The Regionalized Health Care System and Access for Mobile Populations in Southern Ontario

by

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A thesis submitted in conformity with the requirements for the degree of Master of Arts
Graduate Department of Geography and Planning
University of Toronto

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2016

Abstract

This case study of the Ontario regionalized health care system has investigated health care access in the context of an increasingly mobile population (including commuting and seasonal travel). Semi-structured interviews were conducted with staff members of Local Health Integration Networks and a Health Centre within southern Ontario alongside secondary research on federal and provincial health system structures and governance. The results of this research suggest there are mobility and geography system barriers to health care access in this region. The participants characterized obtaining transportation to health services as a current access challenge, and urban development and population growth as future concerns. Commuting and seasonal travel were not considered to present significant barriers outside logistics in arranging appointments. The health care system’s ability to mitigate such barriers may be limited by the structure of the health care system due to the regional-focus of planning and the necessity of inter-organizational collaboration.
Acknowledgments

I would first like to thank my supervisors, Dr. Alana Boland and Dr. Sarah Wakefield, for all of their support throughout the process and for believing in the project. Thank you for your patience and encouragement in getting the project off the ground and for making this a valuable learning experience for me.

Many thanks to my committee members, Dr. Kathi Wilson and Dr. Michael Widener, for their guidance and recommendations in the later stages of the thesis. Their expertise and thoughtful feedback have been extremely helpful.

Thank you to all of the participants in the study, for their time and for sharing their insight on the health care system.

Finally, I would like to thank my family. Their support and encouragement has meant the world to me and I would not have been able to do this without them.
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BCHC</td>
<td>Barrie Community Health Centre</td>
</tr>
<tr>
<td>CHA</td>
<td>Canada Health Act</td>
</tr>
<tr>
<td>CIHI</td>
<td>Canadian Institute for Health Information</td>
</tr>
<tr>
<td>CELHIN</td>
<td>Central East Local Health Integration Network</td>
</tr>
<tr>
<td>CFMA</td>
<td>Commitment to the Future of Medicare Act</td>
</tr>
<tr>
<td>CCAC</td>
<td>Community Care Access Centre</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>CCRS</td>
<td>Continuing Care Reporting System</td>
</tr>
<tr>
<td>DMG</td>
<td>Data Management Group</td>
</tr>
<tr>
<td>DAD</td>
<td>Discharge Abstract Database</td>
</tr>
<tr>
<td>DA</td>
<td>Dissemination Area</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drugs Act</td>
</tr>
<tr>
<td>FLS</td>
<td>French Language Services</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GGH</td>
<td>Greater Golden Horseshoe</td>
</tr>
<tr>
<td>GTA</td>
<td>Greater Toronto Area</td>
</tr>
<tr>
<td>GCHC</td>
<td>Guelph Community Health Centre</td>
</tr>
<tr>
<td>HBAM</td>
<td>Health Based Allocation Model</td>
</tr>
<tr>
<td>HSP</td>
<td>Health service provider</td>
</tr>
<tr>
<td>HSFR</td>
<td>Health System Funding Reform</td>
</tr>
<tr>
<td>HRR</td>
<td>Hospital Referral Region</td>
</tr>
<tr>
<td>HSA</td>
<td>Hospital Service Area</td>
</tr>
<tr>
<td>ICES</td>
<td>Institute for Clinical Evaluation Sciences</td>
</tr>
<tr>
<td>IHSP</td>
<td>Integrated Health Service Plan</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>---------</td>
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</tr>
<tr>
<td>LHIN</td>
<td>Local Health Integration Network</td>
</tr>
<tr>
<td>LHSIA</td>
<td>Local Health System Integration Act</td>
</tr>
<tr>
<td>LI</td>
<td>Localization index</td>
</tr>
<tr>
<td>MLAA</td>
<td>Ministry-LHIN Accountability Agreements</td>
</tr>
<tr>
<td>MLPA</td>
<td>Ministry-LHIN Performance Agreements</td>
</tr>
<tr>
<td>MOHLTC</td>
<td>Ministry of Health and Long-term Care</td>
</tr>
<tr>
<td>NACRS</td>
<td>National Ambulatory Care Reporting System</td>
</tr>
<tr>
<td>NPHS</td>
<td>National Population Health Survey</td>
</tr>
<tr>
<td>NPM</td>
<td>New public management</td>
</tr>
<tr>
<td>NRS</td>
<td>National Rehabilitation Reporting System</td>
</tr>
<tr>
<td>NSMLHIN</td>
<td>North Simcoe Muskoka Local Health Integration Network</td>
</tr>
<tr>
<td>OHIP</td>
<td>Ontario Health Insurance Plan</td>
</tr>
<tr>
<td>PRHC</td>
<td>Peterborough Regional Health Centre</td>
</tr>
<tr>
<td>QBP</td>
<td>Quality-Based Procedure</td>
</tr>
<tr>
<td>SAAs</td>
<td>Service Accountability Agreements</td>
</tr>
<tr>
<td>SES</td>
<td>Socioeconomic status</td>
</tr>
<tr>
<td>TCLHIN</td>
<td>Toronto Central Local Health Integration Network</td>
</tr>
<tr>
<td>TTS</td>
<td>Transportation Tomorrow Survey</td>
</tr>
<tr>
<td>WWLHIN</td>
<td>Waterloo Wellington Local Health Integration Network</td>
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Chapter 1
Introduction

1.1 Background and Research Objectives

The restructuring of the publicly-funded health care system in Ontario has affected how the health care system operates, particularly what level of government is responsible for planning and delivering health care. In 2004, the Ontario government began a process of devolving and decentralizing administrative authority (Ardal, Baigent, Bains, Hay, & Lee, 2006a), which shifted responsibility for planning, managing funding, and coordinating the integration of health services (Secker et al., 2006; Fenn, 2006) to the newly created Local Health Integration Networks (LHINs) (Ardal et al., 2006a). This model of “regionalization” was promoted to achieve fiscal and bureaucratic repositioning alongside a number of health care system reforms of the early 2000s (Fenn, 2006) and was intended to improve local responsiveness, capacity to plan and the process to collect and analyze data (Secker et al., 2006; Fenn, 2006). These aims are reflected in the goals of LHINs in the legislation, which are to “plan, fund and integrate the local health system” (Local Health System Integration Act, 2006). The term “health planning” is used here to describe a “process to produce health” by creating “an actionable link between needs and resources” (Ardal, Butler, Edwards, & Lawrie, 2006c, p. 2). Health planning generally includes such tasks as defining goals for the health care system, setting out activities and strategies to achieve these aims, and measuring progress on targets (Issel, 2004).

Health care in Canada is funded by a variety of sources, including public funding for physicians and hospitals, and a combination of private and public funding for other services (e.g. drugs, home care, dental care, and eye care) (Stolberg, 2004). On the federal level, the Canada Health Act (CHA) sets out the conditions for which federal funding is provided to the provincial governments, ensuring universal access for “medically necessary” care (Curtis & MacMinn, 2008; Nabalamba & Millar, 2007; Dunlop, Coyte, & McIsaac, 2000; Finkelstein, 2001). The provincial/territorial level has jurisdiction over the administration and delivery of health care services, as guided by the CHA (Government of Canada, 2015). For Ontario, the Ministry of Health and Long-Term Care (MOHLTC) administers the Ontario Health Insurance Plan (OHIP) (Health Canada, 2008) with funding from provincial taxes (Ministry of Health and Long-Term Care, n.d.-b) and federal assistance under the CHA through fiscal transfers (Government of Canada, 2015). The MOHLTC enters into negotiated agreements with each of the LHINs to
receive funding (Ontario Hospital Association, 2009), and this funding is in turn allocated by LHINs to their local health service providers (HSPs) through additional agreements between LHINs and HSPs (Local Health System Integration Act, 2006). The LHINs are required to report to the province on their performance goals, targets, and future plans for spending MOHLTC funding (LHSIA, 2006).

The creation of LHINs benefitted from observing the challenging regionalization processes that occurred in other Canadian provinces before the restructuring of the Ontario health services (see Bickerton, 1999; Gosselin, 1984; Reay & Hinings, 2005; Lewis et al., 2001) by avoiding the loss of community support (Elson, 2009). However, there are many HSPs and organizations reporting to LHINs, as the Ontario regionalization process refrained from consolidating services wherever possible, which has limited their capacity to attain integration goals (Elson, 2009). Moreover, the legislation presiding over LHINs does not provide clear standards on the LHINs’ expected tasks, especially in terms of integration, as noted by Fierlbeck (2011), which may have contributed to the regional variation present in LHIN planning documents (Integrated Health Service Plans or IHSPs). Integration is an important goal for health care reform, as an integrated system is said to be able to service patients’ needs more comprehensively and improve the accessibility of health services (Ardal, Butler, & Edwards, 2006b).

At the same time as regionalization has been undertaken, the population in Ontario has continued to grow and change, in particular becoming increasingly mobile. For example, commuting patterns have experienced rapid change; most significantly auto-driver trips have increased substantially since the mid-1960s in comparison to all other forms of transportation (Miller & Shalaby, 2003). Miller and Shalaby, in their study conducted prior to regionalization, linked the increases in commuting in Ontario to various phenomena, including the considerable population decentralization of southern Ontario (2003). At the time, they reported that 47 percent of Greater Toronto Area (GTA) residents lived in suburban communities surrounding Toronto and Hamilton (Miller & Shalaby, 2003). This trend has continued as between 2006 and 2011, the population in Toronto grew 4.5 percent while the contiguous census divisions of York and Peel grew by 15.7 and 11.8 percent respectively (Statistics Canada, 2012f; Statistics Canada, 2012i; Statistics Canada, 2012d). Overall, the Greater Golden Horseshoe (GGH) is experiencing substantial growth, as Statistics Canada found that, between 2001 and 2006, the population in this region grew by 8.4 percent (as cited in Axisa, Scott, & Newbold, 2012).
Employment has also decentralized to such areas as Peel and York, which has led to increasingly “dispersed and complex” trip patterns in the GTA (Miller & Shalaby, 2003, p. 20). While there is limited literature on population decentralization, residential location, and commuting in Canada (Axisa et al., 2012), the Transportation Tomorrow Survey (TTS) has found that the number of trips for commuting has continued to rise in southern Ontario (for the 20 municipalities studied in the TTS) since the creation of LHINs. Based on the amounts reported in the TTS origin-destination matrices, the trips made by residents of the study area to destinations in the area (i.e. excluding trips made to and from areas external to the TTS area) increased between 2006 and 2011 by over 8 percent (Data Management Group, n.d-a, p. 5 & 9). In addition, the number of trips to Peel and York to get to work in the morning increased by over 6 and 9 percent respectively, while the average growth was less than 4 percent (excluding trips to Toronto) (DMG, n.d-a, p. 8 & 12). Suburbanization further affects commuting rates, in that building suburbs farther away from cities leads to increases in automobile-dependency, thereby allowing individuals to move to residences even farther from their workplace (Axisa et al., 2012). In addition to commuting patterns, the population of areas considered to be in “cottage country” (i.e. within a three-hour drive of the GTA) is increasing due to the pull of seasonal activities, a retiring and aging population, and an increase in multiple residency in the province (Bourne, Bunce, Taylor, Luka, & Maurer, 2003).

In the tradition of health geography, health is linked to where individuals are born, live, and work (Dummer, 2008). In other words, the spatial location and geographical context of places directly affects health experiences and risks, and are related to the services individuals are able to access (Dummer, 2008). Further, the complex contextual effects of place and space can be used to examine processes and provide explanations of health variation (Curtis & Jones, 1998). The most influential literature from this field of study has focused on social class and the spatial context, as in the argument made by Macintyre, Maciver, and Sooman (1993) related to the areas in their study: “physical and social environments in our more middle class area might be systematically better than those in the more working class area, in ways which might promote the physical and mental health of residents of the former” (Macintyre et al., 1993, p. 229). Health geography typically argues against “placeless” study of health and health planning, or the lack of consideration of spatiality and the local (Jones & Moon, 1993). Some work in this field hypothesizes specific pathways by which context may affect human health; for example
Macintyre, Ellaway, and Cummins (2002) suggest that the availability of public transit in an area can be considered a characteristic in understanding the interplay between supply and demand for services. In other words, health geography demonstrates that place and space affect health status and access, and, in following this literature, factors such as increases in commuting, mobility, and population can be considered parts of this geographical context to Ontario that should be included in studies of health.

However, there is literature that is more specifically related to the increases in mobility; for example, the relationship between health status and commuting has been studied. Some of the reported impacts of commuting include the increased risk of traffic accidents, respiratory and cardiovascular disease due to air pollution, and reduced time available for behaviours promoting health, including regular doctor’s visits, sleep, physical exercise, and healthy eating (Lyons & Chatterjee, 2008). Lyons and Chatterjee (2008) argue that the health impacts of commuting will be more serious as time spent commuting increases. Additionally, Frumkin, Frank, and Jackson (2004) argue that urban sprawl has ramifications for human health and that land use (referring specifically to sprawling suburbs versus dense urban areas) is important to human well-being. People living in sprawling areas must drive, which they explain contributes to air pollution and traffic accidents, and limits opportunities for physical activity and activities promoting mental health, all of which negatively impact human health (Frumkin et al., 2004).

This literature considers commuting as a health behaviour in determining health status, but there remains a gap in understanding how mobile populations, or those who regularly or routinely travel, access health care. While there has been extensive study of health care access in Canada, it has primarily focused on individual or demographic aspects to health care access (e.g. level of income) rather than geographical “system barriers” (Wellstood, Wilson, & Eyles, 2006). The term “system barriers” has been used to describe the impact of the health care system’s structure or organization of services on access, or, more specifically, the constraints of the health care system that can impede the use or delivery of services (Wellstood et al., 2006; Mandelblatt et al., 2000). Focusing solely on such factors as income does not consider the importance of place or the challenges that the health care system itself presents for patients navigating the system, such as wait times and hours of operation (Wellstood et al., 2006). Rosenberg and Hanlon (1996) describe the broader study of health care access as examining the “health service environment”, which includes whether an individual lives in an urban or rural area as well as the population
density and the availability of service providers in the area. This work on exploring system barriers further advances the consideration of geographical context in studying health care access. Additionally, some of the system barriers identified in the literature appear to be related to mobility, such as securing transportation to services and scheduling appointments within regular office hours, although they have not been grouped in this way previously.

Moreover, the restructured health care system itself is an additional aspect of the broader context to accessing health care services in southern Ontario to mobility and geography. Aday and Andersen’s (1974) influential framework for understanding access from the broader context of the health care system demonstrates the influence of such features of the health care system as its structure, resources, and policies on financing and organization. They explain that a study of access “may be conceptualized as proceeding from health policy objectives through the characteristics of the health care system (…)” (p. 211), in particular suggesting health policy as a starting point for the “consideration of the access concept” (p. 212) (Aday & Anderson, 1974).

