Commentary

Integrated Health Services Plans: From Planning to Action

John Ronson

The recent creation of integrated health services plans (IHSPs) by Ontario's 14 regional local health integration networks (LHINs) is an impressive example of collaborative planning, well documented in the lead article. The list of potential areas for improvement in health and healthcare is a long one – and the IHSP process has identified them well. Unfortunately, excellent planning, while an important precursor, does not ensure implementation success. Moving from planning to action is where many well-designed strategies disintegrate.

Multiple dimensions of traditional healthcare power dynamics must be addressed as LHINs move from planning to implementation. The traditional power bases of hospitals and physicians, largely unthreatened in planning, will move to the forefront during implementation. The "command and control" nature of the Ministry of Health and Long-Term Care must also be neutralized if LHINs are to be successful. Action strategies must be adopted immediately or LHINs will be tempted to retreat to the refuge of yet more planning.

The Dynamics of the IHSP Consultation Process

The 14 LHINs undertook broad consultation processes as they did their planning. These consultations overrepresented the interests of smaller community-based agencies and under-represented those of physicians and hospitals. Hospitals were often treated as one organization, like any other organization, with little recognition that they are generally dominant healthcare providers in their communities. In the case of physicians, many have little patience for long meetings and extended planning exercises. As physicians point out, they are not paid to attend meetings, and the traditional fee-for-service compensation system creates adverse incentives to their involvement.

Ontario's chosen healthcare reform route has left boards in place – leaving LHINs with even more players to manage.

Planning processes are non-threatening – jobs are not lost and incomes are not cut. As the lead article correctly points out, most change will need to be effected through resource reallocation, not the allocation of new funding. Breaking down the traditional healthcare silos and creating a truly integrated system from the patient's perspective will run into massive resistance from powerful forces. Other Canadian provinces dealt with this phenomenon by abolishing hospital and other provider boards by legislative fiat. Ontario's chosen healthcare reform route has left boards in place – leaving LHINs with even more players to manage as they pursue their healthcare integration agendas (Ronson 2006).

The LHIN planning process has raised community expectations. These are legitimate expectations, but they will run headlong into the traditional power bases and financial interests of hospitals and physicians. LHINs must be prepared to address this dynamic, and, just as important, the ministry must be prepared to support LHINs in making tough decisions and in addressing the inevitable "end-runs" to the ministry when decisions are made that offend individual providers and the associations that represent them.

Structural Impediments to Change

Assuming LHINs are serious about reform, they may have been set up for failure through no fault of their own. The creation of the LHINs is occurring in the context of a broader "transformation" agenda of Ontario's Ministry of Health and Long-Term Care. The ministry is actively working to transform itself from a focus on operations to one of "stewardship" – in other words, from what Osborne and Gaebler (1992) call from "rowing to steering."

The ministry's own transformation appears to be bogged down in labour relations and other bureaucratic impediments. The bureaucratic survival imperative is in full operation. Other provinces embarking on a healthcare regionalization agenda set arbitrary and aggressive targets to downsize the central ministry bureaucracy. In the case of British Columbia, the target, fully achieved, reduced the size of the BC ministry by 50% of employees in six months. Failure to act with this degree of courage inevitably puts the IHSP agenda at risk.

LHINs were deliberately structured to be lean and nimble – with no more than 20–25 staff in total. While laudable in concept, this may leave them significantly under-resourced to manage an agenda that encompasses "planning, coordinating, integrating and funding" involving over $20 billion annually of healthcare spending. 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. This must be addressed quickly or the LHINs and their ambitious agendas will fail.

Successful implementation requires relentless focus on results and in a world of constrained resources will result in at least the perception of winners and losers.

LHIN Executive Committee

One of the early innovations put in place after the LHIN chief executive officers (CEOs) were appointed was regular meetings of the LHIN CEOs and senior ministry officials. This innovation should be extended to give the LHIN CEOs much more control over provincial healthcare agenda setting. This will require a ceding of power by senior ministry officials and their assumption of more of a stewardship role as the LHIN CEOs assume more decision-making authority.

The healthcare information management and information technology (IT) agenda would be an interesting test case. Historically, Ontario has adopted a curious mix of a highly centralized approach to providing information technology infrastructure and applications and a completely hands-off attitude to IM/IT investments by hospitals and other providers. The highly centralized elements have suffered from a track record of poor implementation, including a particular lack of attention to the needs of potential system users (Smart Systems for Health Agency, Ontario 2006). Hospital investments, on the other hand, made without any coordinated planning, have resulted in a patchwork quilt of information systems and no integrated approach to the sharing of clinical records or the realization of efficiencies to be gained by a more coordinated approach.

The LHINs have made a good start on regional IM/IT planning with the development of integrated regional plans (as part of the IHSP development process). Many of these require transparent organizational IM/IT planning as well as coordinated regional IT investments. Concurrently, the LHIN CEOs should be given decision-making control over most central IM/IT investments. This should include control over appointments to the board of directors of the provincial network and application provision organization, the Smart Systems for Health Agency.

Avoiding the Refuge of Planning

LHINs have already demonstrated through the IHSP process that they are very good at planning. Implementation will be much more difficult. There may be a natural tendency to retreat back to what they know and do best when implementation challenges arise. Is it telling that the first two of the eight priorities identified in the article relate to more planning?

In many respects good implementation is the opposite of good system planning. Good system planning is broad and collaborative. Successful implementation requires relentless focus on results and in a world of constrained resources will result in at least the perception of winners and losers.

Summary

It will be critical that decision-making be grounded in the public interest, be transparent and evidence based, and put the interests of patients and citizens first. And yes, "We are all in this together." Every citizen coping with a chronic disease or waiting for a surgical procedure should be cautiously optimistic that Ontario's experiment in regional planning can successfully make the shift from excellent planning to excellent implementation.

References

Osborne, D.E. and T. Gaebler. 1992. *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector.* Reading, MA: Addison-Wesley.

Ronson, J. 2006. "Local Health Integration Networks: Will 'Made in Ontario' Work?" *Healthcare Quarterly* 9(1): 46–49.

Smart Systems for Health Agency, Ontario. 2006. *Smart Systems for Health Agency: Operational Review Final Report*, November 6, 2006. Toronto: Author. <http://www.ssha.on.ca/operationalreview/index.asp>.

About the Author

John Ronson is a founding partner of Courtyard Group, a global company with offices in Canada, the United States and the United Kingdom that is dedicated to transforming the healthcare system.