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A Case Study in Northern Governance

Local Decision Making in the Northern Ontario Health Care System

By Eric Everett

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About the Author

Eric Everett

Eric Everett is a policy professional who has been inspired to dig deeper into systemic challenges and new opportunities facing the North(s).

A life-long learner, Eric returned to graduate school in the unique Master of Governance and Entrepreneurship in Northern and Indigenous Areas program, which is jointly administered by the University of Saskatchewan's Johnson Shoyama Graduate School of Public Policy and UiT The Arctic University of Norway's Centre for Sami Studies. Field studies have taken him to different Norths, including Saskatchewan, Labrador, Iceland, and Norway, and at least one South – South Korea. He is particularly interested in Northern governance and comparing how different regions around the world approach similar issues.

Previously, Eric completed a Master of Public Health (MPH) at Lakehead University and published a thesis exploring ethical issues faced by practitioners at a Northern public health unit. He also has undergraduate degrees in Biology, Chemistry, and General Arts.

For the past 11 years, Eric has worked in progressively responsible positions in multiple Ontario government ministries, predominantly related to building partnerships in Northern Ontario, across the province, and across Canada. Previously, Eric supported technology transfer and research development in the Innovation Management Office at Lakehead University.

Actively engaged in his community, he is passionate about community safety and emergency management. He has volunteered in different roles for rural fire departments for over 19 years, including as a firefighter, medical responder and training officer. Moreover, he's an advanced first aid instructor certified by the Canadian Red Cross.

Eric lives with his family and menagerie of pets in the Municipality of Shuniah, just outside Thunder Bay, Ontario.

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Executive Summary

Like other provincial Norths in Canada, a growing body of public policy and academic literature suggests that Northern Ontario consider new governance solutions that enable greater local and regional control in order to better respond to systemic social, health, and economic problems that are generally worse or different than the southern regions of the province.

This paper presents a short research project on governance in Northern Ontario, specifically through the lens of the health care system. Relationships between Ontario's two Northern Local Health Integration Networks (LHINs) and hospitals are assessed to determine whether these governance bodies and the provincial government, are meeting their original mandate to enable local decision-making. Additionally, the study is framed through three governance theories – provincial Norths, very complex policy problems, and health care regionalization – in order to analyze the organizational nature of the system.

Key informant interviews were conducted with a purposive sample of individuals from hospitals and LHINs across Northern Ontario. Participants provided insights that were organized into three thematic focus areas: governance system design; leadership in the North; and the complexity of the health system. Overall, the majority of participants acknowledged that provincial health care reform is not yet finished and that while the situation has improved, more work needs to be done to improve local decision-making and control in Northern Ontario health care governance and to better manage an increasingly complex heath system within unique local conditions. Additionally, the author provides a summary of five key themes, observations and recommendations that can be used to improve local decision making in Northern Ontario health care system:

1. Greater integration and more local and regional control of Northern Ontario's health care system.

2. There are challenges in recruiting, developing and retaining skilled board members for health service providers, as well as senior leaders who can manage increasing complexity and build cross-sectoral relationships.

3. The growing complexity of the health care system requires solutions rooted in local decision making and innovative governance solutions.

4. Health reform is too fragmented and incremental, partly due to differing views and inconsistent focus on what the central vision of health care delivery actually is.

5. Consider whether a one-size-fits-all governance model is appropriate across this large province. Solutions can and should be developed by Northerners for Northerners.

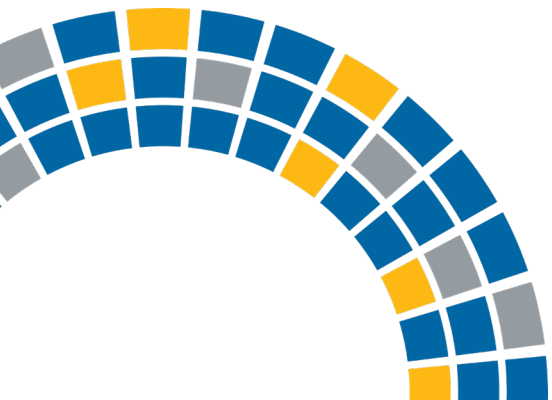
6. The Ontario government should convene a broad public policy discussion, with inclusive representation from all government levels, Indigenous peoples, and key players from health care and Northern Ontario more generally. The discussion ought to focus on the state of health governance in Northern Ontario and ways to tackle these challenges in a more holistic, integrated way.

Introduction

Northern Ontario continues to face troubling, interrelated, and seemingly intractable social, health, and economic problems. National media attention is drawn to crises in the region, such as recent tragedies in the decades-long suicide epidemic in remote First Nations communities or the mounting issues involving policing, youth safety, public leadership, and Indigenous relations in Thunder Bay (Blackwell 2017; Coates and Poelzer 2014a; Friesen 2017; Winter and Talaga 2017). The health of the population remains poorer in the region than in Ontario as a whole by a number of indicators (Health Quality Ontario 2017, 11). Moreover, for decades Northern Ontario has experienced protracted economic stagnation and slower growth than the rest of the province or the northern regions of other provinces (Coates and Poelzer 2014a; MacKinnon 2015).

Why do these problems persist? A growing body of policy and academic literature points to the need for new governance solutions that address the unique circumstances of Northern Ontario. Governance has many definitions, but, as a baseline for this paper, it refers to processes of rule in public administration that include networks centred on an ongoing, collaborative engagement process with multiple stakeholders, as opposed to a traditional top-down management hierarchy (Bevir 2012, 3). Or simply, it is the rules on how to play the game – and the players who decide on the rules.

Although not yet sufficiently researched, most northern regions of the provinces – the so-called provincial Norths – seem to have inadequate governance (Coates and Poelzer 2014a; Coates and Poelzer 2014b, 72). They are typically accountable to policy makers in capitals located far to the south, while immersed in discussions about resource development, the marginalization of Indigenous peoples, and how to serve a large, sparsely populated geography (Coates and Poelzer 2014a).



Nevertheless, the situation is not altogether negative. There is growing evidence of a new regionalism in the provincial Norths that seeks to overcome political marginalization, social alienation, and regional grievances by creating new institutions to strengthen local decision making and control over resources (Summerville and Poelzer 2005). In Northern Ontario, there have long been sporadic suggestions that the region govern itself because of major differences from southern Ontario in terms of climate, size, and industry. Recent policy discourse builds on the theme of the region's taking control of its own destiny (MacKinnon 2015, 2016; McGrath 2018). What regional governance structures could better serve Northern Ontario's unique situation?

Governance is a broad topic, but relatively new regional institutions in Ontario's health care system could serve as examples from which to draw early lessons. Regionalized governance through the province's 14 Local Health Integration Networks (LHINs) has existed for just over a decade, operating under the premise that "the health care needs of local communities are best understood by those who live in them" (North West LHIN 2016, 3). This paper accordingly describes the Northern Ontario health care system as a case study in northern governance from a public policy perspective. More specifically, a description of the relationships among the Ontario government, northern LHINs, and the hospitals they fund could lead to a better understanding of whether these governance bodies are meeting their original mandate to enable local decision making. The paper also recommends areas where public policy dialogue and action might be needed.

