: “A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities”, June 2003. See <http://www.bcauditor.com/AuditorGeneral.htm>

The key functions of Strategic Health Authorities are to:

- Create a coherent strategic framework for the delivery of services across all local organizations;
- Provide an interface between government and local providers;
- Support providers in delivering care;
- Build capacity and secure performance improvement; and
- Agreeing annual performance agreements and performance management.

Additional roles for LHINs might include:

- Building on central/provincial disease management initiatives by developing and managing local disease management strategies and networks;
- Acknowledging the “unique” roles played by specialty hospitals (i.e., complex continuing care, rehabilitation, mental health) and academic health centres in the provision of services at both the regional and provincial levels.
- Advancing key requirements and priorities, such as French language services, aboriginal nations and denominational beliefs during the creation of LHINs. The Working Group recommends that separate consultations be held to address these issues.

## Funding

The Working Group acknowledges and supports the government’s phased-in approach to divesting funding responsibilities to LHINs. Considerable work is required before these responsibilities can be devolved to LHINs. For example, jurisprudence makes it very clear that the “related employer” provisions of the *Ontario Labour Relations Act* can be invoked when the funding and control of health services are held by a non-crown entity. In this case, the funding agency (i.e., LHIN) could be deemed the employer for labour relations and other matters falling within the LHIN. This potentially has profound implications for collective bargaining, compensation (e.g., wage parity), pay equity, health and safety, union certification and a myriad of other labour matters.

There are other issues that need to be addressed, such as ensuring fair and equitable funding for each LHIN and provider; continuing to promote greater provider efficiency through funding formulae; the ability to fairly compensate providers for treating patients residing in other LHINs; and the need to minimize possible cost shifting from one LHIN to another.

Given these and other implications, the Working Group recommends that funding not be divested to LHINs for at least two years until a full funding strategy can be developed. The Working Group also recommends that the OHA prepare a separate policy paper in consultation with hospitals, other community stakeholders and government. This paper will identify issues

### Funding

*How will health services in LHINs be funded – on a population basis or by volume of services provided or, by a blended formula?*

*What are the short and long-term expectations for LHINs with respect to funding and resource allocations?*

*Will each LHIN be allowed to decide what to pay providers for a particular service? Can they deviate from provincial rates? If so, what criteria will they use to set rates? Will they utilize Community Care Access Centre competitive bidding processes?*

*Will a LHIN be able to negotiate the role and responsibilities of community providers through service contracts (e.g., program rationalization)?*

*How will the province prevent “cost-shifting” among LHINs? Will there be a role for MOHLTC to adjudicate funding disputes among LHINs?*

with respect to the implementation of the funding role of LHINs. In the interim, the Working Group offers the following observations with respect to funding:

- The OHA, hospitals and government, through the JPPC, need to continue to develop a common provincial funding formulae that rewards performance and ensures adequate and equitable funding for hospitals (and other health care providers) for the volume and complexity of services they provide (adjusted for special factors such as isolation, uniqueness, growth, needs and teaching, etc.);
- Consistent with the funding announcement of December 14, 2004, to reduce wait times, the government continue to move towards service-based funding<sup>14</sup> (adequate rate times volume) to foster greater efficiencies and reward performance;
- To ensure provincial clinical standards are met, the government create a “provincial specialized services agency” to monitor, fund and evaluate provincially based programs and services, such as Cancer Care Ontario and Ontario Cardiac Care Network;
- To reward performance and prevent cost shifting among LHINs, funding needs to follow the patient. When a patient is referred to a provider in another LHIN, funding should follow that patient to ensure the service provider is adequately compensated;
- Consideration should be given to making LHINs responsible for managing and allocating “incentive funds” and/or “special project funds” to support strategic integration projects, such as regional PAC systems;
- The Working Group believes that funding responsibility for LHINs must be phased in and be based on provincially determined funding rates and funding formulae; and
- The Working Group believes that capital funding and health research should remain with the government given their significance in meeting national and provincial objectives.