Aday and Andersen’s (1974) framework can be used to extend the concept of “system barriers” to encompass the broader health care system and the trip patterns of the highly mobile population in southern Ontario. This study has contributed to addressing the gap in the literature on understanding access and mobility, but through the lens of the regionalized health care system. The local authorities of Ontario health care, LHINs, oversee both the regional and local levels, and thus have insight vital to this research undertaking on both the health care system and the level of access residents experience in their jurisdictions. Therefore, this study explores how these health decision makers in a regionalized system plan for a mobile population and how they understand the health care access mobile populations receive. The objectives of this research are to:

i. Review the Canadian health care system legislation presiding over the provision of health care, particularly for mobile populations;

ii. Investigate how key informants within the health care system characterize regional health care access by mobile populations;
iii. Document the factors or barriers key informants identify for mobile populations in accessing health services and how health care access for mobile populations is addressed by the regionalized health care system; and

iv. Interpret the key informants’ understandings of access and mobility through the related literature and legislation.

In this study, I used the term “mobile populations” to refer generally to people travelling within and between health regions in Ontario. The kinds of mobile populations the study focuses on are commuters and seasonal residents. This research is important to the field of geography because it simultaneously explores health care access for a particular population (i.e. mobile residents of southern Ontario) as well as the context of the broader regional health care system and policy. Further, the need for such research lies in the increasing amount and complexity of travel in southern Ontario. This research also contributes to the case for considering system barriers in the research on health care access and in health planning.

1.2 Outline

The second chapter of this thesis outlines two major literatures. The first part describes what regionalization is and provides a brief history on the regionalization process in Canada before Ontario’s restructuring. This sets out the context for the later discussion on the creation of LHINs to understand Ontario’s regionalization process as a reaction to the challenges faced in other parts of the country. The Canadian context on regionalization therefore provides background information on the structure of the health care system concerning the provision of care for mobile populations. In the second part of this chapter, the dominant and most relevant literature on access to health care in Canada, with a focus on mobility, is reviewed. The conceptions of access and health care barriers that exist in the literature will be explained to provide information on essential ideas to the chapters that follow, particularly in understanding the qualitative data on access by mobile populations. These concepts will be used in identifying geography and mobility factors and barriers to access raised by the participants and in understanding how they portray access for the mobile population.
Following this, the third chapter is a description of the research methods of the study. I gathered the perspectives of individuals working in health care organizations in southern Ontario through qualitative, semi-structured interviews. As qualitative research methods focus on seeing the research topic from the perspective of the interviewee and to understand why they have this perspective (King, 1994), these methods will be useful in identification and description (Miller & Crabtree, 1999a) of how access for mobile populations is addressed by the health care system and the barriers or factors for access that exist. This study also uses secondary research on health care legislation, policy, and documentation created by health care organizations to position and understand the context of statements from the participants on access for mobile populations.

The secondary research is the focus of the fourth chapter, which explains the regionalization process leading to the creation of LHINs, the legislation on the role of LHINs, and the structure of the Ontario health care system. It is important to clarify the structure of the health care system and the relationship between health care access and planning to determine where structural barriers may exist in providing care to mobile populations. Reviewing this secondary literature and legislation brought forward concerns regarding the regional focus in planning and the funding formulas.

The fifth chapter contains the results of the interviews with the participants. The results section is organized into the major themes from the data, and documents the barriers and factors to health care access for mobile populations and how their access is planned for. While many of the research questions in the interviews concerned commuting and seasonal travel, the participants did not present these as major challenges to health care access in southern Ontario, instead calling attention to other factors of mobility.

I discuss the data from the interviews and the secondary research in the sixth chapter. The discussion is focused on two tasks: 1) interpreting why the participants may have presented the perspectives on access for mobile populations shown in the results, including inferences about the variation in these points of view, using the literature on access and barriers; and 2) exploring how the perceptions of the participants are different from the literature or what gaps in the literature are elucidated through the interview data. I also identify some limitations of the data collected and the study.
Finally, the seventh chapter contains the conclusions from the interview data and secondary research. This section explores the interview data, collected in patterns, to draw conclusions on 1) how health decision makers plan for the mobile population; 2) what barriers and factors to health care access have been identified by the participants and in reviewing the legislation; and 3) where future research could expand on these findings.
Chapter 2
Literature Review

2.1 Introduction

There are two literatures that this study draws upon, which have been summarized in separate sections of this chapter: the regionalization of the Canadian health care system and access to health care services. **2.2 Regionalization in Canada** starts by outlining the major pieces of federal legislation on health care. I continue on to describe the dominant Canadian conceptualization of regionalization, the reasoning for the reforms, and the challenges in its implementation in Canada, aside from Ontario. This is intended to provide context to the eventual discussion of Ontario regionalization, as the participants of this study are members of the organizations that were created during the regionalization process. The goals of **2.3 Access to Health Care** are to introduce the dominant understandings of access in the literature and the different system barriers related to access and mobility in Canada and Ontario. The discussion of the former is intended to briefly describe the greater body of research that the more relevant, geography-based literature branches off from.

2.2 Regionalization in Canada

2.2.1 Federal Responsibilities and Legislation in Health Care

The majority of legislation relevant to health service provision in Ontario is provincial, including the *Local Health System Integration Act* (LHSIA), the *Public Hospitals Act*, the *Excellent Care for All Act*, and the *Broader Public Sector Accountability Act*, rather than federal (Hawkins, Pessione, Lawson, & Lovren, 2013b). The federal role of the health care system will be briefly explained to provide a background on the more pertinent aspects of the structure of the health care system to this study.

The major pieces of federal legislation affecting health service provision include the *Canada Health Act* (CHA), and the *Food and Drugs Act* (Hawkins et al., 2013b). The federal government is also responsible for delivering care to specific populations, such as First Nations and “providing other health-related functions such as public health and health protection programs and research” (Government of Canada, 2005). While all of these pieces of legislation are part of
the structure of the health care system, the CHA is the most relevant for this research because it
guides the provincial level (i.e. the MOHLTC), which, in turn, has authority over the regional
level (i.e. the LHINs) (Hawkins et al., 2013c). Thus, the remainder of the thesis will largely refer
to the CHA rather than other federal legislation.

In 1984, the *Medical Care Act* and the *Hospital Insurance and Diagnostic Services Act* were
replaced by the CHA, which enumerated five principles that have come to define the Canadian
health care system: public administration, universality, accessibility, portability, and
comprehensiveness (Stolberg, 2004). Provinces must meet the five pillars of health care to
receive federal health system funding under the CHA (Hawkins et al., 2013c). A mix of funding
systems is used in the Canadian health system, including largely public funding for physicians
and hospitals, and a combination of private and public funding for services such as drugs, home
care, dental care, and eye care as well as delivery and administration (Stolberg, 2004).

Efforts to overcome financial barriers to health care services utilization have been historically
significant for Canada, with the implementation of hospital insurance in 1958 and medical
insurance in 1968 (Dunlop et al., 2000). All ‘medically necessary’ health care has been covered
since 1972, which was reinforced with the CHA (Curtis & MacMinn, 2008). The CHA mandates
the universal right to publicly funded insurance for ‘medically necessary’ care, with the goal of
ensuring equitable access for all Canadian citizens, and preventing discrimination based on
income, age, or health status (Curtis & MacMinn, 2008; Nabalamba & Millar, 2007; Dunlop et
al., 2000; Finkelstein, 2001). As stated in the CHA:

> It is hereby declared that the primary objective of Canadian health care policy is to protect,
> promote and restore the physical and mental well-being of residents of Canada and to
> facilitate reasonable access to health services without financial or other barriers. (CHA,
> 1985, c. 6, s. 3).

Here it is important to note the language of this section of the CHA, particularly the emphasis of
“financial or other barriers” (CHA, 1985, c. 6, s. 3), for its implications to the provision of health
care to Canadians. Asada and Kephart (2007) call the Canadian universal health care system,
“one of the most ambitious with public financing for all physician and hospital services deemed
medically necessary with no payment at the point of service” (Asada & Kephart, 2007, p. 1).
However, while the CHA outlines its objectives and the means to the goal, the terms ‘reasonable’ and ‘access’ are not defined in Canadian legislature (Birch & Abelson, 1993; Wellstood et al., 2006; Eyles, Birch, & Newbold, 1995; Birch, Eyles, & Newbold, 1993). Wilson and Rosenberg (2002) state that this concept has not been entirely undefined however, as Health Canada has identified economic and physical reasonable access. The idea of ‘medical necessity’ has also been referred to as a major determinant of ‘reasonable access’ (Eyles et al., 1995) although ‘medical necessity’ has historically been the subject of much debate and has similarly remained largely undefined in federal policy and legislation (Charles, Lomas, Giacomini, Bhatia, & Vincent, 1997). Charles et al. (1997) discovered a number of prominent meanings of “medical necessity” in studying federal policy and legislative review, ranging between the provision of services that is scientifically justified and the maximum services that taxpayers can afford (see more definitions in Charles et al., 1997).

It can be inferred from this review of the federal legislation and literature that the delineations of “reasonable” levels of care to be granted to an individual are somewhat vague. As the provincial level is guided by the CHA, this is in turn relevant to this study in understanding the provincial and regional approach for health care access for mobile populations. Further implications and impacts to access for mobile populations are discussed in 2.3.3 System Barriers to Health Care Access.

2.2.2 The Conceptions and Goals of Regionalization in Health Care

Regionalization is described by Williamson, Milligan, Kwan, Frankisk, & Ratner (2003) as, “the devolution of responsibility for both policy and program decisions and service provision from provincial/territorial health ministries to health regions” (p. 177), and was the most prominent governance reform in health during the 1990s (Fierlbeck, 2011). Generally, the process of regionalization has entailed provincial governments devolving power to geographically-based regional health authorities (RHAs) within each province, and consolidating the power of previous and numerous local boards for health care promotion (Lewis & Kouri, 2004; Naylor, 1999). Although health regions, governance systems, and the arrangement of services to include in restructuring are not consistent between the provinces, Lewis & Kouri (2004) identify four main features of Canadian regionalization: 1) the regions occupy a specific geography; 2) the
organizations exist and have authority at the pleasure of the provincial government, as they are not self-defined entities; 3) the organizations consolidate the authority of previous programs (Lewis & Kouri, 2004); and 4) according to the Canadian Centre for Analysis of Regionalization and Health, the organizations are responsible for a range of health services, such as community-based care, long-term care, acute care services, mental health and addictions, public health, and health promotion (as cited in Lewis & Kouri, 2004).

Lewis and Kouri (2004) refer to two axes of regionalization. First, there is the continuum of authority which ranges from devolution to consolidation of power (Lewis & Kouri, 2004). The other is the continuum of centralization versus decentralization of services, specifically referring to the location or the organization of services (Lewis & Kouri, 2004). These two axes are used to generalize the process of regionalization that occurred across the country, in that provincial governments devolved authority to regional organizations which in turn consolidated the power of local boards (Lewis & Kouri, 2004; Fierlbeck, 2011). By contrast, Gosselin (1984) argues that regionalization does not necessarily entail decentralization; however, this argument is largely not supported in the majority of the literature. For example, Naylor (1999) writes that, “Regionalization invariably involves a combination of decentralization and centralization” (Naylor, 1999, p. 13-14). In summary, the services provided by the provinces underwent these processes of devolution, consolidation, centralization, and decentralization to different degrees. Distinguishing between these concepts can be used to clearly discern the processes that occurred in each province, elucidating the varied experiences in the country. Later chapters (see Chapter 4 and 6.2.1 The Limitations of Regional Structures) will draw on these terms to better understand the degree that each of these phenomena occurred in Ontario and to provide further detail on the provincial structure of the health care system.

Regionalization has been promoted in Canada through a variety of processes and approaches, but the justifications for regionalization have almost always been related to the goal of cost-cutting (Lewis et al., 2001). The restructuring of responsibilities took place in a setting of great fiscal change across the country in the 1990s (Naylor, 1999). However, the highly centralized social welfare system was criticized even earlier, during the 1980s, as it was deemed inflexible, economically inefficient, and ineffective in providing services (Fierlbeck, 2011). Internationally, this ideology was promoted by supporters of the ‘new right’ in Western nations, with the goal of rolling back the welfare state (Fierlbeck, 2011). “New public management” (NPM) came from
this movement, and had the broad goals of cost control and individual empowerment for those receiving and providing services (Fierlbeck, 2011). In Canada, many characteristics of NPM were implemented at the provincial level from the late 1980s to the early 2000s, and regionalization emerged from the idea that centralized control over service delivery was unresponsive and inefficient (Fierlbeck, 2011).

At the same time, federal support for health, postsecondary education, and social services have declined (Naylor, 1999). By moving toward regionalized health governance in the 1990s, the burden of coping with fiscal restraints was intended to be decentralized (Naylor, 1999). As a result, all provinces saw a shift towards regionalization in health care. Regionalization was almost universally recommended by provincial commissions and task forces for health care reform in the 1980s with several common goals in mind, including improving citizen participation, economic efficiency, and accountability (Williamson et al., 2003; Lewis & Kouri, 2004). A main concern from the perspective of the provinces was the atomization of the Canadian system, as provincial health care systems prior to regionalization were considered to have an excessive number of local health boards (Lewis & Kouri, 2004). For example, the Saskatchewan system had 435 health boards for a population of one million, which was a convoluted structure for the public and difficult to coordinate (Lewis & Kouri, 2004). Thus, regionalization was proposed to consolidate the authority to reduce the fragmentation of the system (Lewis & Kouri, 2004).

There have been additional justifications for regionalization. Lewis and Kouri (2004) outline two categories of the goals for regionalization across the country: those focusing on increasing effectiveness and efficiency (including aligning needs and resources and integrating services) and those responding to demands for accountability and public input (such as public participation procedures). Gosselin (1984) speaks to the latter, stating that government officials and health care managers in Quebec “stressed the need to make health care delivery more responsible to local needs and health care resources more effective in fulfilling those needs.” (p. 7). Moreover, Fierlbeck (2011) argues that there were problems with the health service delivery model granting all decision-making authority to health care providers: 1) it was too expensive with the rising cost of treatment; 2) transfers between various levels or kinds of care were poorly coordinated and there was little communication between different fields of care; and 3) the system was ‘one-sided’ in that the ‘information asymmetry’ did not allow for patients to have autonomous
activity. In summary, regionalization in Canada has been commonly justified as a way to cut costs and promote efficiency and accountability to local needs. Such a description of the provincial governments’ reasoning for regionalization is useful in providing context to the structure and goals of the Ontario health care system. The reported difficulties in managing a fragmented system are particularly noteworthy.