It should be emphasized that this paper is a study of northern regional governance issues, not a detailed analysis of the health system itself, which is a complex subject with facets that cannot all be accounted for here. For example, there is no discussion on the effects of funding, demographics, and personal behaviours in Northern Ontario, or socio-economic determinants such as adequate housing or employment status. While focusing narrowly on one aspect of organizational issues in the health care system runs the risk of oversimplifying problems, at a higher level, the paper seeks to make the case that more effective governance, with local decision making, can better manage the unique characteristics of Northern Ontario. It is, in effect, a brief look at one attempt to give Northerners more control over the rules of the game.

Background

There are many ways to approach the complicated subject of governance. Using a multidisciplinary public policy perspective, this study is framed by interrelated governance theories in three main areas: the provincial Norths, very complex policy problems, and health care regionalization in Ontario and Canada as a whole.

Provincial Norths and Northern Ontario

In Coates and Morrison's seminal book on Canada's "forgotten North," the authors describe the lower profile of subarctic provincial Norths through common histories and shared characteristics of a cold climate, little political power, primarily resource-based economies, lower populations with larger geographies, few regional centres, and relatively larger Indigenous populations, to name a few (1992, 2, 9).

Operating as internal colonies with less control over their own future than other regions in Canada, the provincial Norths face challenges related to rapid resource development, Indigenous rights, and the need to deliver services to a vast region (Coates, Holroyd, and Leader 2014; Coates and Poelzer 2014a). All provincial governments have developed structures to respond to northern issues, but little decentralization has occurred, resulting in inadequate services and the political marginalization of some of Canada's most disadvantaged people (Coates, Holroyd, and Leader 2014). Nonetheless, as noted, a new regionalism is emerging, with the provincial Norths seen as "political communities in transition," changing their relationships with the South and finding their own solutions (Summerville and Poelzer 2005, 119).

These challenges are keenly felt in Northern Ontario. To outline briefly, Ontario's North accounts for almost 90 per cent of the province's landmass – over 800,000 square kilometres, an area larger than France – but only about six per cent of Ontario's population. Unlike in the rest of the province, the North's population is either stagnating or in decline, with the only notable growth occurring in Indigenous communities (Coates, Holroyd, and Leader 2014; Conteh 2013; Southcott 2013). This vastness and low population density have made it difficult to import southern regional municipal structures, leaving little administrative or policy control in Northern Ontario.

Consequently, inadequate governance and fragmented policy approaches are contributing to or perpetuating many of the region's problems (Coates, Holroyd, and Leader 2014; Conteh 2017; MacKinnon 2016).
An emerging body of economic research has begun to describe key governance issues in Northern Ontario, which include: a systemic lack of horizontal policy coordination across sectors (Conteh and Segsworth 2013, 9); long-standing tensions between Northeast and Northwest, insular debates, lack of data, and unsuitable performance benchmarking against southern Ontario (MacKinnon 2015); and feelings of isolation and alienation leading to periodic calls for provincial status (Brock 1978; Coates and Morrison 1992; MacKinnon 2015; Tabachnick 2017). Consequently, the creation of suitable regional governments has been proposed in Northern Ontario to bridge divisions and build economies of scale, "to develop a stronger regional identity, and to take more responsibility for its own future" (MacKinnon 2016, 15).

Very Complex Public Policy Problems

In the modern policy environment, it is important to characterize appropriately the nature of the problems themselves. The inability to respond effectively to complicated problems could result from political and other public decision makers not knowing enough about them and about the effect of proposed governance solutions (Sørensen and Waldorff 2014). In this case, modern health care on its own is a complex, "wicked problem" (Glouberman and Zimmerman 2002; Raisio 2009). Wicked problems, a concept developed over the past four decades, essentially are characterized by the ambiguous, many factored, and novel nature of each problem, as well as by the trial–and-error, one-shot, and creative components of solutions that are neither right nor wrong, "only 'better', 'worse', 'good enough', or 'not good enough'" Gollagher and Hartz-Karp 2013, 2344; Rittel and Webber 1973).

Similarly, complex adaptive systems approaches have also been applied to health care delivery due to its many interacting parts, interactive complexity, and continuing self-organization (Tan, Wen, and Awad 2005). More than fifteen years ago, the British Medical Journal published an informative series highlighting the need for new conceptual frameworks and management styles based

on complex adaptive systems to improve the health care system (Fraser and Greenhalgh 2001; Plsek and Greenhalgh 2001; Plsek and Wilson 2001; Wilson, Holt, and Greenhalgh 2001).

Altogether, a growing body of literature describes novel approaches to respond to complexity, notably including collaborative policy innovation and governance approaches to contribute new policy definitions and ideas to confront wicked problems (Sørensen and Waldorff 2014); deliberative collaborative governance (DCG), also to deal with wicked problems, but also declining public trust (Gollagher and Hartz-Karp 2013); and the governance capabilities required to address wicked problems, including reflexivity, resilience, responsiveness, and revitalizing (Termeer et al. 2015). Although this research into governance theories for dealing with complexity might seem esoteric, many offer case studies and practical guidance to health governors and policy makers.

Local Decision Making through the Regionalization of Health Care

Lastly, with the inherent challenges of Northern Ontario and the overall complexity of the system in mind, a third theoretical governance pillar introduces local decision making as one objective of health reform. Overall, Canada's health care system is characterized by a trend toward regionalization: organizing governance of health policy implementation by location and population, rather than by disease (Touati et al. 2007). Born of health care reform movements in the late 1980s and 1990s, regionalization was proposed to improve accountability, increase public participation, and increase effectiveness and efficiency with more horizontal, community-focused care. Cynically, it has also been suggested that regional bodies provide political buffering in an era of sustained fiscal pressures and growing health costs (Forest and Palley 2008; Lewis and Kouri 2004).

Varied regional health authorities (RHAs) were formed across Canada along a spectrum with two axes: devolution of authority from a provincial health ministry on one axis, and decentralization or centralization of delivery based on location on the other (Lewis and Kouri 2004). Other key features included a mix of delivery and/or funding of services, local input into planning and prioritization, increased integration and reduced duplication, and increased emphasis on health promotion (Gardner 2006, 14). Commonly, tensions between health ministries and RHAs have revolved around the latter's true degree of autonomy and the allocation of funds. All the provinces have restructured their RHAs at least once, with a recent shift toward reducing their number.

Ontario's Local Health Integration Networks

Last to regionalize, in 2006 Ontario implemented its Local Health Integration Networks to plan, integrate, and fund local health care, but, unlike in the other provinces, not to govern or provide health care services directly. Ontario's 14 LHINs are non-profit Crown agencies that divide the province geographically, with differing sizes and populations that do not necessarily align with existing units such as electoral districts, public health unit areas, municipalities, or counties. Each LHIN has up to nine board members, who are appointed by the Ontario government. Health service providers (HSPs) maintain their own boards of directors, unlike the consolidation that occurred in other jurisdictions with RHA models (Bhasin and Williams 2007; Gardner 2006; Ontario 2015c). Relationships are governed by the provincial government's legislative and policy framework, as well as by accountability agreements such as those between the Ministry of Health and Long-Term Care (MOHLTC) and each LHIN, and between each LHIN and HSP.