## Critical Success Factors and Enablers

LHINs have the potential to significantly improve health care planning, coordination and integration in Ontario. It will be critically important during the transformation process that patients do not fall through the cracks along the way. Ontario’s health care system is highly complex and implementation must be deliberate and carefully planned to avoid unforeseen consequences. To maximize success, the implementation of LHINs must minimize any significant disruptions to patients/clients and residents.

The following “*success factors*” and “*enablers*” can contribute to such a smooth transition:

- Investments in both time and resources - in evidence-based research to ensure that such research provides the basis for developing policies, priorities and best courses of

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<sup>14</sup> Ontario Hospital Association. Advancing Accountability Through Hospital Funding Reform. April 20, 2004. [www.oha.com/communications/reports and studies](http://www.oha.com/communications/reports%20and%20studies).

action.<sup>15</sup> Decision-making is best supported by the appropriate balance of sound theory and relevant empirical evidence.

- Acknowledgement and support of the role of trustees and volunteers in the health sector. Since volunteers represent local rather than regional communities, LHINs will need to exercise considerable sensitivity to ensure that volunteers continue to contribute to their local hospital, long-term care facility and other health care providers. Based on experience in other provinces, the loss of community and volunteer support in Ontario could put hundreds of millions of dollars at risk. As is required by the Ontario government, local fund-raising is a critical component of hospital capital projects unlike some provinces where hospital capital costs are covered entirely by government. *“The volunteer base, which was an extremely vital and contributing force before regionalization, has eroded, and a valuable resource was allowed to dwindle.”*<sup>16</sup>
- Ensuring that LHIN boundaries effectively facilitate integrated service delivery by ensuring the catchment areas of all community agencies and providers are considered when establishing or adjusting boundaries. It is also important that LHIN boundaries not impede or compromise the continuity and collection of statistics and data, which are vital to further research. Attention to inter-LHIN activities will be an important factor.
- The need for an effective human resource strategy at the provincial level and for each LHIN to address the strategic and change management challenges in transforming to a more integrated health delivery system, such as recruitment and retention, training and development and workplace health and safety. The OHA will be working with members, stakeholders and government in developing a human resource strategy for the province including labour relations issues.
- Undertaking the necessary changes to provide the enabling infrastructure to support LHINs including:
  - Funding to support the up-front costs in setting up LHINs;
  - Development of provincial and region-wide information infrastructure that tracks patients, providers, services and activities provided in each LHIN to ensure secured access of relevant clinical records at the point of care to authorized providers;
  - Improved information management system to monitor and assess health system and provider performance; and
  - Significant “in house” training for LHIN staff to clarify and advance understanding of their new roles in Ontario’s health care system.
- Developing a clear implementation strategy and critical path to support the roll-out of LHINs to include: key milestones and timelines; the process for facilitating open and transparent sharing of information throughout the implementation process; and a

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<sup>15</sup> For importance of evidence-based research in determining health care policy and reform, see World Health Organization, “Health Systems Performance Assessment: Debates, Methods and Empiricism” Edited by Christopher J.L. Murray David B. Evans, 2003. Authors note that the lack of evidence-based decision-making leads to greater reliance on ideology and personal opinions in setting health policies.

<sup>16</sup> Select Standing Committee on Health. “Patients First” Legislative Assembly of British Columbia. December 2001.

commitment to an independent process to measure performance, and evaluate the effectiveness of LHINs.<sup>17</sup>

- Identification of the common core health services for rural and northern networks reflecting population needs-based planning as recommended by the Joint Working Group of the OHA and MOHLTC on the implementation of the rural and northern health care framework.<sup>18</sup>
- Recognizing the critical role played by the public and community in determining the location of health care services through greater public awareness and understanding of system changes. For example, realigning health services within LHINs (e.g., paediatric services) will require community consultation and buy-in.
- Recognizing the provincial as well as the local role of academic health centres in treating the most complex cases and providing specialized treatment, training physicians, nurses and other health personnel and furthering evidence-based practice and research and innovation. A more detailed analysis of the role of academic health centres in LHINs is being prepared by the Council of Academic Hospitals of Ontario (CAHO).