### 2.2.3 Challenges to Regionalization Processes and Outcomes

There have been challenges both to the logic behind the regionalization and the practical implementation. In both Nova Scotia and Quebec, commissions and councils recommended many reforms that would promote regionalization, but their respective governments initially resisted the degree of decentralization proposed and rejected the reforms when they were published (Bickerton, 1999; Gosselin, 1984). For Nova Scotia, such reforms on “regionalization and greater public involvement were too much for the government of the day” and were not put into place until a change of government (Bickerton, 1999, p. 170). Similarly, the original regional authorities that were created in Quebec were essentially powerless in comparison to the recommendations from the commission, and later regionalization efforts were measured (Gosselin, 1984). Alberta’s experience has been consistently described as a “battle”; the province’s 200 hospitals, nursing homes, and public health boards were restructured between 1993 and 1994, resulting in a governance system of 17 RHAs (Reay & Hinings, 2005). Health care restructuring in Saskatchewan led to low public confidence in the system, and, despite having a unique voting process to select the majority of RHA members, there was low voter turnout for elections (Lewis et al., 2001). It was also found there was little difference in the views of elected versus appointed members (Lewis et al., 2001). These examples have been provided to demonstrate the kinds of challenges the Ontario administrative restructuring attempted to avoid, and to help understand the Ontario process as a reaction to regionalization in the rest of the country.

In general, there has been a great deal of criticism of the implementation of regionalization (Fierlbeck, 2011). Lewis & Kouri (2004) describe the Canadian experience as wrought with instability – as mentioned in 2.2.2 The Conceptions and Goals of Regionalization in Health Care, there is no common definition of a health region, uniform understanding of services to
regionalize, or consensus on governance (Lewis & Kouri, 2004). There are many factors that have likely contributed to the instability of RHAs, including the turbulent economic setting they were created in, the frequent changes in methods for selecting board members, changing region sizes and boundaries, and ad hoc reporting (Lewis & Kouri, 2004). Further, many local organizations were eliminated in consolidating power to form RHAs, which reduced the sense of ownership over local services, thus changing citizens’ role in the health care system and, at times, leading to resentment (Lewis & Kouri, 2004; Fierlbeck, 2011).

RHAs are consistently portrayed in Lewis and Kouri (2004) as organizations that are more limited in their authority than they appear. For example, RHAs do not have exclusive authority over services and commonly must enter in agreements with various boards, including non-profits, for-profits and religiously-owned entities (Lewis & Kouri, 2004). The agreements limit the consolidation of services, especially for programs or facilities with strong public support, and these preferences may conflict with public interest and the mandates of RHAs (Lewis & Kouri, 2004). This lack of authority is put into greater relief when considering the tremendous goals that were set out for regionalization. Fierlbeck calls these goals “optimistic”, “ill-conceived” and “contradictory” although she concedes that regionalization may have been implemented so widely across the country in the first place because of the variety of benefits it seemed to have:

(...) those on the left saw it as a means of establishing a system of citizen empowerment; those on the right saw organizational rationalization as a means of achieving economic efficiency; health promotion advocates saw it as a way of shifting a medical model of health care to one supporting preventive health care; governments saw it as a means of deflecting direct accountability for cutbacks, and so on. Many of these objectives were blatantly contradictory, and some of them were simply not feasible given the complexity of modern health care provision. (Fierlbeck, 2011, p. 73).

Fierlbeck (2011) argues that this is the most important fault of regionalization – the failure to meet its expectations, although the relative strengths and limitations of the ideas and implementation of regionalization have become clearer over time (Fierlbeck, 2011). Fierlbeck (2011) characterizes the results of regionalization as “mixed”, finding that, among other things, the administrative reorganization was insufficient to achieve major health promotion goals as it was limited by “a range of political, economic, cultural and institutional barriers” (p. 83). While regionalization did not reach the lofty goals set out for it, Fierlbeck (2011) states that regionalization has been more successful in reducing fragmentation in the system (i.e. reducing duplication and coordinating programs across sectors) which has been able to better “connect
resources to needs” (p. 83). Further, she suggests that regionalization in much of the country has not been integrative enough (Fierlbeck, 2011). Therefore, it is no surprise that integration was a main focus in the process of regionalizing the Ontario health care system, as will be discussed in 4.1 Establishing LHINs.

2.2.4 Conclusion

The literature presented in this section suggests that regionalization has historically involved varying levels of devolution, consolidation, centralization and decentralization of health services. The experiences with regionalization of health care vary across the country but there were two noteworthy challenges: 1) there were numerous, ambitious, but ultimately impractical goals for regionalization, and the resulting organizations had less authority than originally intended, and; 2) the implementation processes of regionalization were fraught with challenges and led to less local ownership of health services and some level of resentment of new RHAs. However, the integration efforts of regionalization are considered somewhat successful in promoting efficiency. This study will return to these key points to show the similarities and differences between the regionalization processes that occurred in Ontario versus the other provinces (see 4.1 Establishing LHINs). This comparison will explore the weaknesses and strengths of LHINs, especially in addressing and planning for mobile populations.

2.3 Access to Health Care

2.3.1 Frameworks Defining Factors of Access

While the first section of the literature review provided context for the health care system to be studied, this sub-section on health care access in Canada will first outline the conceptualizations of access to establish what “access” means in the literature. I will draw on these conceptions of access in discussing the interviews, particularly for identifying the factors for mobile populations accessing the health care system.

The term “access” has been used to refer to many aspects of health care in the literature, such as characteristics of the population or the delivery system, and outcome indicators (e.g. utilization
rates and patient satisfaction scores) (Aday & Andersen, 1974). Given that there are various definitions of “access” in the literature, universally distinguishing this concept from “utilization” is difficult. Utilization of health services is generally thought to be related to access to some degree and is often used as a measurement of access, as seen below (similar to Aday & Andersen, 1974). Aday and Andersen (1974) define “access” in terms of utilization of services by the intended populations, or, in other words, consider the context of utilization in understanding access. Throughout this thesis, I will be using “utilization” to refer to an aspect of access rather than equating utilization with access.

Identifying determinants of access has been an important focus of health research in Canada as well as internationally (Wellstood et al., 2006). Many studies use Andersen’s model of health services use, which was first developed in 1968 and revisited in 1995, to examine the individual relationship between health care need and use of services (Nabalamba and Millar, 2007; Litaker, Koroukian, & Love, 2005; Brown et al., 2004, Wu, Penning, & Schimmele, 2005). While the ‘individual model’ is used extensively in the access literature referred to in 2.3.2 Common Themes in Canadian Access Research, the conceptualization of access described by Aday and Andersen (1974) is more useful for this study. This framework (summarized in Table 1) has been influential in understanding and operationalizing health care access in the broader context of the health care system and has been used in this study for the purpose of considering the regionalized health care system as an aspect of access for mobile populations.

Health planners and policy makers are concerned with evaluating health policy because of its capability to alter access to medical care, regarding the types of policy outlined in Table 1, and may be considered a starting point for studying access (Aday & Anderson, 1974). “Characteristics of the health care system” in this framework refers to the resources and organization of the system to provide services while the “characteristics of the populations at risk” are the various components of an individual’s circumstances that determine utilization (Aday & Anderson, 1974). Finally, “consumer satisfaction” reflects the attitudes towards the system which are relevant to perceptions of access (Aday & Anderson, 1974).
Table 1: Factors of the Health Care System to Studying Access

<table>
<thead>
<tr>
<th>Characteristics of the Health Care System</th>
<th>Components of Characteristics Measured/Studied</th>
</tr>
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| **Health policy**                        | • The political context and programs (also reorganization programs) on concerning:  
|                                          |   ○ Financing,                                |
|                                          |   ○ Education,                                |
|                                          |   ○ Resources,                                |
|                                          |   ○ Organization.                             |
| **Characteristics of the health delivery system** | • The volume and distribution of resources, including health personnel, structures for providing services and education, and equipment/materials to provide services.  
|                                          |   ○ Organization in terms the process to gain entry to health care system and structure of the system in terms of navigating care. |
| **Characteristics of populations at risk** | • Predisposing variables to use services (e.g. age, sex, race, and religion).  
|                                          |   ○ Enabling factors, or the “means” for individuals to be able to use services (e.g. income, insurance, living in a rural/urban area).  
|                                          |   ○ Level of need for services (either perceived or evaluated need).  
| **Utilization of health services**        | • Type of service provided and who provided it (e.g. a physician or dentist).  
|                                          |   ○ Site where the services were received (e.g. a physician’s office or the emergency room)  
|                                          |   ○ Purpose of visit, including preventive, illness-related, or custodial care;  
|                                          |   ○ Time interval of visits, measured in terms of contact (an individual has entered the system), volume (the number of revisits), and continuity (the coordination between services in a given period of time).  
| **Patient satisfaction with services**     | • Subjective perceptions on care received based on:  
|                                          |   ○ Convenience, cost of care, and coordination of services,  
|                                          |   ○ Courtesy of providers,  
|                                          |   ○ Information provided to the patient on their condition,  
|                                          |   ○ The perceived quality of care received.  

*Note. Data adapted from Aday & Anderson, (1974).*

These characteristics of the health system and their components are interrelated; for instance, changes in health policy may directly affect characteristics of the delivery system, such as the supply of physicians in an area, which may in turn affect utilization patterns and consumer satisfaction (Aday & Anderson, 1974). Some have questioned aspects of the model, arguing that reducing service use to broad categories may obscure mediating factors (see Birch et al., 1993). However, these broad categories still provide a useful framework for considering the health care system context and how aspects of the system can affect access for this study. In addition to this, the model has been generally used for broad health care studies to guide quantitative research methods (see Law et al., 2005), although this study is not the first to use it for qualitative work (Condelius & Andersson, 2015). For example, Lin et al. (2015) used the model to identify barriers to accessing health services for African migrants in Guangzhou, China. In addition to
this, Condelius and Andersson (2015) explored access for older people from the perspective of their next of kin, and suggested that the Andersen and Aday model include both formal and informal care in the concept of the access, as caregivers are important in providing and enabling care. Ell et al. (2008) developed an initial coding scheme based on, among others, the Aday and Andersen model, to better understand the quality of life for low-income minority cancer survivors in California. As will be demonstrated later in this chapter, place-based factors and aspects of mobility have been considered in the literature before, but this study focuses on mobile populations moving within and between jurisdictional lines in the health care system, thereby extending the Aday and Andersen model to consider issues related to mobility and access.

The literature also provides ways of conceptualizing access for providers of the health care system in considering access for patients. The work by Mol (2008) discusses two types of belief systems on choice for patients using services, and, while she focuses on chronic conditions in her examples, the bulk of her argument aids in understanding two differing perspectives on choice in treatment. Thus, her consideration of patient choice can be abstracted to better understand the provision of services from the perspective of the health care system, which is key in the approach taken by this study, given its focus on the perspectives of those working in the health system.

One logic system Mol (2008) describes is the “logic of choice”, which is the common belief that individuals must be protected from being treated as passive objects in health care systems. Agency must be preserved so all individuals have equal opportunities to make their own choices (Mol, 2008). Further, others should avoid judgement on treatments, products, or goals, as individuals are free to answer such questions themselves (Mol, 2008). However, Mol (2008) is a proponent of the second logic system on patient choice – the “logic of care” – which promotes viewing care as practically as possible and emphasizes delivering the best care possible, even over providing the opportunity for patients to have choice in their treatment. The logic of care focuses on practical activities in living the best life possible with illness, as explained in the following:

What you want is obviously relevant, but it is not decisive. For what you want most of all is not to have diabetes. But you do. Wishing your diabetes away does not help you live with it. All kinds of other social and material practices that you are involved in rarely fit your wishes either. To some extent they may be changed, but where, and how? To find this out is a practical task, one that is experimental. (Mol, 2008, p. 75).
In summary, this sub-section suggests a number of important factors for studying access. The dichotomy in thought on patient choice is important to better understand the perspective of health care providers in their conceptions of important factors to access. More generally, Aday and Andersen (1974) outlines a number of characteristics of the health care system this study has considered in conducting the research, including health policy, the volume and organization of resources, the utilization of services, patient satisfaction, and factors of the individual and their circumstances in health care access. The latter aspect of the framework will be expanded on in the next sub-section, as demographics are a major focus of the study of health care access in Canada.

2.3.2 Common Themes in Canadian Access Research

Allocating services in line with need for care has been presented as a central way to ensure efficient, effective, and equitable delivery of services within a publicly funded system (Wellstood et al., 2006). As a result, providing care based on need is a priority for the health care system under the CHA (Wellstood et al., 2006). In addition to this, examining the health care system for inequalities in health care access has become an important research issue, particularly the relationship between socioeconomic and demographic characteristics and health care utilization (Curtis & MacMinn, 2008). Examples of this literature have been summarized below to reflect the breadth of this body of work in the Canadian understanding of access. The remainder of this section of the literature review shifts then to focus on those aspects of access that are more geographically-based.

A number of studies have found that there is a relationship between socioeconomic status (SES) and health care utilization in Canada, which conclude that the ways patients use services is related to various indicators of SES and suggest factors such as income and level of education may be barriers in accessing health care (Asada & Kephart, 2007; Curtis & MacMinn, 2008; Nabalamba & Millar, 2007; Dunlop et al., 2000). An example of this is Curtis and MacMinn (2008), as the results of their study showed that those with lower SES tend to utilize fewer physician services and are hospitalized more frequently and for longer periods of time, particularly after the mid-1990s federal and provincial health care budget cuts (Curtis & MacMinn, 2008). In addition, Nabalamba and Millar (2007), found that: 1) the relationship
between income and General Practitioner (GP) consultations persisted for those ages 18-64 and increased for seniors after controlling for other factors such as need, and 2) high income and upper-middle income households reported significantly more consultations with specialists than middle income households (Nabalamba & Millar, 2007). These results are consistent with Rosenberg and Hanlon (1996), who also observed a positive relationship between GP and specialist services utilization and income, as well as an inverse relationship between income and using emergency services and admissions to hospitals (Rosenberg & Hanlon, 1996). Further to this, education and SES have also been related to the probability of seeking out physician and specialist services (see Curtis & MacMinn, 2008; Dunlop et al., 2000; Birch et al., 1993).

Not all studies entirely support these widely accepted relationships. Asada and Kephart (2007) did not find relationships between SES and the volume or frequency of use of specialist services or between hospital contact and level of education (Asada & Kephart, 2007). Further, Finkelstein (2001) explored access to care according to income using administrative data from OHIP and individual-level data from the National Population Health Survey (NPHS), and found that, while expenditures on physician services were explained by health status, they were not based on household income (Finkelstein, 2001). Finkelstein (2001) distinguished his study from others because of his use of administrative data on utilization rather than self-reported health, which he argues is unreliable. As illustrated, there is great variety in the results of this type of health care access research, despite attracting the majority of Canadian research attention, some of which appears to be related to different methodological approaches.