Northern Ontario is split into two LHINs: North East and North West. The North West LHIN is the smallest by population (235,870 in 2015), but the largest by geography, encompassing nearly 47 per cent of the province (458,010 square kilometres, larger than Germany). This LHIN funds and maintains agreements with 129 HSPs, including 13 hospitals (North West LHIN 2016). Likewise, the North East LHIN encompasses 564,410 people living within 400,000 square kilometres (North East LHIN 2016), and funds 194 HSPs, including 25 hospitals. Both regions are experiencing similar demographic and health trends, although with considerable diversity across their large regions. In brief, their populations differ from that of the rest of the province in that they are generally declining, are more rural, have greater access issues to primary health care, and are less healthy according to many indicators (Health Quality Ontario 2017; North East LHIN 2016; North West LHIN 2016). Both LHINs have a higher proportion of Indigenous residents than the rest of the province, estimated at 24.8 per cent in the North West and 13.4 per cent in the North East (Statistics Canada 2017a; 2017b); the North East also has a significant francophone population (Statistics Canada 2017b). Overall, delivering health care in Northern Ontario presents several distinctive considerations and challenges.

The LHINs' Original Mandate

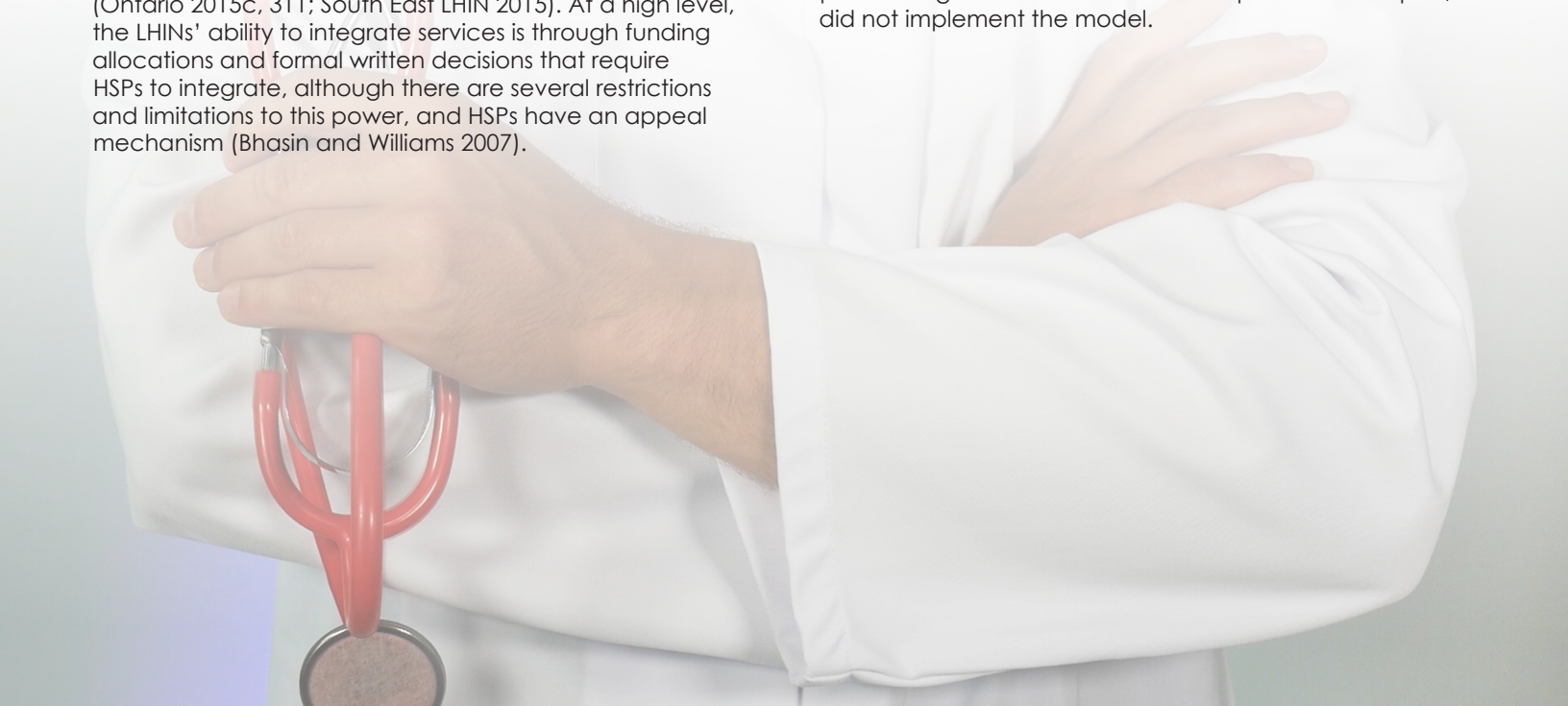
A glimpse at the original mandate and implementation of the LHINs might provide helpful context for describing the state of local decision making in Northern Ontario. Previously, the MOHLTC governed HSPs through seven regional offices, with advice from sixteen District Health Councils (Ontario 2015c, 307). In 2004, the provincial government introduced legislation for the LHINs to enable broader health reforms (Ontario 2015c, 307). The purpose was summarized by then health minister George Smitherman: "Although most health care is local, we are not that effective at planning and responding to local needs…. That's why we will be taking some of the authority which currently resides at Queen's Park away from Queen's Park, and shifting it to local networks, closer to real people, closer to patients" (quoted in Gardner 2004, 4). The intent was to shift MOHLTC to a stewardship role, and to "devolve a good deal of power and authority to the LHINs" (8). The notion was that locals "could better appreciate the actual health needs of the population and address them fairly," as well as mitigate the politics and special interests that can distort centralized health care (Barker 2007, 4; Bhasin and Williams 2007). Ministry stewardship meant setting provincial priorities, legislating and regulating, setting funding levels, and setting overall performance objectives for the broader health system (Bhasin and Williams 2007; South East LHIN 2015).

Under the *Local Health System Integration Act*, 2006, the LHINs were responsible for HSPs in six health sectors – hospitals, long-term care homes, Community Care Access Centres, community mental health and addiction agencies, community support services agencies, and community health centres - but not for the bulk of primary care services (such as physicians and nurse practitioners), public health, or laboratory services, among others (Ontario 2015c, 311; South East LHIN 2015). At a high level, the LHINs' ability to integrate services is through funding allocations and formal written decisions that require HSPs to integrate, although there are several restrictions and limitations to this power, and HSPs have an appeal mechanism (Bhasin and Williams 2007).

There is a relative dearth of academic literature about the effectiveness of the LHINs (or RHAs in general) as a governance model, particularly in recent years. Early on, health care experts flagged potential citizen participation challenges, questioning agreements that made LHINs accountable to the MOHLTC rather than to communities, the large geographic size of the regions, and the original absence of a legislated community engagement process (Barker 2007). Occasional commentary later critiqued implementation. For example, it was suggested that LHINs were being "throttled by Ministry directives" by an unnecessarily large ministry bureaucracy, and should be quickly replaced with smaller, integrated regional health organizations with more authority (Ronson 2011, 6).