## **Concluding Remarks**

The Working Group recognizes the significant opportunities and challenges that come with fundamental health care change. It hopes that its deliberations will assist the government, stakeholders and the public in transforming the system to enhance the health and wellness of Ontarians while ensuring a sustainable health care system. The Working Group recognizes the challenges that major change can pose. However, with an open and transparent process and a strong commitment to collaboration, the Working Group believes that the government, stakeholders and the public can be successful in implementing effective change.

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<sup>17</sup> A resource for this work could be the tool developed by the Child Health Network to evaluate the performance of the “Network” itself.

<sup>18</sup> Joint Working Group of the Ontario Hospital Association and the Ministry of Long-Term Care Report. 2004.

## Appendix A: Strategic Health Authorities

In 2000, The British government launched the National Health System Plan, an extremely ambitious ten-year program of sustained investment and reform to turn the NHS around while making it more responsive to patients and more in keeping with the times.

The establishment of Strategic Health Authorities (StHAs) was a key element of the British government's plan to redefine the NHS by transferring the balance of power away from government and towards patients and front-line staff, a goal not dissimilar to that expressed by the Ontario government in describing the transformation of Ontario's health care system. Having tried and rejected the regional health authority approach, the British government chose to move in a direction very like that planned for Ontario. Strategic Health Authorities have **four key functions**<sup>19</sup>:

1. Creating a coherent strategic framework for the delivery of services across all local organizations.
2. Building capacity and supporting performance improvement.
3. Supporting providers in delivering care.
4. Agreeing annual performance agreements and performance management.

These functions are intended to be performed within a set of clear principles developed by the NHS to govern how StHAs should work:

- Committed to *service quality and patient safety* – creating an environment where they are at the centre of decision making.
- *Empowering* – seeking to devolve power to the frontline and to patients and the public and supporting them in tackling the improvement of the health care system. StHAs should focus on their core roles and not seek to retain those functions which could be operated on a collaborative basis by providers.
- *Facilitative* – sitting at the centre of a range of networks that represent a health care system, not as the peak of a hierarchy, and brokering solutions across those networks that address the needs of patients from all parts of society.
- *Developmental* – ensuring that the capacity, skills and infrastructure are in place to support local clinical teams in the redesign of services.
- *Involving* – building patients, the public and staff into all the work of StHA and the wider health community; working closely with other local and national agencies.
- *Leading* – ensuring that leadership for the professions and of professional issues is provided for the local health community; ensuring that leadership on key areas of policy (such as public health, workforce and clinical priority areas) is in place, commands support, and reflects the diversity of modern society.

StHAs provide an interface between government/Ministry of Health and local providers; secure performance improvement; broker strategic solutions, as required; resolve conflicts; ensure delivery of objectives and coordinate the development of the workforce. While StHAs are not responsible for funding services, they do have access to some discretionary capital for use in funding strategic change.

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<sup>19</sup> See <http://www.nhs.uk/england/aboutTheNHS/default.cmsx>

## **Appendix B: Working Group Members**

### **CHAIR**

- ❖ Bruce Harber                      President and CEO, York Central Hospital

### **MEMBERS**

- ❖ Bob Baynham                      President and CEO, Headwaters Health Care Centre
- ❖ Pat Campbell                      President and CEO, Grey Bruce Health Services
- ❖ Garry Cardiff                      President and CEO, Children’s Hospital of Eastern Ontario
- ❖ Sheila Jarvis                      President and CEO, Bloorview MacMillan Children’s Centre
- ❖ George Langill                      CEO (Retired), Royal Ottawa Health Care Group
- ❖ Barry Monaghan                      President and CEO, West Park Healthcare Centre
- ❖ John Oliver                      President and CEO, Halton Healthcare Services
- ❖ Marian Walsh                      President and CEO, Bridgepoint Healthcare

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