Other aspects of accessing the health care system and individual factors have also been studied in the literature. Having a regular source of health care is an additional indicator of access to health services because it reveals the ease of entry into the health care system, also called an individual’s ‘potential access’ (Litaker et al., 2005) (also see Talbot, Fuller-Thomson, Tudiver, Habib, & McIsaac, 2001; and Dunlop et al., 2000). Additional demographic factors to SES have been studied, the most prominent being age and gender, as women and individuals older than 65 have been found to be more likely to use health services (Nabalamba & Millar, 2007; Talbot et al., 2001; Wellstood et al., 2006; Rosenberg & Hanlon, 1996). However, this should not necessarily be equated with better access, especially for women, who may experience lower levels of access due to greater demands placed on their time with employment and domestic responsibilities (Wellstood et al., 2006). In addition to this, there has been extensive research on
health care access for immigrants to understand any challenges they face in Canada, although this is not specifically relevant to this study (see Stewart et al., 2006; Wu et al., 2005; Quan et al., 2006; Lai & Chau, 2007). Nonetheless, the Canadian research on access generally concludes that there are multiple factors for individuals that may be predictors of access to health services, including SES, age, gender, and immigrant status, which suggests that there are limitations to the degree that all Canadians have “equal access”. While the literature summarized here highlights general contours of the current research on access in the Canadian health system, in the following section, I narrow in on literature that has built on these debates, oriented to the more geographical and context-based work.

2.3.3 System Barriers to Health Care Access

Despite the extensive literature on understanding health care access, some researchers argue that there is little attention to non-income barriers in the literature and legislation, which omits the work that examines system barriers to health care (Wellstood et al., 2006; Birch et al., 1993). Research on system barriers endeavours to identify aspects of the health care system that may impact an individual’s use of services. For example, Mandelblatt et al. (2000) focused on cancer services, stating that “[b]eyond specific patient or physician factors, system attributes can either facilitate or hinder obtaining needed care for cancer services” and the “[p]otential system barriers include organizational and structural factors, reimbursement and financial forces, quality measurement, and regional resources.” (p. 2383).

In comparison to SES, less known about the role of place and system barriers, including wait times, geographic location, and hours of operation (Wellstood et al., 2006), all of which are related to the mobility of people and geography of where either patients live or services are located. Wellstood et al. (2006) found that system-related factors were the most prominent barriers in accessing primary care within two socially contrasting neighbourhoods in Hamilton, Ontario. The most common barriers raised in their study were waiting times, followed by geographic distance to doctors’ offices, and women appeared to experience more system and individual barriers to access than men (Wellstood et al., 2006). Further to this, Rosenberg and Hanlon (1996) refer to non-income barriers more generally as those that define the “health service environment” that individuals seek care within, such as the consideration of living in a
rural/urban area and the local population density and availability of providers and services. Given their results, they suggested that, as the population is more dispersed and rural, physician services are limited and the use of emergency services and hospital admissions are likely to increase (Rosenberg & Hanlon, 1996). They conclude that utilization must be viewed in a framework incorporating an individual’s health and their health service environment in addition to SES (Rosenberg & Hanlon, 1996).

The lack of attention to system barriers has its roots in federal legislature. It is clear that the underlying sentiment of the “accessibility” in the CHA is to ensure access to “medically necessary” services for all Canadians regardless of ability to pay (Wilson & Rosenberg, 2002). Thus, the CHA implies that removing direct payment or financial barriers for health services translates into accessibility and is a sufficient condition for reasonable access (Wellstood et al., 2006; Birch et al., 1993; Birch & Abelson, 1993). Wellstood et al. (2006) argue that other barriers exist for individuals beyond what is described in the CHA, for example geographic and sociocultural barriers. Further to this, Birch et al. (1993) found that community context and regional patterns were related to utilization in addition to level of education in their study. They argue such findings indicate that there may be “non-income related barriers to reasonable access such as education, social support and region of residence”, and that these are not reflected in the CHA (Birch et al., 1993, p. 99).

Moreover, while the CHA removes direct costs, indirect costs may be significant barriers, as taking time off work without pay and the cost of public transportation are financial burdens that can prevent seeking care (Wellstood et al., 2006). At the individual-level, opportunities to use services are not only affected by the price at the point of delivery but the “opportunity cost to the individual going to, remaining at, and returning from the point of delivery” (Birch & Abelson, 1993, p. 634). Birch and Abelson (1993) maintain that price at the point of delivery is one element of the cost of utilization and that the full cost of care to the user, such as travel times and lost earnings, is not distributed evenly in the population (Birch & Abelson, 1993). Further, reasonable access is consistently interpreted as access according to need for services (Birch & Abelson, 1993). If need is the main factor in deciding access to the system through health planning, opportunity cost and system barriers may not be considered in the process of planning. Moreover, this emphasis on ‘need’ in planning may actually produce structural barriers specific
to mobile populations given the possible opportunity costs to using health services and system barriers to access services linked to mobility and geography.

In summary, this literature suggests that there is a relationship between system barriers and opportunity costs, in that individuals faced with system barriers to accessing services may experience opportunity costs in the process of obtaining care. Given the possible link between access for mobile populations and system barriers, the literature on opportunity costs to accessing services and the implications of “reasonable access”, will be drawn upon later in the thesis. These concepts will be connected to the literature to interpret the barriers raised by health decision makers for mobile populations, and provide insight on their conception of access and mobility.

This study focuses on access in terms of broader social factors, such as system barriers, viewed from the perspective of health decision-makers. While this literature on system barriers lays the groundwork, I will engage with these concepts in the context of geography and mobility affecting access. For the remainder of this section, the existing literature on the main social factors of access relevant to mobility will be reviewed (transportation and the urban-rural divide). The literature presented in the following sub-sections is integral to the purpose of this study as it will be used to recognize the barriers and factors from the interview data. These key points will be expanded on later in the thesis, to be compared with the documented factors of health care access from the interview data and to draw inferences from the literature and the health decision maker’s perspectives concerning access for mobile populations.

2.3.3.1 Transportation to Health Care Services

There has been a growing interest in the study of relationships between health behaviours and measuring spatial accessibility (Salze et al., 2011), and transportation is a key component in facilitating health behaviours. Such research has been considered from various angles, although with a focus on quantitative methods. For example, there have been some studies on access to healthy foods for mobile populations, such as commuters, with the recognition that decisions on food consumption are complex (Widener & Shannon, 2014). The results of such studies in Cincinnati, Ohio, have suggested that commuters may have improved access to healthy foods by
going to supermarkets on the way home from work, rather than close to home, even when using public transit (Widener et al., 2013; Widener et al., 2015). Burgoine and Monsivais (2013) also found that travel for commuting and work may be more important to food-access than just resident neighbourhood alone in the UK. A key theme from this field of work is that accessibility is multi-dimensional and developing studies on accessibility should include aspects of travel behaviour (Salze et al., 2011)

The inability to secure transportation has also been studied, as it has ramifications for residents of both rural and urban areas, and thus constitutes a relevant system barrier in accessing health care to this study. Transportation will be presented in the thesis as an aspect of mobility given its importance to individuals in accessing health care services. Syed, Gerber, and Sharp (2013) speak to this relationship between transportation and health care, particularly chronic diseases as they require reoccurring visits to clinicians and changes to treatment plans to provide appropriate care. Patients with chronic conditions without secure access to transportation may not receive the following aspects of care they need:

…the opportunity for evaluation and treatment of chronic disease states, changes to treatment regimens, escalation or de-escalation of care, and, as a result, delay interventions that may reduce or prevent disease complications. (Syed et al., 2013, p. 989).

Without transportation, delays in receiving these medical interventions can occur, which may lead to lack of proper treatment, unmet health care needs, and exacerbation of existing conditions (Syed et al., 2013). Further, there is the important link between lack of transportation and poverty (Syed et al., 2013). Wallace, Hughes-Cromwick, Mull, and Khasnabis (2005) describe some of the challenges of being “transportation disadvantaged” in the United States, referring to those unable to obtain their own transportation due to such factors as low income, disability, the inability to drive or geographic isolation. This population generally depends on others to go to work, school, stores or health care services and is disproportionately older, poorer, disabled and less educated (Wallace et al., 2005). The dependency on others can result in poor access to routine and non-emergency services, and resulting untreated conditions that later may lead to the need for emergency care (Wallace et al., 2005). In their study of the consequences of transportation disadvantage, Wallace et al. found that transportation disadvantage leads to these individuals having a higher prevalence of all medical conditions examined and greater prevalence of comorbidities (Wallace et al., 2005). While this is an American study, this is a
particularly concerning potential impact of failing to recognize barriers to mobility in obtaining health care.

The distinction between distance to health care services and access to transportation is discussed in the literature as well. Syed et al. (2013) questions the importance of distance in affecting health care access, providing a hypothetical example to illustrate their point:

A patient may live in a wealthy suburb, own several cars, and have no problem accessing health care, even at a distance. Conversely, a seemingly shorter distance for a patient who has to walk or cannot afford public transit may prove to be too far of a distance, and hence be identified as a barrier by the patient. (Syed et al., 2013, p. 989).

Access to a vehicle was consistently associated with increased access to health care even after controlling for SES (Syed et al., 2013). Similarly, Arcury, Preissner, Gesler, and Powers (2005) argue that, without transportation in remote areas, “even a short distance to care can become an insurmountable problem” particularly where the distances are vast, the roads of poor quality and public transportation is not an option (p. 31). They found that for several remote North Carolina counties, the transportation characteristics with the most significant associations with health care utilization were having a driver’s license and having a relative or friend who regularly provides transportation to the respondent of the study, although public transportation was crucial to a small portion of their respondents (Arcury et al., 2005). In summary, access to transportation has been found to be a barrier to health care access in the literature, with additional links to poverty and distance.

2.3.3.2 Urban-Rural Divide in Ability to Access Care

The Canadian health care system has struggled with the urban-rural divide in providing equal access to services for many years (Sibley & Weiner, 2011; Bacsu et al., 2012). Commonly raised attributes of rural areas affecting health care utilization are low population density, isolation, and the large distances between residences and services (Arcury et al., 2005), which have shaped expectations for service coverage in rural areas. For instance, rural areas face particularly challenging issues in lack of transportation to health care services. The need for transportation can be decreased by increasing the number of health care providers in rural areas, but transportation often remains an issue as the distance between residents and providers cannot
logistically be reduced to walking distance in sparsely populated rural areas (Arcury et al., 2005). This phenomena has been referred to as ‘distance decay’ for rural communities, where the use of services decreases with increasing distance to health care facilities (Wong & Regan, 2008).

While the research is not entirely consistent on degree of rural disparities in access (see Goodridge, Lawson, Rennie, & Marciniuk, 2010), inequalities between urban and rural residences may not be evident without careful consideration of place of residence in large scale evaluations (Sibley & Weiner, 2011). Complex factors have been found to affect the use of health services by rural residents in Canada. Wong and Regan (2008) in their study on primary health care perspectives of rural residents in British Columbia, found that health care access for this population depends on a number of aspects, including how seriously they view the need for care, whether they are able to obtain the necessary services in their community, and whether they have the means (such as transportation or financial means) to access services (Wong & Regan, 2008). Sibley and Weiner (2011), in their examination of health need and access between rural and urban residents, discovered that the greatest degree of inequality was found in utilization of specialist physician services, with urban residents being more likely to have visited a specialist than rural residents (Sibley & Weiner, 2011). In addition to this, those residing in the most urban and the most rural areas were reported to be less likely to have a regular doctor (Sibley & Weiner, 2011). Sibley and Weiner argue that for rural residents, this is likely due to fewer physicians residing in the area, whereas, in urban areas, they note a high number of walk-in clinics that are serving the function of regular doctors for some residents (Sibley & Weiner, 2011).

While this literature provides context on possible geographic system barriers to health care access, there are two under-researched aspects of rural and urban areas of particular consideration to this study that are important in understanding the discussion. First, the mobility of individuals depending on the season and how this may relate to health care utilization pertain to the study area. Although there is little research to the possible relationship between seasonal travel and access, senior mobility, including the “snowbird” phenomenon, has been researched. Northcott and Petruik (2011) describes that many elderly Canadians spend up to six months each winter in the Sunbelt of the United States (Florida, Arizona, California, and Texas), some being permanent vacationers who have sold their family homes and spend their time in Canada at the cottage. The considerable amount of research on the possible impact of Canadian snowbirds
generally concludes that these mobile seniors tend to be younger and healthier while making few demands on health and social services in the US (Northcott & Petruik, 2011; Marshall, Longino, Tuker, & Mullins, 1989). These seniors seem to prefer to return to Canada for health care, due to the high cost of using the services in the US, and cease travelling if their health deteriorates, so seniors’ impact on health care systems remains in Canada (Northcott & Petruik, 2011; Marshall et al., 1989).

Secondly, understanding the dynamics specific to urban areas is also important given the locations of the LHIN jurisdictions. While urbanization’s impacts on health have been prominent in the literature historically, studies of modern features of urban areas and aspects of urban living influencing health have been “sparse” (Vlahov & Galea, 2002). However, the conceptualization of urban health in Vlahov and Galea (2002) may be useful in understanding health decision makers’ perceptions of geographical aspects to health care access. These researchers focus on features of urban areas affecting health in two key dimensions for urban health: 1) urbanicity or the impact of living in urban areas; and 2) urbanization or the change in a city’s features (Vlahov & Galea, 2002).

Urbanization includes the establishment or destruction of buildings, neighbourhoods, and transportation routes, as well as population influx, while urbanicity factors are those that are more common to urban areas, such as population density and transportation in general (Vlahov & Galea, 2002). Urbanization would appear to be particularly important in understanding urban health care access in this study, given the current population increase southern Ontario is experiencing. As an example of the impacts of urbanization on health, Vlahov & Galea (2002) suggested that population increase may overburden the infrastructure of a city (including transportation, housing, jobs and health care), which can further lead to spreading disease and straining available jobs.

In summary, the literature has demonstrated a number of important characteristics of urban and rural areas affecting health care access. First, the distance between rural residences and health facilities can be difficult to overcome in attempting to access health care. Second, there is a disparity in utilization between rural and urban areas, in that rural residents generally use services less often than urban residents. Finally, there are certain features of cities that affect health care access for urban residents, which have been grouped into the dimensions of
urbanicity and urbanization. In **3.5 Study Area**, some components of the LHIN regions will be compared to the geographical aspects raised in this sub-section. The similarities identified in that section will be later referred to in drawing inferences on any geographical barriers to access for mobile populations that arise in the interview data.

### 2.3.4 Conclusion

The Canadian health care system has been constructed on principles that seek to ensure equal access for all, while focusing on financial barriers to health care. “Reasonable access” and “medical necessity” lack clear definitions in the legislature (particularly the CHA) and the literature, despite their continued use in policy. However, “reasonable access” is consistently associated with ability to pay, which does not acknowledge how broader social factors may impact access. Further, the focus on providing care based on need under “reasonable access” without consideration of opportunity costs of system barriers may actually produce structural barriers, especially for mobile populations. Thus, “reasonable access” and opportunity costs will be revisited to understand if the legislation’s implications are reflected in the participant’s perspectives of access for mobile populations.