In addition, the LHINs have been evaluated periodically by government- appointed panels and organizations at arm's length of government. The 2012 report from the Commission on the Reform of Ontario's Public Services (known as the "Drummond Commission") included structural recommendations to integrate health services fully under a reconstituted LHIN model with sufficient authority and resources, reduce the number of organizations that LHINs must oversee, consolidate existing agencies and their boards where appropriate, and remove political influence from operations (Drummond et al. 2012).

In another example, the Expert Advisory Committee on Strengthening Primary Health Care in Ontario recommended the creation of population-based Patient Care Groups that would contract primary care providers and be accountable by agreement to the LHINs (Price et al. 2013). Although it focused on primary care, the report presented a new model of governance within the LHIN structure based on subregional geography (much like school districts), with different local circumstances accounted for in implementation. In the end, although the provincial government considered aspects of the report, it did not implement the model.



In 2015, the Office of the Auditor General of Ontario conducted a value- for-money audit of the LHINs, and criticized the MOHLTC's inaction on previous commitments to plan for long-underserviced rural and northern communities. In response, the MOHLTC committed to meeting these challenges through greater integration and locally governed services (Ontario 2015c, 330). Around the same time, the Multi-Sector Rural Health Hub Advisory Committee recommended a "rural hubs" concept, which the MOHLTC supported by working with the LHINs and the Ontario Hospital Association toward finalizing a work plan by March 2018 (Multi-Sector Rural Health Hub Advisory Committee 2015; 2017, 109).

Finally, in recent years, the MOHLTC has guided further reform through its "Patients First: Action Plan for Health Care" and associated legislation (Ontario 2015a). In 2015, public remarks from then-health minister Eric Hoskins summarized the current role of the LHINs versus their original promise:

> I believe that a system that best meets the needs of patients in an equitable way is one that is truly population-focused and that is deeply integrated at the local level. And that starts with strong local governance. That was the driving force behind the creation of our Local Health Integration Networks, that local governance is the best way to meet a population's local needs – not by managing everything from our offices here in Toronto …. LHINs know the needs of their population and they know the partners and the service providers who care for that population. They have become much more sophisticated and they must continue to evolve. LHINs have the capacity to play a role that better acknowledges the true importance of local decision-making and local management. And that ladies and gentlemen includes primary care. (Hoskins 2015)

Notably, in the latest iteration of the action plan, the LHINs are newly responsible to deliver home care (absorbing the Community Care Access Centres), expand their role in (but not fully control) primary care planning, establish smaller geographic planning zones, and implement patient advisory committees (Ontario 2016). These significant changes were being implemented while interviews were conducted for this study.

Methodology

This research project was undertaken between March and August 2017 and, as previously mentioned, it focused on part of the Northern Ontario health care system as a case study in northern governance issues. Qualitative methods were chosen to reveal and describe attributes and develop a deeper understanding of this aspect of the health care governance.

A twofold approach to data generation involved a documentary review and 12 key informant interviews with a purposive sample of individuals from hospitals and LHINs in Northern Ontario. Participants were selected in consultation with Northern Policy Institute and advisors in health care and academia. Efforts were made to balance representation based on hospital size and regional geography. Participant availability and the limited duration of the project were factors in selection and sample size. Participants varied in terms of experience, length of service, and prior vocation, but the sample sizes were too small to draw quantitative conclusions based on these factors.

Findings

Detailed responses from hospital and LHIN participants (N = 12) provided an informative look into regional governance and local decision making. In general, when asked if the current health system reflects the needs of Northern Ontarians, nearly all participants provided a mixed-to-positive response; only one clearly said "no." A similar breakdown of participants felt that local input was reflected in their LHIN's decisions. Indeed, the interviews revealed that while some of the policies being created are southern-centric, sometimes policies for all of the northern LHINS do not always reflect the variety of needs. In contrast, participants were split when asked the central question about whether the LHINs had achieved their original mandate. Some felt that there is still work to be done while some participants felt that LHINs had sufficient control and authority to set priorities that reflect regional circumstances. Another suggestion was that LHINS should evolve to the full RHA model. Referring to HSPs, over two-thirds of participants felt that their institutional governance structures had sufficient scope and authority to make effective decisions about health care delivery within their own institution.

Furthermore, while most participants felt that indicators collected by Health Quality Ontario reflected local needs and priorities, most also reported that their institutions did not have sufficient decision-making authority to drive results for all indicators. LHIN participants provided mixed responses about their own authority to drive those same performance obligations.

Overall, three major focus areas for responses emerged: governance system design; leadership in the North; and the complexity of the health system. Within these, Table 1 summarizes several common themes mentioned by most or nearly all participants.

Table 1. Common Themes Referenced by Most or Nearly All Participants by Major Focus Areas

Governance System Design	Leadership in the North	Complexity of the Health Care System
• Need to better appreciate geographic and demographic diversity • Too much central control by government • Politics negatively influencing results • Greater integration needed beyond acute care sector (e.g. primary care, system issue with mental health, need for community supports)	• Leadership capacity challenges for senior administration and boards (e.g. talent gaps, training needs, succession planning, increasing requirements) • Strong relationship builders are needed at LHINs and HSPs with the current model. • Challenges for HSPs to take a system perspective (e.g. parochialism, fiduciary responsibility to hospital)	• Varied references to a central attractor or vision for health care (e.g. patient, community, disease, value for money, vulnerable populations) • Recognition of complexity from different perspectives (e.g. changing landscape, jurisdictional complexities, transformational journey)

Discussion

Given the poorer health indicators and known service delivery challenges in Northern Ontario, the findings in this study are not as negative as expected. Most study participants acknowledged that they were on a "transformation journey" that had not yet reached its end. The consensus was that the situation for Northerners had improved since decades past. It was also apparent, however, that more work needed to be done to improve local decision making in Northern Ontario health care governance. Keeping this study's theoretical framework in mind, a few key findings are discussed below.

Interestingly, study participants favoured a point of view that was either primarily "structural" (for example, system design, processes, policies – the rules) or primarily "people" (for example, leadership, relationship management – the players) when describing health care governance problems and solutions in Northern Ontario. This span of ideas might not be surprising considering the interrelated nature of these aspects and because wicked problems are said to have no right or wrong solutions (Gollagher and Hartz-Karp 2013).

Structural Elements of Governance

Central versus Local Control

According to many participants, the "local health system" still has too much central control from Toronto. Frequently, participants expressed that the government should set health outcomes and let local health care leaders worry about how to deliver care. Others described instances where the MOHLTC should best leave matters to local control such as parking fees. On the other hand, it was expressed that there is also the opportunity to show how these institutions direct provincial funding priorities down to the local areas.

Moreover, nearly all participants cited political factors that resulted in governance issues, marginalization, or barriers to reform. For example, it was expressed that problems in governance develop due to the disconnection between reality and what can be done. Additionally local politics could also be a negative factor – for example, by blocking or delaying an evidence-based rationalization of services in a smaller municipality. The participants' statements in Table 2 highlight the range of comments related to the politicization of the health care system.

