

LHINs at Five Years – What Now?

John Ronson

Trying to predict the future is always dangerous. At the inception of Ontario's local health integration networks (LHINs), I wrote two pieces for Longwoods – “Local Health Integration Networks: Will ‘Made in Ontario’ Work?” (Ronson 2006) and a commentary on an article submitted by the LHIN chief executives, “Integrated Health Service Plans: From Planning to Action” (Ronson 2007). Looking back five years, how did I do? And, more importantly, how have LHINs done and where do we go from here?

I gave the LHINs and their constituent healthcare organizations three years to prove themselves effective – failing which, I predicted major changes after the 2007 Ontario provincial election. I was wrong. It is now 2011, and the basic 14 LHIN construct with independent healthcare organizations funded by them remains in place. However, perhaps only my timing was off. Tim Hudak and his Progressive Conservative Party, currently leading in the polls, have said that LHINs are toast should they form a government this fall. Dalton McGuinty's Liberals are also unhappy with current performance of the healthcare system and the inability to get better value for money.

Power Throttled

On paper, the LHINs are exceedingly powerful, with over \$20 billion of funding authority and the power to issue integration orders compelling healthcare organizations to alter and even merge services to improve healthcare. In spite of these formidable powers, in 2006 I wrote, “Many fear that LHINs will simply be a funding conduit, perpetuating the status quo; or that they will simply do the Ministry's bidding and add another layer of unnecessary bureaucracy and contribute further to the inefficiency of the ‘system.’” Sadly, this prediction has basically come true, with LHINs largely reverting to traditional planning exercises, throttled by ministry directives and acting much like their predecessor district health councils, which were broadly viewed within the Ontario healthcare community as ineffectual.

So what went wrong? In my second article I wrote, “Leaving the Ministry over-resourced creates a power imbalance and a temptation on the part of Ministry employees to interfere with the legitimate role of the new LHINs” (Ronson 2007). One disillusioned former LHIN chief executive officer estimated to me that over 30% of his staff's time was spent dealing with enquiries from ministry bureaucrats rather than working with his local healthcare providers to better coordinate and improve care. Senior ministry officials were sincere in their desire to move to more of a “stewardship” model for the ministry's operations, but the failure to downsize the ministry in the process has meant that the good intentions were almost completely thwarted. To be clear, I am not talking about a 5% downsizing at the margin. As I discussed in the first article, there needs to be a downsizing

of at least 50% of staff, and there are precedents for this both in British Columbia and in Ontario, with Cancer Care Ontario. Absent this, LHINs have been and are set up to fail.

Leaving Critical Functions Outside

“While the role of the new LHINs is massive, at least on paper, there are significant omissions that may limit their effectiveness in truly improving patient care. Public health, physician services, ambulance services, laboratories and provincial drug programs are all excluded from the mandate of the new organizations” (Ronson 2006). I wrote this five years ago, and these omissions continue to hamper an effective integration model today. Primary care is particularly problematic. Ontario now has an alphabet soup of primary care models, with family health teams holding the most promise, but with none of them being held publicly accountable for service or performance standards. It is past time to move to truly integrated care.

Form Follows Function

So, what should change? The adage “form should follow function” may be old, but that doesn't make it wrong. In healthcare in Ontario (and in Canada generally), we have split different healthcare delivery functions across multiple types of organizations. Incredibly, we are surprised when we get poorly integrated care delivery at very high cost! With the creation of LHINs, we attempted to split the planning function from actual healthcare delivery; but we left a massive ministry bureaucracy in place and hundreds of individual and separately governed healthcare organizations for LHINs to attempt to coordinate. Plus, we left some of the most important functions (primary care, prescription drugs, etc.) outside of the model completely.

In designing community care access centres (CCACs), we insisted on a strict purchaser-provider split, with aspirations that “competition” between providers would lead to better and more affordable care. I have yet to see the evidence. To cite just one example, the CCACs conduct patient (or client) needs assessments and then the chosen care provider is required to repeat virtually the same assessment. How is this either “patient centred” or an efficient use of scarce healthcare resources?