Further, as highlighted earlier in this section of the literature review, the impact of SES and other factors on access to health care is somewhat inconclusive but the majority does suggest some level of unequal utilization. The aspects of inequality of greatest relevance to this study are the system barriers such as access to transportation and geographic distance, and, while there is a lack of research on these dimensions, there are several key points important to this study. Firstly, individual access to a method of transportation (as well as distance to a lesser degree) has been found to impact access to health care. Secondly, there are differences in the utilization of services for rural and urban residents and a number of features of these geographical contexts have been found to be important to access. Characteristics of rural areas affecting access include low population density and high distance between residence and services. Specifically for urban areas, building and demolishing neighbourhoods and transportation routes have also been linked to changes in health care access.
These observations in the literature point to system barriers that may be relevant in the consideration of access for mobile populations. Thus, these key points will be drawn upon in the results of the thesis to better understand the system barriers raised by the participants, particularly in drawing inferences on why the participants characterize these as aspects of access. In the next chapter, I describe the methods by which I achieve these and other objectives of the study.
Chapter 3
Methodology

3.1 Rationale for Using Qualitative Research Methods

Achieving the research objectives of this study - particularly to review the relevant Canadian health care system legislation, investigate how individuals in the health care system characterize health care for mobile populations, and document factors identified by these individuals for mobile populations’ access - is best suited to qualitative research methods. Qualitative approaches emphasize “interpretation and understanding, particularly of daily life-experiences and meanings” in producing knowledge (Martin, 2010, p. 407). The goal of such methods is to “(...) see the research topic from the perspective of the interviewee, and to understand how and why he or she comes to have this particular perspective.” (King, 1994, p. 14). As qualitative methods focus on the perspective of the interviewee, they generally have a low degree of structure while focusing on open questions and specific situations or action sequences in the world of the interviewee rather than abstractions (King, 1994). Qualitative research also recognizes the relationship between the interviewee and the interviewer, viewing the participant as actively taking a role in shaping the course of the interview through responding to the interviewer’s questions (King, 1994). This thesis, concerned with the perspectives of health system decision makers, has thus taken advantage of this methodology. The participants were asked open-ended questions so they could raise and describe important aspects of mobility and access based on their knowledge and expertise. Further, qualitative research recognizes that knowledge is produced from an exchange, such as interviews, as it is conceptualized as “contextual, interpreted and always negotiated” (Martin, 2010, p. 408). This aspect of qualitative methods is an effective way to avoid bias, even when asking questions the participants may not have considered before.

Miller and Crabtree state that there are at least five different aims of scientific inquiry: identification, description, explanation-generation, explanation-testing, and control (Miller, & Crabtree, 1999a). Identification is the main goal of this study, i.e. to document the factors that impact health care access for mobile populations in the southern Ontario commuter belt that health decision makers identify (Miller, & Crabtree, 1999a). Miller and Crabtree call this “one of the most neglected aspects of scientific inquiry” (Miller, & Crabtree, 1999a, p. 6) as investigators often instigate studies to demonstrate concepts created based on their own gut feeling or the
literature. However, another aim of this research is qualitative description (i.e. understanding how health decision makers characterize health care access for mobile populations and how mobile populations are addressed by the health care system), which “explores the meanings, variations, and perceptual experiences of phenomena and will often seek to capture their holistic or interconnected nature” (Miller, & Crabtree, 1999a, p. 6). Inquiry and description are usually attained through qualitative research (Miller, & Crabtree, 1999a) and this study has followed suit.

Further, King (1994) outlines circumstances where qualitative research interviews are most appropriate, three of which are relevant to this study: 1) “Where a study focuses on the meaning of particular phenomena to the participants”; 2) “Where individual perceptions of processes within a social unit are to be studied prospectively, using a series of interviews”; and 3) “Where exploratory work is required before a quantitative study can be carried out” (King, 1994, p. 16). This study focused on understanding the importance and impact of mobility on access to health care from the perspective of health care decision makers, or in other words, studying the meaning of this phenomenon to the participants. This will also provide the participants’ individual perceptions of these processes. Lastly, this research endeavoured to explore if mobility and access raises concerns for health system experts before measuring any individual effects of mobility and access quantitatively. There are a number of opportunities for future research that this study illustrates, as will be noted in the conclusions.

There have been examples of the use of qualitative research methods for understanding health care systems and organizations. Caronna argues that qualitative methods are best suited to address the complexity and multilayered nature of rapidly changing health care organizations, considering such factors as organizational structures and culture, and broader societal values and beliefs (Caronna, 2010). In addition to this, Collin proposes the use of qualitative research methods for understanding how health professionals adapt to organizational and policy reforms (Collin, 2010). She states that “[b]ecause they enable researchers to identity the values and views of different actors in the system, qualitative studies provide a highly valuable perspective on such questions and a real understanding of how reforms are received by professionals and implemented on the ground” (Collin, 2010, p. 54). In summary, this sub-section has demonstrated that qualitative research methods are best suited to the research objectives given
their focus on the perspective of the participants and their ability to identify barriers to health care access for mobile populations in this context.

### 3.2 Interview Guide

The qualitative data collected for this study was gathered through in-depth, semi-structured interviews, and one focus group (the latter was conducted using the same protocol). Semi-structured interviews allowed for the use of the same interview guide for a number of organizations despite the different contexts or geographically-specific issues for these organizations, given the capacity for adaptability with this type of interview (Dearnley, 2005). The interviews in this study followed the example of Dearnley (2005), where, in her work, the participants were encouraged to discuss their experiences, prompted by open-ended questions, and the ordering of questions was determined by their responses.

As such, I asked participants in this study to talk about their opinions and beliefs on mobility and access, in addition to further questions to better understand their perspective. Nonetheless, the interviews in this study were also in-depth interviews or, “a particular field research data-gathering process designed to generate narratives that focus on fairly specific research questions.” (Miller & Crabtree, 1999b, p. 93). Miller and Crabtree call in-depth interviews “an entranceway to narrative understanding” as these interviews present a way to understand “how particular individuals arrive at the cognitions, emotions, and values that emerge from the conversational journey.” (Miller, & Crabtree, 1999b, p. 106). This research was also approached as a case study, or “[q]ualitative data organized to coherently tell the story of the case (person, organization, community, etc.) that has been purposefully sampled” (Patton, 2015, p. 551). Cases can be defined as an occurrence within a specific context (Miles & Huberman, 1994). In this study, the case is the regionalized health care system to be understood through the lens of mobility and access.

The interviews were conducted with staff members of health planning organizations and primary care givers – four Local Health Integration Networks (LHIN) and one Community Health Centre (CHC). Defining the research questions and creating the interview guide were the first steps in embarking on the research (King, 1994). These topics were created in line with the research
literature and, for the second round of interviews with the LHINs, the preliminary interviews (King, 1994). The interview guide was first created with the goal of understanding if the regionalized health care system and local health services for regions are effective in dealing with health care concerns in the southern Ontario commuter belt (see Appendix A). After conducting the pilot interviews with the Barrie Community Health Centre (BCHC), a new interview guide (see Appendix B; hereby referred to as “the interview guide”) was made to narrow the focus of the research, and was used in the interviews with the Toronto Central LHIN (TCLHIN) and Central East (CELHIN) participants, and in the focus group with the North Simcoe Muskoka (NSMLHIN) participants. A shortened version of this interview guide was used during the interview with the Waterloo Wellington LHIN (WWLHIN) participant due to the time constraints of the participant (see Appendix C). The interview guide, and thus the shortened version, were used to focus on the current research objectives, by identifying and understanding health care access for different kinds of mobility and mobile populations from the perspective of health care decision makers.

The interview guide organizes the questions into three main sections in addition to summary and conclusion sections. The first section of questions concerns continuity of care and the necessity of transportation in accessing health care services. The second set of questions focuses on understanding commuters’ use of services, how this affects the health care system, and if this is considered in health planning. Next, inquiries about other kinds of mobility that could have specific health care needs are contained in the third section. The questions in the fourth section were intended to summarize the interview to be clear on the thoughts and opinions of the participants. The interviews were concluded in the fifth section, giving each participant the opportunity to ask the interviewer any questions about the study and to provide their suggestions on contacting additional participants.

3.3 Recruitment of Participants and Data Collection

As a qualitative study, purposive sampling was employed in this research. Curtis, Gesler, Smith, and Washburn (2000) state that qualitative research methods are increasingly recognized for their importance in geography of health and health care. They reviewed a checklist of attributes of
sampling from Miles and Huberman’s (1994) well-known manual on qualitative data analysis. They interpreted Miles and Huberman’s (1994) checklist as the following:

1. “The sampling strategy should be relevant to the conceptual framework and the research questions addressed by the research”.
2. “The sample should be likely to generate rich information on the type of phenomena which need to be studied”.
3. “The sample should enhance the ‘generalizability’ of the findings.”
4. “The sample should produce believable descriptions/explanations (in the sense of being true to real life).”
5. “Is the sample strategy ethical?”

This study achieves most of Miles and Huberman’s (1994) criteria, although the sampling strategy has shifted over time. The recruitment was conducted following a strict ethics protocol (outlined below) and the sampling strategy became more practical given the limited resources and was relevant to the conceptual framework, in granting organizations significant control. Before the onset of interviews, the potential participants contacted were purposefully sample based on group characteristics (Patton, 2015), with the group comprising individuals working in or on the boards of LHINs or Health Centres. This sampling method was intended allow for discussion of the participants’ perspectives as a group as well as the variations by geography that exist. However, this shifted to emergence sampling of key informants due to the difficulty obtaining a larger sample size as well as the preferences of the organizations. When approaching the administrative offices of LHINs and Health Centres, interested organizations largely elected or selected members of their organizations to participate in interviews, rather than individuals coming forward themselves to arrange an interview.

Nonetheless, there are a number of benefits to key informants interviews, in that they allow the researcher to: 1) gather information efficiently, 2) gain otherwise unavailable information, and 3) gain a particular understanding of issues (Gilchrist & Williams, 1999). The lengthy and iterative process of qualitative research has been somewhat limited by the fact that the research has been conducted during the short time span of a Master’s thesis. However, sampling has been successful in securing “information-rich interviews”, or in other words interviews providing
significant information to issues of central importance to the research objectives (Patton, 2015, p. 53), as well as obtaining the normally unavailable perspectives of health decision makers. The participants in the key informant interviews could not be selected randomly because the information (as well as the inclination to provide such information) sought after “is not equally distributed within a study group.” (Gilchrist & Williams, 1999, p. 76). Thus, even small sample sizes are able to provide “information-rich pictures of aspects of information or knowledge distributed within the study population” (Gilchrist & Williams, 1999, p. 76). Likewise, Patton explains that qualitative inquiry focuses on relatively small, purposefully-selected samples sizes which allow for understanding a specific case in depth (2015); this suits the objectives of this place- and context-based study.

However, as will be discussed in the 6.5 Limitations, generalizability and believability of descriptions and findings were sought after in contacting many organizations over a wide geographic range, but the small sample size may limit these regardless. Some level of triangulation was used to mitigate the small sample size. According to Denzin, triangulation strengthens a study by combining methods and data sources, under the logic that no single method solves the problem of “rival causal factors” and that multiple sources reveal different aspects of the reality (as cited in Patton, 2015, p. 317). Denzin finds four types of triangulation: data, investigator, theory, and methodological triangulation (as cited in Patton, 2015). The triangulation used in this study does not fit clearly into the types outlined, but represents: 1) data triangulation by interviewing participants from multiple organizations and multiple kinds of organizations, as well as conducting secondary research with government documents and health system literature; and 2) methodological triangulation by conducting in-person interviews, phone interviews, a focus group, and secondary research. Thus, the lengths to verify the information and the breadth of the data lend legitimacy to the sampling strategy. Further, as will be elaborated on later in the thesis, there were sufficient patterns of themes found in the responses, and this study achieves the research objectives, especially to identify and describe factors of access to care for mobile populations.

Data was collected from September 2015 to February 2016 through a total of six interviews and one focus group that I conducted as the primary researcher. Participants were recruited through emails detailing the purpose of the study, my affiliation with the University of Toronto as the researcher, and the procedures of the study (see Appendix D for the invitation letter and
Appendix E for the consent form). Office administrators were my primary contacts to the organizations to distribute invitation letters, consent forms and schedule interviews. All of the organizations took some agency in deciding who would be contacted to participate. Of those that eventually agreed to participate in the study, four requested to see the interview guide before the interview to determine if they wanted to move forward with scheduling.

There were members from seven different LHINs invited to participate, as I was interested in speaking to the LHINs in southern Ontario within commuting distance of Toronto. Individuals from four of these LHINs were included in the study based on their responses to the invitations. Likewise, three CHCs were contacted and members from one CHC consented to participate. Originally, three CHCs (the BCHC, the Peterborough Regional Health Centre (PRHC), and the Guelph Community Health Centre (GCHC)) and three LHINs (the WVLHIN, NSMLHIN, and CELHIN) were contacted to participate in the study, with the idea of having interviews with multiple members of each organization. While all three of these LHINs consented to participate (although representing a smaller sample size than expected), the PRHC and the GCHC declined to participate in the study, stating that they were too busy to take part and that the research topics were not entirely relevant to their centres. The NSMLHIN participants were hesitant to participate, suggesting a group phone interview instead of single-person interviews, which resulted in an ethics amendment to allow for focus groups.

To seek approval to conduct the study and encourage participation of southern Ontario LHINs, the MOHLTC was contacted in an email to explain the project. With the support of the MOHLTC, four additional LHINs (the Central LHIN, Toronto Central LHIN, Central West LHIN, and Mississauga Halton LHIN) were invited to participate, providing a contact from the MOHLTC to confirm that the study had received approval. Out of these, an individual from the TCLHIN consented to participate. Another of these LHINs initially appeared very interested but ultimately declined, cancelling the scheduled interview after being sent the consent form (although no reason was provided). I was not able to secure participants from the remaining two LHINs, due to the difficulty getting in contact with staff members other than administrative assistants.

The qualitative data is comprised of four in-person interviews (one in the city of Toronto and three the city of Barrie), two phone interviews (one each with the CELHIN participant and the
WWLHIN participant), and one focus group (over the phone and involving three participants from the NSMLHIN) with members from one CHC and four LHINs. This means that, while multiple individuals from each organization were originally intended to participate, there was only one staff member each that consented to participate from three out of the four LHINs involved (i.e. the TCLHIN, CELHIN, and WWLHIN). I understood the time impositions that interviews presented and the necessity of choosing a venue comfortable for the participant, and invited the participants to suggest times and places for interviews (Dearnley, 2005). All in-person interviews took place at each participant’s place of work, which were deemed the most convenient for the participants, during regular working hours.

The most challenging aspects of data collection were recruiting participants and scheduling interviews given their busy schedules. While most of the interviews were about an hour, the participant for WWLHIN was unable to take part in an interview this long, so the interview guide was shortened and the interview conducted was approximately 20 minutes long. No one withdrew from the study after signing a consent form. All participants were informed of their confidentiality within the study and my background and academic affiliations, as the researcher. The study’s approval by the MOHLTC was made clear to the four additional LHINs contacted as the first three LHINs had been in communication beforehand. The participants were asked for permission to record audio of the interviews for more accurate transcription of their words (see Appendix E for the consent form) and all nine of the individuals involved agreed.