Table 2. Recurring Participants' Statements Related to Politics in the Health Care System

- Political route is available as last resort (HSPs escalating unfavourable decisions)
- Scepticism about government's commitment to local decision making
- Politicians' involvement results in inefficiencies
- The government is focused only on one-off issues
- The LHIN's role is limited by politicians
- Limiting political interference will result in better business decisions
- Keeping too many HSP boards is a political decision
- Ministry avoidance of negative media attention encumbers the LHINs
- Politics (at all levels) gets in the way of integration
- Commitment and political will are needed (to make bolder changes)
- The LHIN has devolved into a political animal
- Similar areas (that is, similar-sized municipalities) are treated differently due to politics
- The main issue is politicization of health care

Why does this matter? Significantly, a continued top-down policy approach could stifle the policy innovation needed to tackle new challenges in a constantly changing environment (Sørensen and Waldorf 2014, 3). Government micromanagement and disproportionate political reaction to narrow, sensational issues do not lend themselves to thoughtful solutions suitable for complex systems. The literature heavily supports the need to think holistically to solve wicked problems (Raisio 2009; Termeer et al. 2015). It is difficult to think holistically, however, within and between traditional government ministries, let alone between governments. Local health leaders are in a better position to make many decisions, but most say they are limited because LHINs do not control the full care continuum. Study participants frequently lamented the fact that primary care, for example, was still funded directly by the MOHLTC, even though physicians work in hospitals.

In one sense, this persistent fragmentation might point to the failure of government and other system leaders to revitalize their approach, which has been described as a necessary governance capability to deal with wicked problems and to "unblock stagnations and reanimate policy processes" (Termeer et al. 2015, 685). If something is not working, try something else. Having deficits in this capability risks more of the same or even regression. In a similar way, a case study on flagging national health reform in Finland found that, although health planners recognized the complexity of problems, the solutions were still more appropriate for simpler problems and often seen as "too pragmatic, too bounded and too linear" when much bolder and more holistic reforms were needed (Raisio 2009, 491). Many of the participants in this study similarly felt that the approach has been too cautious, when the provincial government should have committed early on to the full RHA model.

Geography and Demography

Northern Ontario's particular geography and demography add further questions. Is the region, even when split in two, too large and spread out to be governed in the same way as the South? Governance bodies with territories larger than many countries seem too large to make effective local decisions and, as noted above, various reports and commentators have called for smaller, subregional units.

Likewise, most study participants identified distinct subregional geographies and vulnerable populations – such as Indigenous peoples, Francophones, and mental health and alternate-level-of-care patients – that pose coordination challenges within the current model. The single HSP level is generally too small, as the need for leaders to "think beyond their hospital walls" was often expressed. Most municipalities in the region are also too small to provide a critical mass and economies of scale for many services (Multi-Sector Rural Health Hub Advisory Committee 2015). Unsurprisingly, even while supporting their LHIN's plans, adopting a system perspective was challenging for hospital boards whose primary legal responsibility is achieving their own organization's fiscal balance. Of course, it was expressed that parochialism in HSPs was a challenge, as well as trying to find that geographical sweet spot.

This is an area where the North has taken the lead. Based on concepts originally pioneered by the North West LHIN, the MOHLTC has now mandated subregional planning zones based on population demographics, economic circumstances, and cultural landscape (North West LHIN 2016; Ontario 2016). The patient-centred idea for this initiative has been advocated since at least 2010 and the Rural and Northern Health Care Panel Report. In addition, the Ontario Hospital Association and Ontario Medical Association, through the Multi- Sector Rural Health Hub Advisory Committee, have further developed the concept and recommended an end vision of a fully integrated rural health hub, funded by the LHIN, which would provide end-to-end integrated services across the health continuum. Each hub would have one administrative body and one skills-based board of directors with cross-sector representation (Multi-Sector Rural Health Hub Advisory Committee 2015). These would not be a "one-size-fits-all model."

Although they have not yet gone that far, the Northern LHINs continue to implement subregional planning zones. The North West LHIN is creating Local Health Hubs, Integrated District Networks, and regional programs through the 2016–19 planning timeframe (North West LHIN 2016, 12). Local Health Hubs plan and provide a broad range of health services to local communities. Regional programs set standards across the LHIN, while five Integrated District Networks – consisting of the Kenora, Rainy River, and Thunder Bay districts, as well as the City of Thunder Bay, and Northern, which extends into the Far North of the province – coordinate vertically integrated services to residents across their respective areas (Multi-Sector Rural Health Hub Advisory Committee 2017; North West LHIN 2016, 12). In each, one hospital is designated as a District Centre. The Northeast LHIN has established a similar number of planning hubs, including Sudbury-Manitoulin-Parry Sound, Nipissing-Temiskaming, Algoma, Cochrane, and James and Hudson Bay (North East LHIN 2016, 10).

Rural hubs provide an example of incremental governance changes within the constraints of the current system. While most participants' responses to the hubs were favourable, the catchment areas should not be too large in case further rationalization of organizations be required. It was also suggested that perhaps these units can replace the LHINS in the future so as to reduce administrative burden.

The development of subregional zones was largely evidence-based, taking advantage of traditional boundary lines (such as districts) and population

characteristics. Although lacking a history of regional administrative structures such as the counties or regional municipalities of Southern Ontario, recent governance research outside of health has moved beyond traditional Northwest and Northeast Ontario policy demarcations that incorrectly imply homogeneity in the region. Conteh, in fact, has identified eleven discrete economic zones that incorporate nuances often overlooked in Northern Ontario's geography. Utilizing these zones offers potential benefits of sufficient density for longer-term planning and reduced parochialism to address common challenges (Conteh 2017, 27). These benefits are also needed in health care, but further research is required on more appropriate regional governance units and scales in Northern Ontario.

Despite willingness to change, the system has a ***large number of players*** and ***finite resources***.

A Sense of Urgency

Building upon these structural considerations, the pace of change was a recurring theme in the interviews, with an apparent perception of disconnect about the time available to solve problems. Indeed, a differing sense of urgency between deliverers and policy makers was alluded to by large portion of participants: health reform moves too slowly; health crises move too fast. For example, simply transferring a patient from one hospital to another for more advanced procedures could take more time than necessary. Why should it take so long to make a decision that would save lives and make financial sense? The negotiated model of integration moves more slowly than do other models of RHAs. Indeed, the transferring of resources not only takes time, but requires engagement and partnerships. Despite willingness to change, the system has a large number of players and finite resources.

The People Side of Governance

The shift away from more traditional, hierarchical, and formal management systems for health care has resulted in a more complicated system of multilevel governance. This implies a diversity of arrangements and new non-governmental organizations in networks (Alcantra and Nelles 2014). Currently, the Northern Ontario LHINs hold accountability agreements with a whopping 262 HSPs. LHIN participants discussed how this administrative workload kept them busy, and they expected the load to double with the incorporation of the Community Care Access Centres into their organizations. Moreover, the need for relationship building extends to a broader range of stakeholders.

Interestingly, this complexity has been illustrated by Sturmberg, O'Halloran, and Martin's (2012) "health vortex" to describe Australian health reform. Greatly simplifying this tool for the present discussion, one can visualize the health system in Northern Ontario as a funnel (see Figure 1). Numerous organizations operate in this swirling vortex at different levels – indeed, many more influencing agents are not shown in the figure. At the top are several government ministries, which make policy decisions in relatively discrete silos. The degree and complexity of interaction among organizations increases as the funnel narrows. As a result, so does unpredictability. Moving down, the LHINs must interact with numerous organizations, including professional groups, dozens of municipalities and municipal organizations, district social services administration boards, First Nations, tribal councils, political territorial organizations, and many others. The HSPs operate at the narrowest point of the funnel with the highest degree of interaction, working with even more local stakeholders. The complexity and unpredictability are greatest here: HSPs must translate the funding, policies, advice, and other direction from all the organizations above them into care for complex humans.