The key functions of the healthcare system are in no way patient centred. They follow traditional models and create numerous “hand-offs” of care and information that all present opportunities for miscommunication and other care challenges. One of the biggest issues in healthcare today is poorly managed care transitions – from acute care to home care to primary care. One of the main reasons for the poor handling of transitions is that no single organization is publicly accountable for ensuring that they are managed properly. Separating system planning and operations at the regional level is a mistake. Regions should be made smaller and more manageable, but they should be given much more operational responsibility. In this commentary, I will call them integrated healthcare organizations (IHOs). At a

minimum, they should be responsible for acute care, primary care and home care. There are several potential measures that could be used to judge effectiveness at system integration and performance. One of the best is the percentage of patients readmitted within 30 days of a prior hospital stay. This is a measure of the effectiveness of acute care, primary care and home care rolled into one: acute care because it takes into account the health of the patient on discharge, and how well the acute care organization transitions information and follow-up care to both home care and primary care; and primary care and home care because it measures how well they “pick up the ball” and manage care after hospital discharge. This is not always easy to choreograph, and this is a great measure to assess how the new IHOs are doing.

Create Single Points of Accountability

We need to stop dividing functions across multiple organizations and start aggregating them. We must create single points of accountability wherever possible. We can't do this all at once, but it needn't be overly complicated. We have some good building blocks and some logical places to start. We should make the models manageable in size. For example, I would probably split the Southeast LHIN into three IHOs – Quinte to the west, Kingston and environs in the middle and Perth/Smith Falls/Brockville to the east. Each would get full responsibility and accountability for primary care, acute care and home care for its population. All primary care physicians would be part of a network tied to their region and accountable for individual and system performances. Home care would be provided by the IHO, using either employees or contracted services, whatever is most efficient and appropriate. To be clear, I would start with these three critical functions, but I would add others on a publicly announced and reasonably aggressive timetable. At the top of my list would be prescription drugs and ambulance services, followed by public health. The end goal, of course, would be a fully integrated and truly patient-centred system of care, at a manageable geographical and organizational size. Areas of big geography such as the northeast and northwest would pose particular challenges, but these would not be insurmountable. Cancer Care Ontario, through outstanding regional and provincial leadership, has already shown what is possible with integrated planning and delivery in large areas such as Northwestern Ontario. The Greater Toronto Area would also be a challenge, for different reasons. The super-specialized tertiary and quaternary hospitals could be networked together and operate outside the model.

Subsequently, the province could be divided into no more than a half-dozen “super regions” in order to coordinate care across the IHOs. The most senior and respected leaders from across the system would be appointed to lead the super regions. They would form an executive committee with the deputy minister to provide oversight to the whole system and to continuously move toward greater system integration. They would not be burdened with boards of directors.

Summary

In summary, here is my prescription for healthcare reform:

- IHOs of manageable size, and based on traditional patient referral patterns, would be created, using the most appropriate existing organization in the area (likely a hospital or hospital system such as Grey-Bruce Health Services or Quinte Health Care Corporation). There would probably be 30–40 of these across the province, not an unreasonable number for a province of over 13 million residents.
- All primary care physicians, both in group practices and solo, would be required to formally affiliate with the IHO for their region and to be held accountable for the quality of their practice and for health outcomes.
- LHINs and CCACs would be eliminated. The LHIN planning function would be split, with part of it going to the IHOs and the high-level functions going to the executive committee outlined below. The CCAC role would devolve to the IHOs.
- The ministry would be downsized by at least 50% over the course of 2012. Further downsizing would be contemplated as the IHOs assumed additional functions in future years and the minister moved to a true “stewardship” role.
- A handful of senior leaders from the system would be appointed to oversee “super regions” (think all of Eastern Ontario, for example) and form an executive committee together with the deputy minister to monitor and evaluate overall system performance and integration.

Move Quickly

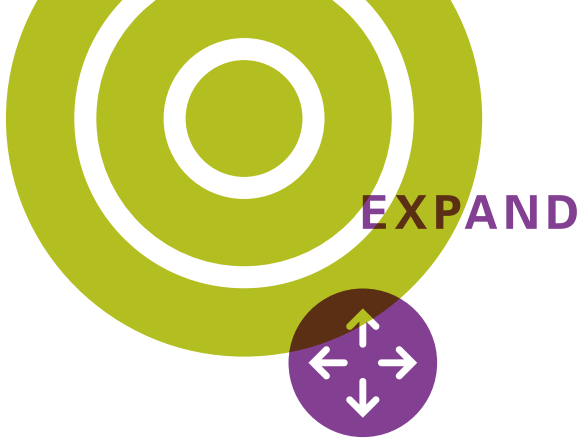
Above all, we don't need and can't afford years of additional planning and study. Cancer care services in Ontario were very effectively restructured over a 12-month period as described in my 2006 article and an article by Terry Sullivan et al. (2004). The new government, of whatever political stripe, should set aggressive targets and stick to them. It will not be easy. Change never is. But it is absolutely essential if we are to escape from the organizational and institutional morass we have created. What is proposed here will, over time, deliver much better care at an affordable and sustainable cost. **HQ**

References

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