Secondary data from grey literature was collected through internet searches, often using key terms describing the policy information to be collected, such as “Ontario Health System Funding Reforms”, and “Canadian Federal health care role”. The majority of the information and documents are from government websites such as the MOHLTC, LHINs, and the Institute for Clinical Evaluation Sciences (ICES) websites, and often their websites’ search functions were used. Some of the primary documents examined were the Integrated Health Service Plans (IHSPs) for 2016 to 2019 of LHINs, which were downloaded from each respective LHIN’s websites, as they are open to the public. The documents were carefully read to understand the goals, general directions, and community engagement efforts of each IHSP. They were then compared based on a number of factors around their goals (e.g. the structure of, detail provided on, data used in setting, and justification provided for goals), the kind and degree to which data was used in explaining targets or indicators, and level of detail provided on their environmental
scans. The meeting minutes for the LHINs’ regular Board Meetings are also publicly available and were skimmed to gain an understanding of the current tasks of and concerns for the organizations. This included any minutes available on meetings that occurred between January 2016 and June 2016 for the WWLHIN, NSMLHIN, CELHIN and TCLHIN. Only the agendas of meetings were available during this time period for the TCLHIN’s meeting minutes, although, while this did not provide much detail, the agendas did suffice for the purposes for this study.

3.4 Data Analysis

As the researcher, I transcribed audio recordings verbatim which allowed for familiarity with the data and the perspective of the participants. As King (1994) recommends, high familiarisation with the data can be further achieved by reading transcripts more than once and listening to each interview. Each audio recording was listened to twice, first for transcription, then to confirm that the transcript was as accurate as possible. To ensure anonymity, the names of participants have not been used; instead, they are referred to as a participant from their organization. Originally, whether the participant was a staff or board member of the organization was going to be identified (as seen in the consent form in Appendix E), but only the organization an individual belongs to has been stated.

For analysis, the data was considered in two ways. The first priority was to gain an understanding of the data related to the research focus using an “editing organizing style” for interpretation (Miller & Crabtree, 1999a). In Miller and Crabtree, this process of interpreting data is described as “cutting, pasting, and rearranging until the reduced summary reveals a helpful interpretation” (Miller & Crabtree, 1999a, p. 23). The researcher finds meaningful segments of the text that are both independently interesting and related to the study’s objectives (Miller & Crabtree, 1999a). The segments are sorted into categories which are in turn explored for patterns and themes in analysis (Miller & Crabtree, 1999a). For this research study, two of the research objectives were considered at this time: understanding how the participants characterize health care access for mobile populations; and how health care access for mobile populations is addressed by the health care system. This was done by considering two questions in reading through the transcripts:
i) Do the different mobile populations (with a focus on commuting and seasonal mobility) use the health care system differently from the general population and how?

ii) Do health planners account for the different usage by these mobile populations and how?

While reading the transcripts, statements that seemed relevant to or answered these questions (from the perspective of the participants) were copied into a new document, and organized around the questions by organization, thus being used as the categories under this analysis style. For (i), the participants’ statements chosen were those that described how each mobile population accessed the health care system and any challenges mobile residents faced. The statements chosen for (ii) were those that described the health care system’s responses to the answers in (i), e.g. programs set up by the health care system to help with or mitigate any challenges faced by residents. After gathering the quotes, the perspectives from each organization were summarized as initial findings.

Coding was used to highlight additional patterns in an inductive way, with the main goal of identifying the factors of access for mobile populations brought up by the participants. Codes were chosen based on two factors. Some were based on key words, phrases or ideas appearing frequently both within an interview and between all of the interviews. Looking for reoccurring regularities is suggested by Patton (2015) as a starting point in the coding process to reveal patterns to sort into categories. Other codes were chosen that seemed indicative of a participant’s perspectives on mobility, mobile populations, geography, and access. For example, the funding system was not the most frequently occurring topic in the transcripts but, as health decision makers, their views on funding are important in understanding mobility and access relationships. Creating the code book was an iterative process. First, codes were added to the code book while reading through the transcripts and coding phrases as they came up. Next, I went back through the transcripts to ensure consistent coding. The most important patterns in the codes were summarized based on the participants’ perspectives on the topic, the way topics were raised, and the connotations of their statements for mobility and access. The patterns between the codes were determined by considering convergences and divergences in the data (Patton, 2015), the codes were ultimately placed in the broad categories of those concerning mobility and other describing geography factors to health care access, which provided structure to the analysis.
According to Patton (2015), qualitative findings are judged by their substantive significance, which is determined by the analyst who must largely make their own judgements. This involves working back and forth between the data and the analyst’s perspective to make sense of the evidence (Patton, 2015). Thus, interpretation focused on a number of queries: 1) why does each participant have the perspectives that they do? 2) what is similar or different between the participants, and why is this? and 3) for the aspects identified in coding, how are they related to mobility, geography and access? Interpretation was also necessary for the secondary research on the structure of the health care system. The collected documents were read and the data was pieced together and organized as clearly as possible in Chapter 4. The information was then considered through a mobility and access lens, as seen in 4.5 Discussion.

In writing the conclusion, I considered what I believed to be the most important results and findings of the study. These were determined in a number of ways. Firstly, reoccurring themes throughout the interviews were considered significant. Secondly, corroborated or complementary data from the secondary research on the implications of the structure of the health care system were similarly found to be important. Thirdly, the literature was also considered in determining what findings of this study were new and what was supported by the literature. Finally, the outcomes possibly of relevance or beneficial for future studies, especially for those attempting to conduct similar regional and qualitative studies with health decision makers, were presented. The findings were organized around the research objectives.

3.5 Study Area

I interviewed participants from the four following LHINs: the Central East LHIN, the North Simcoe Muskoka LHIN, the Toronto Central LHIN, and the Waterloo Wellington LHIN. On Figure 1, the geographical jurisdictions of each LHIN in Ontario are labelled 3509, 3512, 3507, and 3503 respectively.

These regions cover a variety of geographic areas. Both the CELHIN and the WWLHIN encompass a mix of urban and rural landscapes. The land area of the CELHIN reportedly contains “densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements.” (Central East Local Health Integration Network, n.d.).
Figure 1: Map of LHINs in Ontario

For the WWLHIN, the vast majority of their population is urban (containing the major cities of Waterloo, Kitchener, Cambridge, and Guelph) although most of their land area is rural (Waterloo Wellington Local Health Integration Network, n.d.-a). In contrast, the NSMLHIN website emphasizes that their jurisdiction is “in and around cottage country” and is an increasingly popular retirement destination (North Simcoe Muskoka Local Health Integration Network, n.d.-a), while the TCLHIN encompasses the core of the city of Toronto and Scarborough, North York, and Etobicoke (Toronto Central Local Health Integration Network, n.d.). The population residing in each LHIN is shown in Table 2. In addition, the recent changes in the population size are
illustrated in Figure 2. The figure shows that the population sizes are growing by approximately the same rate in each LHIN relevant to this study and that the areas surrounding the City of Toronto are growing rapidly.

Table 2: LHIN Population Sizes

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>CELHIN</td>
<td>1,498,650</td>
</tr>
<tr>
<td>NSMLHIN</td>
<td>439,400</td>
</tr>
<tr>
<td>TCLHIN</td>
<td>1,150,010</td>
</tr>
<tr>
<td>WWLHIN</td>
<td>723,445</td>
</tr>
</tbody>
</table>

Note. Data for the total population in the CELHIN from Statistics Canada (2012c), for the NSMLHIN from Statistics Canada (2012e), for the TCLHIN from Statistics Canada (2012g), and for the WWLHIN from Statistics Canada (2012h).

Figure 2: Population Change of LHINs 2006 to 2011

There were additional participants in this study from the Barrie Community Health Centre, an organization residing in the city of Barrie. The Centre is a funded health service provider by the NSMLHIN (NSMLHIN, n.d.-b). This organization takes a community-focused approach to health promotion and primary health care services, with a staff of community health workers, health promoters, nurses, social workers, physicians and more (Barrie Community Health Centre, n.d.).

There are some notable differences in characteristics between the remote locations in Arcury et al. (2005) and those in southern Ontario. Two of the participating LHINs are located in popular destinations for vacations, seasonal travel, and cottaging within the province – the CELHIN and NSMLHIN (CELHIN, n.d.; NSMLHIN, n.d.-a). Bourne et al. (2003) states that the population of areas considered to be in cottage country or the “city’s countryside” (within a three-hour drive of the GTA) is increasing due to the pull of seasonal activities, a retiring and aging population, and an increase in multiple residency in the province. They argue that this is the shortcoming with the conventional “urban” versus “rural” perspectives, preferring to describe Toronto as a node of residential mobility across regions (Bourne et al., 2003).

The argument in Bourne et al. (2003) pertaining to the labels “urban” and “rural” is applicable to the regions in this study. The regions under the jurisdiction of the CELHIN and NSMLHIN have characteristics that are comparable to rural areas discussed in the literature. In most areas, the NSMLHIN and CELHIN have lower population density than larger metropolitan areas (see Figure 3). Further, Table 3 displays the percentages of daily trips that residents of the area make using automobiles and daily trips made to the area with automobiles. The percentage of trips made within the regions and by residents of WWLHIN, CELHIN and NSMLHIN are much higher than those in the TCLHIN, which may indicate that they do not expansive transportation systems. However, these regions are not, strictly speaking, rural areas, as discussed earlier in this sub-section. On the other hand, the TCLHIN can safely be referred to as an urban area and the WWLHIN may be considered largely urban, given that the vast majority of the population is urban.
Figure 3: Population Density in Southern Ontario (person per km$^2$)

![Population Density Map]


Table 3: Percentage of Automobile Trips within the LHINs

<table>
<thead>
<tr>
<th>LHIN</th>
<th>City, Regional Municipality, County, or Town within LHIN</th>
<th>Percentage of automobile trips made by residents of the area every 24 hours</th>
<th>Percentage of automobile trips made to the jurisdiction every 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCLHIN</td>
<td>City of Toronto</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>CELHIN$^a$</td>
<td>Durham Region</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>City of Kawartha Lakes</td>
<td>75</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>City of Peterborough</td>
<td>68</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Peterborough County</td>
<td>74</td>
<td>73</td>
</tr>
<tr>
<td>WWLHIN</td>
<td>Waterloo Region</td>
<td>71</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>City of Guelph</td>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Wellington County</td>
<td>76</td>
<td>75</td>
</tr>
<tr>
<td>NSMLHIN$^a$</td>
<td>City of Barrie</td>
<td>72</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>City of Orillia</td>
<td>67</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Simcoe County</td>
<td>73</td>
<td>73</td>
</tr>
</tbody>
</table>

Note. Data from DMG (n.d.-b).

$^a$This table does not include the entire geographic area of these LHINs.
These aspects of the regions describe part of the context within which mobile populations seek health care. The regions containing the LHINs relevant to the study encompass a wide geography, including areas with the traits of both urban and rural areas in population size and density. While the populations in the CELHIN, NSMLHIN, TCLHIN, and WWLHIN are not increasing drastically, the areas surrounding the TCLHIN are growing at a higher rate than the national average. The WWLHIN, CELHIN, and NSMLHIN populations are much more automobile-dependent than the TCLHIN population, and it can be assumed that automobiles are the main method of transportation to health care services in these regions as well. Lastly, the CELHIN and NSMLHIN jurisdictions contain “cottage country” which is relevant to the study of seasonal mobility. The creation of these geographic boundaries, alongside other useful context on the Ontario regionalization process, is described in the next chapter, where I present the results of the secondary research.
Chapter 4
Structure of the Ontario Health Care System

In this chapter, I will present the findings of my secondary research on the structure of the provincial health care system. This is intended to situate LHINs in the health care system context by providing background on the system and overviewing the process of regionalization in Ontario. In addition to this, the information is reviewed from a mobility lens to understand how this system may work for the mobile population.

4.1 Establishing LHINs

Within the province of Ontario, Local Health Integration Networks (LHINs) are crown agencies reporting to the Ministry of Health and Long-Term Care (MOHLTC). These not-for-profit organizations were established in 2004 (Ardal et al., 2006a) and are constituted under the *Local Health System Integration Act* (LHSIA) (LHSIA, 2006). The objects of LHINs are to “plan, fund and integrate the local health system” (LHSIA, 2006, c. 4, s. 5) and oversee health service providers (HSPs) in a particular geographical area (Hawkins et al., 2013a). The HSPs funded by LHINs include hospitals, long-term care facilities and community-based providers (Community Care Access Centres (CCACs), Community Health Centres (CHCs), community mental health and addictions services, etc.) (Ontario Hospital Association, 2009). There are many different responsibilities associated with the “objects” of LHINs (as referred to as such in the LHSIA) that can be organized around these main goals of the LHSIA, as illustrated in Table 4 (LHSIA, 2006).

As outlined in Table 4, LHINs were designed to facilitate integration in contrast with the other provinces earlier attempts at regionalization (Fierlbeck, 2011). A new provincial government was elected in 2003, which faced a daunting agenda of health care reform in a short period of time alongside administrative and fiscal changes (Fenn, 2006). The LHIN model was promoted as part of this reform portfolio as means for transforming the provincial health care system (Secker et al., 2006; Fenn, 2006); in particular, the MOHLTC sought to improve the health care system at the local level in terms of responsiveness and capacity to plan, integrate, and fund, all while focusing on patient-centredness (Secker et al., 2006). In addition to this, the LHINs were
intended to be a regional platform for evaluating performance and regional transparency in collecting and analyzing data, thus assuming the Ministry’s traditional role of managing the health system (Fenn, 2006).

Table 4: The Objects and Responsibilities of LHINs

<table>
<thead>
<tr>
<th>Main Purpose or Objects:</th>
<th>Responsibilities from the <em>LHSIA</em>:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planning</strong></td>
<td>• Identifying, planning, and making recommendations to the Minister about health services for the region.</td>
</tr>
<tr>
<td></td>
<td>• Engaging the region’s community with planning and setting priorities.</td>
</tr>
<tr>
<td></td>
<td>• Participating in developing, cooperating with, and implementing provincial planning, priorities, programs, and services.</td>
</tr>
<tr>
<td></td>
<td>• Monitoring, evaluating, and reporting on the performance of the local health system including access, utilization, integration, and cost-effectiveness.</td>
</tr>
<tr>
<td></td>
<td>• Ensuring appropriate procedures to raise concerns about health services.</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>• Allocating funding to HSPs to provide agreed upon health services.</td>
</tr>
<tr>
<td></td>
<td>• Creating agreements on the performance standards of HSPs to ensure achievement of these standards.</td>
</tr>
<tr>
<td></td>
<td>• Effectively and efficiently managing human and financial resources of the LHIN.</td>
</tr>
<tr>
<td></td>
<td>• Creating economic efficiencies in the delivery of health services for a more sustainable system.</td>
</tr>
<tr>
<td><strong>Integration</strong></td>
<td>• Promoting the integration of health services for coordinated, appropriate, and efficient health services.</td>
</tr>
<tr>
<td></td>
<td>• Cooperating with HSPs to improve integration and coordination of health services.</td>
</tr>
<tr>
<td></td>
<td>• Conducting and participating in joint-LHIN strategies for patient care and access.</td>
</tr>
<tr>
<td></td>
<td>• Promoting knowledge transfer between HSPs and other LHINs and disseminating best practices.</td>
</tr>
</tbody>
</table>

*Note.* Data from Local Health System Integration Act (2006).