What creates the pull at the bottom of the vortex? This is where the visual tool of Figure 1 is helpful. On paper, the MOHLTC says its vision is patient-centred, but it has been argued that this vision for health care reform can be achieved only if policy makers are able to shift this central attractor to people's perception of health (Sturmberg, O'Halloran, and Martin 2012). Participants in the present study expressed diverse viewpoints and often uncertainty about what the attractor was and what it should be: the patient, vulnerable populations, dollars, disease, even staffing numbers? Moreover, the current model was said to be inadequate at addressing the social determinants of health and the support of vulnerable populations that span boundaries. Sturmberg, O'Halloran, and Martin (2012) make the point that a health system can produce only what it is designed to do. It could be said that the LHIN model's incremental approach to transformation itself – based on negotiation rather than authority – is better described as institution-centred change, in the form of navigating politics, protecting local jobs, or managing organizational interests, rather than *patient-centred* change.

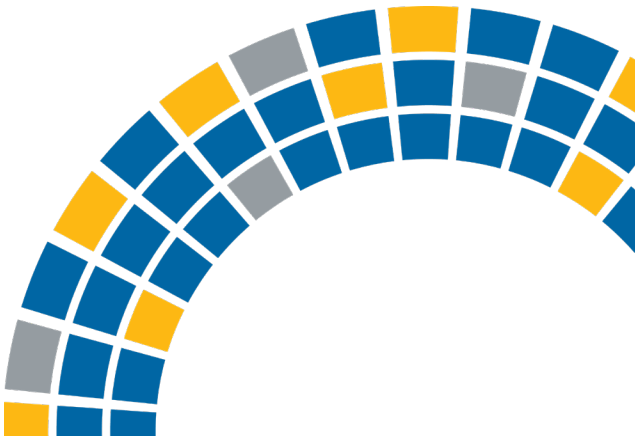
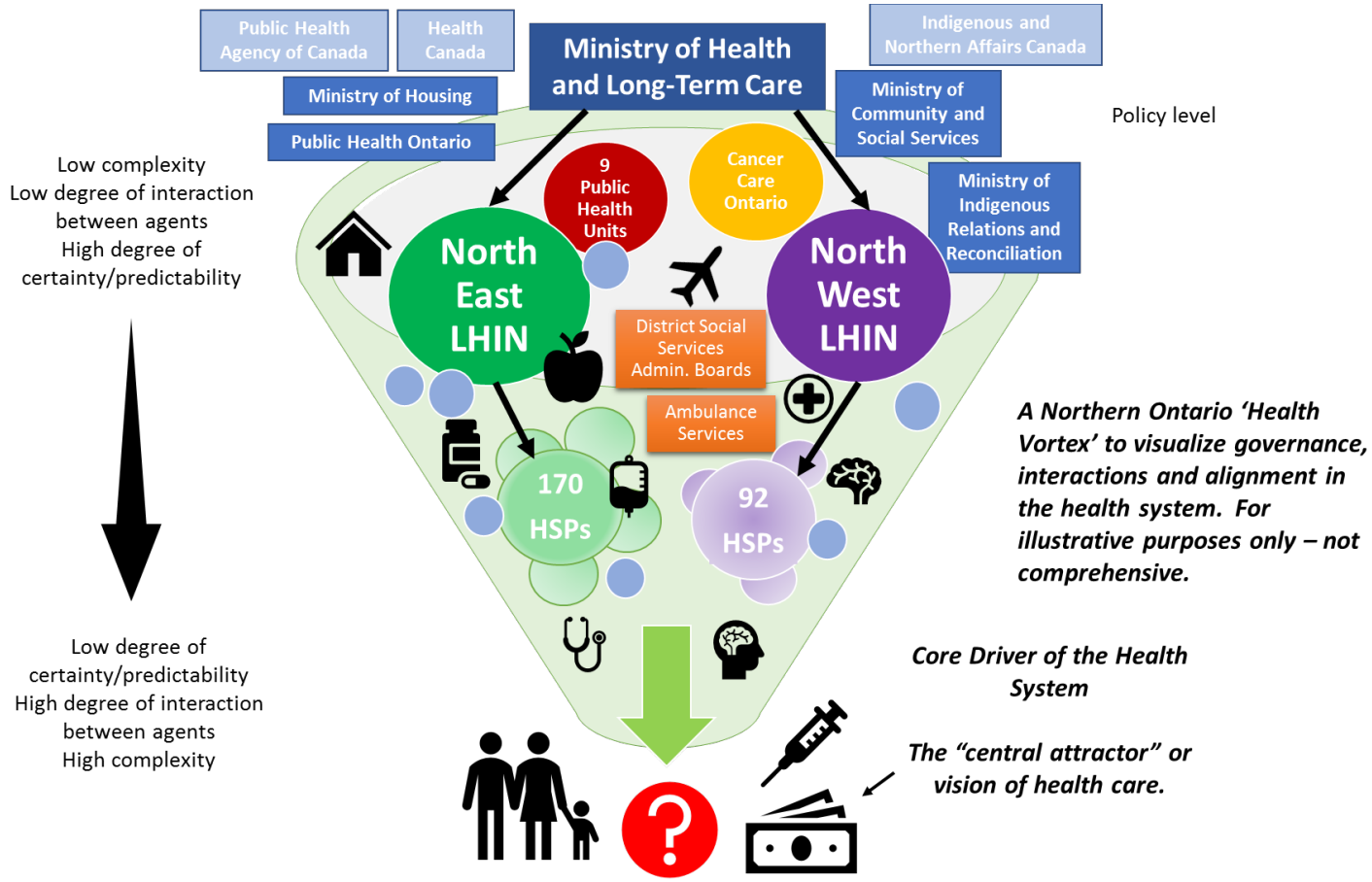


Figure 1. The Northern Ontario Health Vortex: What Is the Central Attractor?



Source: Simplified and adapted from Sturmberg, O'Halloran, and Martin 2012.

Jurisdictional Chaos

Relatedly, most participants also identified jurisdictional complexities as another governance challenge. For example, it was expressed that Indigenous communities and groups view the LHIN as a connector between providers and governments. As Northern Ontario has a large Indigenous population, LHINs must work with both Indigenous groups and Health Canada, which provides health services on First Nations reserves. For example, the North West LHIN already has funding relationships with 44 Indigenous organizations, and trilateral negotiations continue with the federal government (mostly at higher levels). According to participants, there has been a considerable amount of early-stage discussion on potential models that blend federal and provincial authorities and/or funding, with some recent progress on that front. In 2016, the MOHLTC launched Ontario's First Nations Health Action Plan, and on July 24, 2017, the federal Minister of Health, the Ontario Minister of Health and Long-term Care, and the Nishnawbe Aski Nation Grand Chief signed the Charter of Relationship Principles Governing Health System Transformation in Nishnawbe Aski Nation Territory (Canada 2017). Despite this positive step, opportunities ought to be taken for bolder governance innovation to blend provincial and federal responsibilities.