The regionalization process in Ontario entailed a similar restructuring of responsibilities to thee other provinces (Elson, 2009). Perhaps the most significant difference is that the MOHLTC did not dissolve or restructure health care organizations in Ontario (Elson, 2009), meaning that structural changes in program administration were “few and strategic” (Fenn, 2006, p. 538). The other provinces created regional health authorities (RHAs) to simplify their health systems by consolidating services, while the new level of administration that was introduced in Ontario (i.e. the LHINs) separated system planning and management activities from operational accountability (Elson, 2009). Another layer of governance was implemented to avoid dissolving the existing governance structures with local health providers in the health care system, as
amalgamating organizations “had been undertaken with considerable effort – and loss of community support – in the rest of the country” (Fenn, 2006, p. 538).

The boundaries of the 14 LHINs were created by the Institute for Clinical Evaluation Sciences (ICES) and the MOHLTC, using an evidence-based methodology to reflect the local areas where residents seek health care (Ardal et al., 2006a). This process involved determining the Hospital Service Areas (HSAs) of patient usage versus residence, and grouping HSAs into Hospital Referral Regions (HRRs) (Ardal et al., 2006a). HSAs were defined using the Canadian Institute for Health Information’s (CIHI) hospital discharge abstract data (DAD) to represent the area where the majority of its residents are admitted to the area’s hospital (Rothwell, 2005). The DAD was examined for all Ontario acute care hospitals for 2 fiscal years – April 2001 to March 2003 – capturing all patient admissions to acute care and patient postal codes (Rothwell, 2005). Postal codes were converted to Dissemination Areas (DAs) which were mapped and visually inspected to determine if the DAs within an HSA formed a contiguous boundary (Rothwell, 2005). Any manual adjustments were made based on travel patterns (e.g. a non-contiguous DA assigned to an HSA within another HSA) and the proportion and volume of patients accessing, and distance travelled to the three most frequently used hospital DAs in the region (Rothwell, 2005). The localization indices (LI) (the percent of an HSA’s patient admissions that visited hospitals within the HSA) were calculated for HSAs (Rothwell, 2005).

In the second step, HSAs were grouped into HRRs, with the criteria that each HRR contained one or more tertiary care facilities (Rothwell, 2005). The 50 highest volume hospitals were grouped into 13 to 15 different HRRs based on “regional travel patterns” (Rothwell, 2005). The HRRs were to be presented to the Ministry, and each had to have a population greater than 120,000 and the minimum LI had to be greater than 65 percent (Rothwell, 2005). When the Ministry was presented with the HRRs, different options were assessed by considering the LIs and feedback from various regional groups (Rothwell, 2005). The HRRs were revised and became the LHINs (Rothwell, 2005). These boundaries were tested, finding that between 59.1 and 97.2 percent of the population in the LHINs use their local health care system (Ardal et al., 2006a). There are measures in the legislation to protect such mobility in accessing care, such as those to remove geographic barriers to receiving care in Ontario; according to the LHSIA, LHINs “shall not enter into any agreement or other arrangement that restricts or prevents an individual from receiving services based on the geographic area in which the individual resides.” (LHSIA,
2006, c.4, s. 20 (2)). Currently, not all of the LHINs can be precisely duplicated using current data and there are some areas that cross LHIN boundaries because LHIN boundaries are based on 2001 Census geography (Ardal et al., 2006a).

There are a number of aspects of the establishment of LHINs to note. Firstly, Ontario regionalization emphasized local responsiveness, patient-centredness, and avoiding loss of community support for the health care system. However, the latter came at the cost of hampering integration efforts, which were one of the three main goals for the LHINs in the LHSIA. The restrictions on integration will be returned to later in this chapter and in the discussion to determine any possible implications for mobile populations. Secondly, while the methodology for establishing LHINs does not necessarily indicate that mobility and travel patterns have been considered, it does appear that the methodology was sensitive to the issue of geographic flexibility and choice for Ontario residents. Moreover, the ability to travel and receive care has been protected in the legislation, although this does not necessarily indicate that mobility is supported through programming. It is surprising, however, that the methodology for determining LHIN boundaries hinges on hospital utilization. For example, LIs reflect the percentage use of local hospitals even though LHINs also fund long-term care facilities and community-based providers. The focus on hospital utilization suggests that an individual’s travel and health care utilization patterns have not been comprehensively considered in the delineation of LHIN boundaries.

There are limitations to the level of detail in this data which restrict the conclusions that can be drawn on the establishment of LHINs and mobility. Firstly, Rothwell (2004) states that grouping the 50 highest volume hospitals into HRRs was based on “regional travel patterns” and LHINs were based on the resulting geographic boundaries, but there are no details on what travel patterns were considered or how the patterns were used in assigning hospitals to HRRs. Further detail on these patterns would be helpful in understanding the degree to which mobility and what kinds of mobility in the province were used in shaping the structure of the health care system. Secondly, there are some discrepancies in LIs between sources. Ardal et al. (2006a) states that the LIs calculated for the LHINs were between 59.1 and 97.2 percent, but Rothwell (2004) states that the criteria for the original HRRs was an LI over 65 percent and the cause for the difference is unclear. This could be the result of a number of things such as the adjustments made by the Ministry in approving the boundaries, changes over time, or slight differences in the calculation.
of this measure. The percentage itself is not integral to this study, but, in the event that the discrepancy is due to the Ministry adjustment, the justification for lower local use of health services would be relevant to understanding how the health care system characterizes health care access for mobile populations.

4.2 Situating LHINs in the Ontario Health Care System

Aside from the federal legislation outlined in 2.2.1 Federal Responsibilities and Legislation in Health Care, the Ontario health system is shaped by two major types of accountability agreements on explicit performance outcomes and funding amounts: Ministry-LHIN Accountability Agreements (MLAA) and the Service Accountability Agreements (SAAs) between LHINs and HSPs (Ontario Hospital Association, 2009). The accountability agreements between the Ministry and LHINs span more than one fiscal year and include: performance goals, objectives, standards, targets and measures; requirements of the LHIN to report on performance; and a plan for spending Ministry funding (LHSIA, 2006). Similarly, HSPs receiving funding from LHINs will enter into an SAA as part of the Commitment to the Future of Medicare Act (CFMA), a piece of provincial legislation which reaffirms commitment to the CHA (LHSIA, 2006; CFMA, 2015). The LHSIA mandates that each LHIN and HSP shall separately and together identify opportunities to integrate services of the local health system to “provide appropriate, co-ordinated, effective and efficient services.” (LHSIA, 2006). The LHSIA does not delineate specific tasks involved in integration, but does state that to “integrate” includes:

(a) to co-ordinate services and interactions between different persons and entities,
(b) to partner with another person or entity in providing services or in operating,
(c) to transfer, merge or amalgamate services, operations, persons or entities,
(d) to start or cease providing services,
(e) to cease to operate or to dissolve or wind up the operations of a person or entity, (LHSIA, 2006, c. 4, s. 2 (1)).

An integrated health system has been suggested to service people’s health needs “more completely and comprehensively”, but LHINs are given agency in deciding what kinds of integration are appropriate (Ardal et al., 2006b, p. 4). Integration has been promoted as a way to
improve the accessibility of health services and allowing for easier navigation through the health system (Ardal et al., 2006b) seemingly presented as an ideal for the health care system. Kodner and Spreeuwenberg (2002) argue that integration is necessary for health systems to counteract the traditional division and specialization of health care services, as the components or organizations are meant to work together. Without integration, “[p]atients get lost, needed services fail to be delivered, or are delayed, quality and patient satisfaction decline, and the potential for cost-effectiveness diminishes” (Kodner & Spreeuwenberg, 2002, 2).

In summary, there are various accountability agreements that govern the provincial health care system at different levels, which individually outline the responsibilities for each level of health care governance and funded organization. One of the main goals for LHINs and HSPs is to identify integration opportunities. Integration has been presented as something of an ideal for health care systems to improve accessibility of services and cost-effectiveness. However, the legislation for LHINs does not include specific guidelines for associated tasks to integrate health care services in Ontario.

4.3 The Funding System and Reforms

Funding systems are integral in health care system management as built-in incentives and disincentives drive the behaviour of health care organizations (Ontario Hospital Association, 2009). As described in 2.2.1 Federal Responsibilities and Legislation in Health Care, the contribution of Federal funding to the provincial health system is legislated by the Canada Health Act (CHA), as the provinces must meet the five pillars of health care (public administration, comprehensiveness, universality, portability, and accessibility) to receive funding (Hawkins et al., 2013c). The provincial level, or the MOHLTC in Ontario, is funded by provincial taxes (MOHLTC, n.d.-b) in addition to the federal assistance provided under the CHA (Government of Canada, 2015). The MOHLTC in turn allocates funding to the LHINs, who administer their funding to HSPs (Hawkins et al., 2013c).

With the establishment of LHINs, changes were made to the funding arrangements with HSPs (Ontario Hospital Association, 2009). The negotiated amount specified in an SAA is based on the volume of services that HSPs agree to provide, based on projections from previous health
system data (Ontario Hospital Association, 2009). Much of the data for health system analysis to determine the quality and quantity of services provided is collected through hospitals, including inpatient discharges, emergency department visits, and complex continuing care facilities (Ardal et al., 2006a). Under inpatient discharges, the data falls under numerous fields such as institution, type of institution, patient ID number, the patient location in comparison with the institution location, readmission code, discharge disposition, alternate level of care, and cost and complexity of procedure (Ardal et al., 2006a).

Traditionally, Ontario hospitals received an annual lump-sum or “global” budget based on past funding requirements, rather than volumes or performance, as well as additional support for specific programs, expansion of services and facilities, and on-call services from the Ministry (Chalk, Morgan, Dietrich, Beduz, & Bell, 2014; Hawkins et al., 2013c). As LHINs independently negotiate SAAs for each HSP, SAAs differ when not specified by the MLAA (Ontario Hospital Association, 2009). For example, while the global budget comprises the majority of the funding for hospitals (as of 2013) (Hawkins et al., 2013c), this differs from the funding of long-term care, which is determined by a per-diem method (Ontario Hospital Association, 2009).

However, health care funding, legislation, and policies are highly complex and in a constant state of change, as evidenced by the fact that MLAAs are in the process of being replaced by Ministry-LHIN Performance Agreements (MLPA) (Hawkins et al., 2013c; Sutherland, Crump, & Repin, 2013). In 2012, the Ministry announced changes to the funding formula for HSPs (specifically hospitals, CCACs and long-term care homes) through the Health System Funding Reform (HSFR) to be phased in over a number of years (Chalk et al., 2014; Hawkins et al., 2013c; Sutherland et al., 2013; MOHLTC, 2015c; MOHLTC, 2012). There are a variety of objectives of the HSFR, although the main intention is to align funding with the volume of services provided, the quality of those services, and the needs of the population (Chalk et al., 2014). The reforms are also expected to standardize care, minimize variation in service provision, and encourage investments in quality (MOHLTC, n.d.-a; Sutherland et al., 2013). As of 2015-2016, 70 percent of the funding to hospitals will be based on the HSFR with the remaining 30 percent as global funding (MOHLTC, 2015c).
There are two components to the HSFR: organizational-level funding based on the Health Based Allocation Model (HBAM) (to eventually comprise 40 percent of funding) and funding provided for Quality-Based Procedures (QBP) (to be 30 percent) (MOHLTC, 2015c). HBAM uses a range of information to predict the cost of providing care including clinical, financial, demographic (age, gender, population projections etc), socioeconomic (Chalk et al., 2014; MOHLTC, n.d.-a) and geographic data (MOHLTC, n.d.-a) as well as the provincial averages for unit costs (Sutherland et al., 2013). The funding amount is based on variances between expected costs and actual costs, and thus is a proxy measure of efficiency (Chalk et al., 2014). However, the information available to the public on HBAM does not include details on the data that HBAM uses to predict the cost of care, aside from the information presented in this sub-section. Further, it is unclear at what administrative level (i.e. the LHIN or HSP level) such geographical, demographic and socioeconomic information is collected on, nor is it clear how these are factored into decisions on funding amounts.

QBP funding is allocated for specific procedures – patients with similar needs are grouped and their care is funded at a fixed price, set by a “price times volume” approach (Chalk et al., 2014, p. 42-43). Health care providers are reimbursed for the types and quantities of patients treated (MOHLTC, n.d.-a). It is expected that fixed rates will incentivize hospitals to improve the efficiency of their processes, adopt best practices, and improve coordination between providers to meet performance standards or even earn a profit to reinvest in the hospital (Chalk et al., 2014). There are now ten groups of patient services under QBP funding, such as procedures for chronic kidney disease, hip replacement surgery, knee replacement surgery, cataract surgery, chemotherapy, heart disease and failure, stroke, and more (MOHLTC, 2015b).

These funding formulas require an understanding of person-level costing of services based on high-quality utilization data, such as the length and intensity of service usage, and cost information for usage on a per-stay or per-day basis (Wodchis, Bushmeneva, Nikitovic, & McKilop, 2013). This utilization data is stored in databases by the CIHI and the Ministry (Wodchis et al., 2013). **Table 5** lists some of the multilevel datasets for types of care, illustrating the variety of data collected through the Canadian health care system.

In addition to these databases, OHIP is used as a utilization database for person-level costing for primary and specialist physician service types (Wodchis et al., 2013). Of relevance to this study
is patient residence, which is a common piece of data collected in CIHI databases, generally recorded as a postal code (Canadian Institute for Health Information, 2015). For example, the Continuing Care Reporting System (CCRS), National Ambulatory Care Reporting System (NACRS), Discharge Abstract Database (DAD), and National Rehabilitation Reporting System (NRS) all record patients’ postal codes of residence (CIHI, 2015; CIHI, n.d.-b; CIHI, n.d.-a; CIHI, 2013). The NACRS, DAD, and NRS also record information about the health care provider used (CIHI, n.d.-b; CIHI, n.d.-a; CIHI, 2013). In other words, the information on these databases appears to indicate that some level of mobility is tracked in utilization records that the health system has access to.