A health system can produce
only what it is designed to do

Sturmberg, O'Halloran, and Martin (2012)

Leadership in the North

Rules and processes cannot account for all contingencies and interactions in the changing and complex environment of the "swirling health vortex." For example, participants brought up how the legal structure was used when something was not working – a minimum standard for when conflict arises. At the same time, others stated that people would complain no matter what governance structure was in place.

Most "people" elements in the interview responses amounted to a need for skilled leaders and indeed, smart leadership is critical for complex adaptive systems such as health care (Tan, Wen and Awad 2005, 43). Such leaders require not only competence, but also the ability to adapt to change and to seek continuous improvement (Fraser and Greenhalgh 2001). For example, new funding models and more complicated requirements demand specialized knowledge. Indeed, to bolster the effectiveness of local decision making, the Drummond Commission recommended: "The LHINs need to have leaders who are savvy to political and community issues at play in the regions. Do not appoint them through Orders-in-Council, but rather hire them using executive search best practices to ensure independence and that an appropriate combination of skills and expertise is brought to the table" (Drummond et al. 2012).

Of course, this brings up an interesting question: should HSP boards, particularly in smaller communities, that might have members with little or no background in health care, make tough allocation decisions? Concerns were expressed about the limited pool of qualified people for senior administration or boards owing to Northern Ontario's smaller, dispersed population; to address this shortage, the LHINs have sought to fund leadership development within the system. From the interviews, it was suggested that the overabundance of rules from the government could be the cause behind the simplification of the governance process, as well as the increased risk of losing qualified governors. The same applies for senior administrative leaders who cross over into the private sector.

Among other consequences, this could perpetuate the lack of diversity of both demographics and opinion on boards, adding to concerns in the literature about whether citizen boards are an effective means of citizen input into health governance (Chessie 2009). Seeking practical wisdom from the public brings unique knowledge that is necessary to better address wicked problems (Gollagher and Hartz-Karp 2013).

Relationship Building

Another leadership theme related to relationship management. Relationship skills and big-picture thinking are necessary in governance approaches. Indeed, in lessons learned from existing health hub leaders, the Ontario Hospital Association points out that rural health hubs are based on strong local partnerships, and emphasizes the need for collaboration built on trust and mutual respect (Multi-Sector Rural Health Hub Advisory Committee 2017, 11). For example, take the small towns who deal with isolation and limited resources. Beyond building strong relationships with larger hospitals, it is key to have a common vision, strong leadership skills from health leaders and to demonstrate respect. These are some of the ingredients for success in health governance.

Overall, the relationship picture gathered from this study is mixed-to- positive. Generally, participants reported good working relationships between hospitals and LHINs. This was particularly true for larger hospitals, which are simply closer to centralized LHIN offices. As well, in smaller communities, hospital and LHIN leaders often interact with one another outside their professional capacities.

Yet notable exceptions were reported. Although it might not have been top of mind, a few HSPs felt that communications about the LHINs' absorbing the functions of the Community Care Access Centres had been inadequate. Some HSPs also said that the LHIN should work even more closely with HSP executives and engage through the Ontario Hospital Association. Finally, it was also expressed that providers are a bit isolated and there are no effective collaborative forums for making progress on its gaps in health provision to vulnerable populations.

From the LHINs' point of view, relationships were seen to be improving. They were regularly engaging hospital executives, on a bilateral basis and through semi-formal groups such as "governance to governance" sessions with all the LHIN and HSP board members, and health networks with all chief executive officers in a region. However, building trust with clinical leaders was cited as an ongoing challenge, owing to their historical "suspicion of LHIN intentions."

Finally, the Northern Ontario leadership dimension leaves many questions unanswered. What are the implications for new regional governance structures? Will there be enough skilled leaders to fill increasingly complex organizations? Would consolidation of organizations and boards help (potentially through the need for fewer leadership positions) or hinder this process (by positions becoming more complicated and with more responsibilities)? The recruitment, training, and retention of skilled people in many professions in northern, rural, and remote areas is a much-discussed issue that requires further research.

Addressing Very Complex Problems

The preceding discussion focused on just some parts of the complex problems involved in health care delivery. These in turn can be viewed as but one part of population health, which is but one of many public priorities competing for resources and attention. Traditional management thinking saw the health care system as a machine to be operated using a command-and-control approach. Complexity thinking, on the other hand, appreciates the relationships between the various parts of the system more than the parts themselves. This involves treating organizations as complex adaptive systems, which brings new ways of thinking that de-emphasize targets, minimize controlling processes, and instead promote the "natural creativity and organizing ability of its staff and stakeholders" (Plsek and Wilson 2001, 749).

Complexity thinking ... appreciates the **relationships between the various parts** of the system more than the parts themselves.

New governance approaches might be needed to overcome the tenacious challenges detailed above. The literature contains a growing number of examples, a few of which are briefly referenced throughout this paper. Many novel approaches to the solving of wicked problems emphasize citizen participation. For example, "deliberative collaborative governance" shows promise in promoting the collective ownership of processes by enabling citizens' participation as equal partners to better influence other stakeholders while collectively deliberating problems and solutions (Gollagher and Hartz-Karp 2013, 2356). Some participants in this study identified the use of new tactics related to citizen participation, which has helped improved the quality of care and shift the focus to patient-centred issues rather than health care provider issues.

Generally, most participants appreciated the complexity of the system and expressed that given how human services systems continually change the requirements, health reform will be an ongoing process. Relatedly, another common sentiment was that Ontario was still fairly "young in regionalization," and was still learning.

Conclusion

Despite over a decade of reform, Northern Ontario still experiences comparatively worse health outcomes than the rest of the province, mixed in with systemic social, economic, and other issues. Recent public policy discourse implicates governance problems as an overarching culprit, suggesting the need for more local and regional control. The Local Health Integration Networks, however, do provide a fairly recent example of governance innovation that seeks movement in this direction.

Several insights were gleaned from analyzing hospital and LHIN participants' responses through a multidisciplinary lens of northern governance challenges and opportunities, the implementation of health care regionalization, and innovative responses to "wicked problems." Generally, participants viewed the LHINs as a work in progress, and noted improvement in mandated areas of access, coordination, and management at the local level. Yet participants also identified persistent and serious governance problems within interrelated themes, including system design, leadership in the North, and the complexity of the overall health system.

It is hoped that this paper can reframe and ignite a policy conversation in Northern Ontario health care from a northern governance perspective. Building on growing regionalism in the provincial Norths, public policy and governance solutions in Northern Ontario should be developed in "the North, by the North, for the North" (Summerville and Poelzer 2005). How can innovative health governance ideas guide system transformation to better meet the urgent health needs of this vast region?

Ask Northerners. The limitations of this short, descriptive study mean that one can't recommend any specific governance solutions. On aggregate, however, participants felt that increased local decision making and control was needed to better manage complexity and unique northern issues. To that end, Table 3 offers key considerations for one possible discussion framework. Much work has already been done and numerous ideas have been published, and the participants generally felt there was a need to discuss ways to move forward, as opposed to more government studies.

Finally, the findings of this study offer some lessons from a broader northern governance perspective. The largely one-size-fits-all, overly political, and still too centralized LHIN model challenges the idea of "new regionalism" in the provincial Norths. Although one should be mindful of the study's small sample sizes, many of the themes identified here could be considered when exploring other much-needed regional governance innovation in Northern Ontario, such as implementing evidence-based subgeographies, integrating policy perspectives through a person-centred focus, reducing jurisdictional chaos through new partnerships, and promoting the need for strong leaders to manage complexity and build relationships.

Table 3. Summary of Key Themes, Observations, and Recommendations to Improve Local Decision Making in Northern Ontario's Health Care System

1. There is a pressing need for greater integration and more local and regional control of the health care system in Northern Ontario.
2. Northern Ontario faces challenges in recruiting, developing, and retaining skilled HSP board members and senior leaders who can manage increasing complexity, as well as build relationships across sectors.
3. The growing complexity of the health care system requires solutions rooted in local decision making and innovative governance solutions, such as those that better reflect subregional populations.
4. Health reform is too fragmented and incremental, partly due to differing views and inconsistent focus on what the central vision of health care delivery actually is.
5. Consider whether a one-size-fits-all governance model is appropriate across this large province. Solutions can and should be developed by Northerners for Northerners.
6. The Ontario government should convene a broad, public policy discussion, with inclusive representation from local, provincial, and federal governments, Indigenous peoples, and health and other northern stakeholders, on the state of health governance in Northern Ontario and ways to tackle urgent challenges in a bolder, integrated, and holistic way.

Appendix

Representative Participant Quotes:

On LHIN decisions reflecting local decision-making:

"Yes and no answer… Yes, at times, for sure it is. No, there are other times when a LHIN-wide solution doesn't meet the needs of [the district's] population… I do believe there have been some better decisions because the LHIN's exist versus the old Ministry of Health…That said, there are still decisions that continue to be made out of Toronto that are rolled out in a cookie-cutter fashion that… might make very good sense in the GTA/905 but they make little sense in Northeastern Ontario and way less sense in Northwestern Ontario."

On whether LHINs have achieved original mandate:

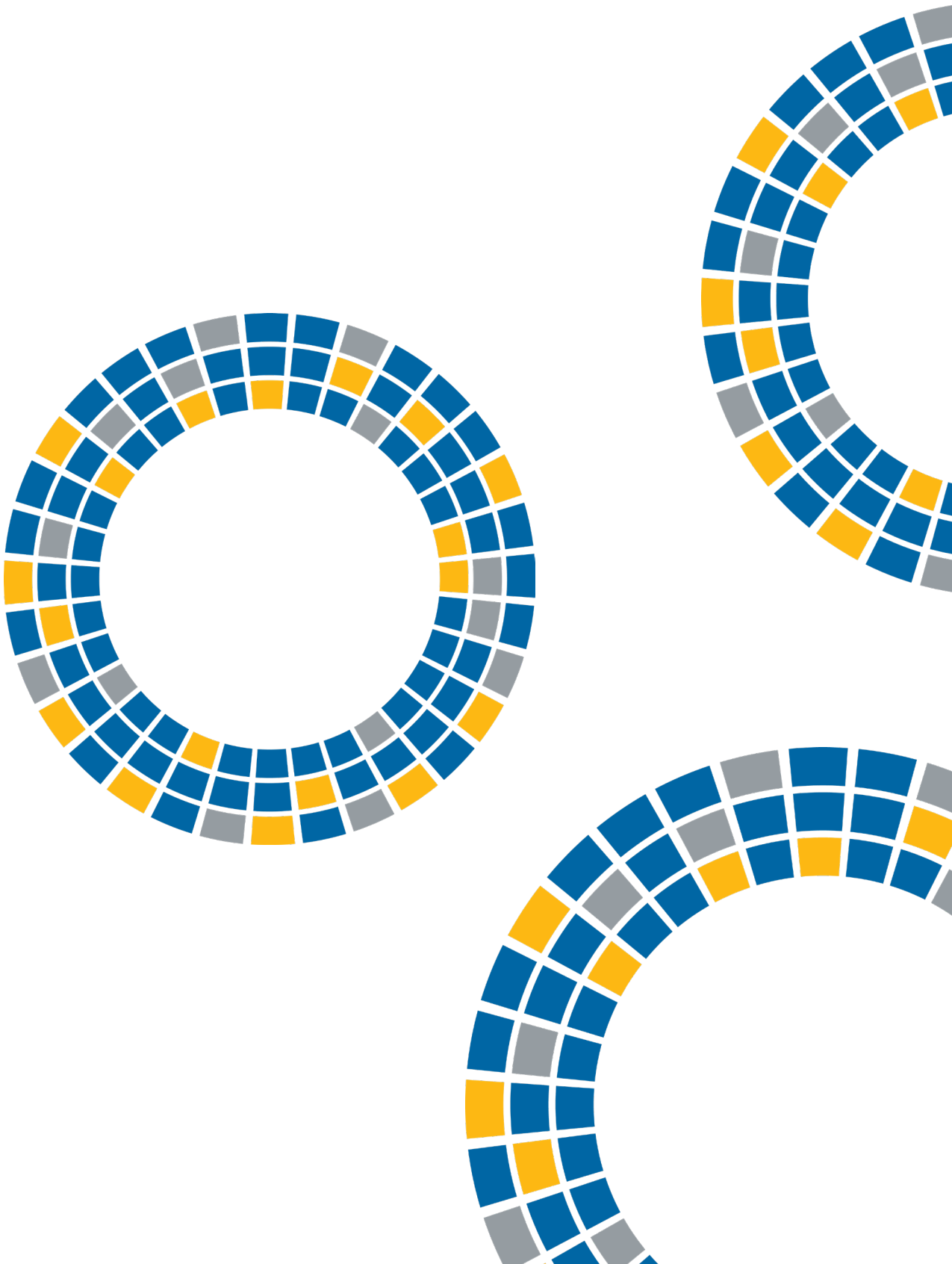
- "the short answer is a qualified yes…better than it was 10 years ago…there's always room for improvement…One of the areas screaming out for better access is primary care, but the LHINs have historically not had accountability for primary care."
- "truly believe that LHINs were set up to be at best marginally successful… [they] had hope, but the Minister quickly neutered them."
- "we don't know if we will ever achieve [health reform]… we will always be at it."

People point of view:

- It "all boils down to trust and relationships, rather than the legal environment."
- On parochialism – "I've looked in the mirror and I've seen the enemy."
- Leaders need to "think beyond their hospital walls"
- On increasing government rules – "dumbing down of governance and increasing the risk of losing qualified governors"

Structural point of view:

- The Ministry should fund a district-sized "body accountable for the delivery and coordination of that service in that region, and then measure the outcomes."
- On need for the integration of primary care - "Barring that, you will never have a true local system"



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Northern Policy Institute is Northern Ontario's independent think tank. We perform research, collect and disseminate evidence, and identify policy opportunities to support the growth of sustainable Northern Communities. Our operations are located in Thunder Bay, Sudbury, and Sault Ste. Marie. We seek to enhance Northern Ontario's capacity to take the lead position on socio-economic policy that impacts Northern Ontario, Ontario, and Canada as a whole.

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