Table 5: Sources of Data for Types of Care

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Services Types</th>
<th>Sources of Data Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Care</td>
<td>Emergency and Ambulatory</td>
<td>National Ambulatory Care Reporting System (NACRS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge Abstract Database (DAD)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital Morbidity Database (HMDB)</td>
</tr>
<tr>
<td>Acute Care</td>
<td></td>
<td>DAD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HMDB</td>
</tr>
<tr>
<td>Continuing Care</td>
<td></td>
<td>Continuing Care Reporting System (CCRS)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
<td>National Rehabilitation Reporting System (NRS)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Home Care</td>
<td>Currently developing Electronic Medical Record content standards.</td>
</tr>
<tr>
<td></td>
<td>Community mental health</td>
<td>Based on primary care data</td>
</tr>
<tr>
<td></td>
<td>Residential care</td>
<td>CCRS</td>
</tr>
<tr>
<td>Specialized Services</td>
<td>Joint replacements</td>
<td>Canadian Joint Replacement Registry (CJRR)</td>
</tr>
<tr>
<td></td>
<td>Medical imaging</td>
<td>National Survey of Selected Medical Imaging Equipment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Canadian MIS Database</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Workforce Database</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Imaging Technology Database</td>
</tr>
<tr>
<td></td>
<td>Mental health and addictions</td>
<td>Hospital Mental Health Data Base</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ontario Mental Health Reporting System</td>
</tr>
<tr>
<td></td>
<td>Multiple sclerosis</td>
<td>Canadian Multiple Sclerosis Monitoring System (Closed as of April 2016)</td>
</tr>
<tr>
<td></td>
<td>Organ replacements</td>
<td>Canadian Organ Replacement Register</td>
</tr>
<tr>
<td></td>
<td>Trauma and injuries</td>
<td>National Trauma Registry (Closed as of March 31, 2014)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DAD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HMDB</td>
</tr>
</tbody>
</table>

*Note. Data adapted from Canadian Institute for Health Information (n.d.-c).*

In summary, funding flows from the federal and provincial level to the LHINs, who in turn allocate funding to HSPs through negotiated accountability agreements. The funding formulas
are reforming to align funding with service volumes, service quality, and the population’s needs. Alongside global budgets, HBAM will provide funding based on a variety of information about the population and the expected cost of services and QBP funding will be allocated to specific procedures at a fixed price to incentivise hospitals to improve efficiency. The funding amounts are determined using utilization data stored in databases from the CIHI and the Ministry. Here, it is important to note that patient residence is a commonly collected piece of data in these databases, as this point will be returned to in the discussion of the thesis. Moreover, the implications of funding reforms for mobile populations will be considered later in this chapter to understand if there are any structural barriers arising from these new systems.

4.4 Structure and Priorities of LHINs

LHINs are generally small organizations comprising of a board of directors, a chief executive officer and the staff considered by the LHIN to be necessary to conduct business (LHSIA, 2006). While not all LHINs make the number of staff they employ available, the North Simcoe Muskoka LHIN and the Waterloo Wellington LHIN state they have 35 and 36 staff members respectively, including their chief executive officers (NSMLHIN, n.d.-c; WWLHIN, n.d.-b). The chief executive officer’s duties include management and administration of LHINs and are under the supervision of the board (LHSIA, 2006). The members of the board, who manage the affairs of each LHIN, are appointed by the Lieutenant Governor in Council and there are to be no more than 9 members (LHSIA, 2006). One member is appointed chair with at least one other to be vice-chair and they preside over the meetings, which are open to the public (LHSIA, 2006).

The Ministry provides a strategic plan for the provincial health system and the LHINs must plan within this (LHSIA, 2006). LHINs are to develop an Integrated Health Service Plan (IHSP) ever three years, including “a vision, priorities and strategic directions for the local health system and shall set out strategies to integrate the local health system”, all of which must align with the provincial strategic plan and the funding provided to the LHIN (LHSIA, 2006). The development of the IHSP must engage the community and entities involved in the region, with particular consideration of Aboriginal peoples and First Nations, and French Language Services (FLS), on an ongoing basis through community meetings, focus groups meetings, or advisory committees
The IHSPs are important in understanding the planning direction for each regional jurisdiction and are described in more detail below.

### 4.4.1 The Integrated Health Service Plans – 2016-2019

Each of the LHINs with staff members participating in this study developed different kinds of priorities in collaboration with their communities, representing a significant amount of variation in the ways these organizations categorize and, as a result, understand the health care goals for their respective regions (see Table 6 for a summary of these goals and tasks). The North Simcoe Muskoka LHIN and the Central East LHIN documents contain the most similar structuring of goals, in that they include a small number of more general priorities and list numerous goals and indicators for each of these. The NSMLHIN’s plan is structured around three strategic priorities (improving access to appropriate care, building capacity and enhancing coordination, and driving system sustainability) and outlines many goals, activities, and interventions related to these (NSMLHIN, 2016a). For example, enabling timely access to and appropriate use of primary care and emergency services will be involved with the priority of improving access (NSMLHIN, 2016a). The CELHIN plan focuses on having more individuals living healthier at home and discusses the following strategic aims for this goal: supporting seniors, improving vascular health, supporting those dealing with mental health and addictions conditions, and supporting palliative patients to die at home by choice (CELHIN, 2016g).

The Toronto Central LHIN’s IHSP goals are similarly structured but have three very broad strategic goals in addition to four broad strategic priorities. For each of the TCLHIN’s priorities, their approaches, process indicators, examples of activities, and impacts/outcomes are listed. The TCLHIN outlines three overarching goals for the region (a healthier Toronto, positive patient experiences, and system sustainability) as well as four strategic priorities to guide investments and activities to achieve those goals (health care system design for the future; adoption of a population health approach; integrating primary health and community care; and improving/strengthening the LHIN’s capacity) (TCLHIN, 2016). The structure is different in the Waterloo Wellington LHIN document from the others LHINs’ IHSPs, as it focuses on the provincial alignment by using the Patients First action plan’s goals (discussed in 4.4.2 Aligning to the Provincial Plan – Patients First). The WWLHIN document lists three or four general
Table 6: Summary of Priorities and Goals for LHIN IHSPs 2016-2019

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Main Goal(s)/Priorities etc.</th>
<th>Strategic Priorities/Sub-goals etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCLHIN</td>
<td>• A healthier Toronto</td>
<td>• Health care system design for the future</td>
</tr>
<tr>
<td></td>
<td>• Positive patient experiences</td>
<td>• Adoption of a population health approach</td>
</tr>
<tr>
<td></td>
<td>• System sustainability</td>
<td>• Integrating primary health and community care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improving/strengthening the LHIN’s capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Timely and appropriate primary care and emergency services.</td>
</tr>
<tr>
<td></td>
<td>• Building capacity and enhancing coordination</td>
<td>• Mental health and addiction services, French language services, and culturally safe care for First Nations residents.</td>
</tr>
<tr>
<td></td>
<td>• Driving system sustainability</td>
<td>• Specialty care closer to home.</td>
</tr>
<tr>
<td></td>
<td>• More individuals living healthier at home</td>
<td>• Establishing infrastructure for better care for seniors.</td>
</tr>
<tr>
<td>CELHIN</td>
<td></td>
<td>• Enhancing coordinated care for individuals with complex needs and collaborative planning for palliative services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increasing electronic integration between providers.</td>
</tr>
<tr>
<td>WWLHIN</td>
<td>• Aligning to the provincial vision(^a) including:</td>
<td>• Enhancing quality and efficiency in the acute care system, and transparency in planning and directing investments.</td>
</tr>
<tr>
<td></td>
<td>• Access</td>
<td>• Improving quality of long term care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strengthening accountability and monitoring of investments.</td>
</tr>
<tr>
<td></td>
<td>• Connect</td>
<td>• Ensuring timely and accessible primary health care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Providing seamless, high quality service delivery.</td>
</tr>
<tr>
<td></td>
<td>• Inform</td>
<td>• Improving access to mental health and addictions services.</td>
</tr>
<tr>
<td></td>
<td>• Protect</td>
<td>• Transforming palliative care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Integrating hospital care to deliver evidence-based best practices.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strengthening home and community care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Modernizing long-term care through infrastructure renewal and quality improvement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Supporting caregivers.</td>
</tr>
</tbody>
</table>

Note. Data for the IHSP Main Goal(s)/Priorities etc. and Strategic Priorities/Sub-goals etc. for the CELHIN from CELHIN (2016), for the NSMLHIN from NSMLHIN (2016a), for the TCLHIN from TCLHIN (2016), and for the WWLHIN from WWLHIN (2016).

\(^a\)See 4.4.2 Aligning to the Provincial Plan – Patients First for more details on the main goals

...tasks the WWLHIN intends to act on pertaining to each broad goal (WWLHIN, 2016e). For example, the “access” priority is associated with ensuring timely, accessible, and supportive
primary care for all individuals as well as seamless service delivery for the four sub-LHINs (WWLHIN, 2016e).

However, the NSMLHIN, TCLHIN and CELHIN documentation appear to be similar in terms of how data was collected and used in establishing the planning priorities. All the IHSPs briefly explain that they use information from HSPs and describe their community engagement process, although with limited detail. However, none of the documents concretely justify the planning priorities. The CELHIN and NSMLHIN IHSPs used population statistics to suggest that there are underserved populations, or simply the existence of great demand for service improvements in outlined areas. The TCLHIN and WWLHIN IHSPs have more of an emphasis on community engagement. For example, the TCLHIN IHSP describes the community engagement process in some detail as well as providing extensive materials in the appendix for making decisions, stakeholder engagement, their full environmental scan, the health equity impact assessment tool and the community engagement guidelines toolkit.

Thus, the TCLHIN IHSP includes the most detail for their environmental scan, as well as their previous plan’s programs and initiatives. While they do not focus on the previous targets, they list and describe numerous projects over the last three years. The WWLHIN IHSP has a very basic environmental scan, in that it simply reviews the population of the area, and the population of seniors, francophones, and aboriginal peoples. The CELHIN and NSMLHIN IHSPs contain about the same level of detail, between these two extremes.

In comparison to the other documents, the CELHIN IHSP has the most level of detail on its priorities. Unlike the other IHSPs, the quantitative progress indicators for the CELHIN’s aims are explicitly stated (CELHIN, 2016g). Each involve reducing the number of days individuals spend in the hospital reflecting a decrease in the need for hospital care (CELHIN, 2016g). The CELHIN has also identified health system enablers and direct care priorities to support health system design and improvement for coordinated care (CELHIN, 2016g). Further, the plan indicates how the current goals are related to the previous IHSP and the indicators for the priorities in this IHSP, including graphics showing the progress on the MLAA goals and the current indicators, and explaining how hospital targets were determined in relation to the MLAA and SAAs of each HSP (CELHIN, 2016g). The NSMLHIN and TCLHIN IHSPs have similar both are less detailed that the CELHIN, in that they lack the targets and the relationship to the
MLAA and SAAs (NSMLHIN, 2016a; TCLHIN, 2016). The WWLHIN document does not quantify their targets (WWLHIN, 2016e).

The last detail to emphasize about the IHSPs is that mobility-access is not discussed in these documents, aside from a few references to transportation services. The CELHIN and TCLHIN IHSPs state the need for improved transportation accessibility, although it is by no means their focus. For example, one of their providers is quoted in the CELHIN IHSP as saying:

Our diabetes education programs need to be redeveloped and be more actively engaged with primary care and the community pharmacies. The programs need additional services such as pharmacists and social workers. We need to address food issues, transportation issues, mental health and stress. The programs need to be more flexible with weekend and evening hours, home visits and telephone support. (CELHIN, 2016g, p. 34).

Transportation was mentioned in a number of minor ways in the TCLHIN IHSP, for example stating that building and fostering integrated networks of care between LHINs will be enabled by improved transportation and network accessibility among many other things (TCLHIN, 2016, p. 46).

From the meeting minutes, it would appear that all of the LHINs are currently discussing similar topics or tasks – overseeing improvement plans or capital submissions of HSPs to get approval for more funding; managing the creation of the IHSPs (often involving reporting on meetings for negotiating funding, agreements, and annual business plans); educational sessions from members of HSPs; and some community engagement.¹ Some of the guests to the board meetings were also representatives from local HSPs in the region, providing updates on integration efforts or presenting proposals for voluntary services integration, sometimes with another HSP. The majority of the tasks addressed in the board meetings were not, however, related to integration. Further, mobile populations, mobility, and access were not a topic addressed in the meetings. This suggests that during this time period, LHINs did not focus on integration of care within the LHINs, nor did they consider mobile populations.

¹The broad trends of the LHN board meeting minutes have been summarized here but please see the following sources for more information: CELHIN, 2016a; CELHIN, 2016b; CELHIN, 2016c; CELHIN, 2016d; CELHIN, 2016e; CELHIN, 2016f; NSMLHIN, 2016b; NSMLHIN, 2016c; NSMLHIN, 2016d; NSMLHIN, 2016e; TCLHIN, n.d.-b; TCLHIN, n.d.-c; TCLHIN, n.d.-d; WWLHIN, 2016a; WWLHIN, 2016b; WWLHIN, 2016c; WWLHIN, 2016d.
In summary, while there is a significant amount of variation in the LHINs’ plans for the future and how they have structured their goals for health care, mobility and access is not a focus of the IHSPs. Further, the LHIN meeting minutes do not discuss programming to address mobile populations, nor do integration efforts appear to be a focus in their agendas currently. The IHSPs do not provide a lot of detail on the data LHINs use in setting goals and targets, nor on the methodology for their community engagement processes, although the importance of community engagement in planning is emphasized.

4.4.2 Aligning to the Provincial Plan – Patients First

The MOHLTC released the next phase of Ontario’s health care system plan, Patients First, in February 2015.² A major focus of the Patients First plan is improving the patient experience. Considering evidence-based procedures and patient experience in decision-making is intended to help in improving access and delivering high quality care. Some of the initiatives of the plan are relevant to LHINs including: improving access by providing faster access to care; delivering better coordinated and integrated care closer to home; providing education, information and transparency to allow patients to make health decisions; and protecting the public health system by making decisions based on value and quality. As a result, all of the LHINs have met to develop provincial strategic initiatives to better align with the objectives of Patients First, agreeing to focus on quality, population health, innovation, and sustainable service delivery to transform the patient experience, and address health inequities. The LHINs will also build integrated networks of care in priority areas such as mental health and addictions services, home and community care, long-term care redevelopment, end-of-life/palliative care, and Health Links. Health Links were originally an initiative from the Action Plan released in 2012 by the Ministry. Each of these represent local integrated systems of care at the sub-LHIN or sub-regional level. For the majority of the LHINs, the Health Links are in the early stages of development but are expected to improve access and coordination between organizations to

² All of IHSPs reviewed in the study contained the same information on Patients First, which has been used to describe the provincial vision as it pertains to LHINs. Please the follow sources for more detail: CELHIN, 2016g; WWLHIN, 2016e; NSMLHIN, 2016a; TCLHIN, 2016.
reduce the number of unnecessary emergency department visits especially for patients with complex health care needs.

4.4.3 Community Engagement

Each of the IHSPs were created with the involvement of many stakeholders in the community. The individual stakeholders referenced in the IHSPs are listed in the Table 7, as well as the specific initiatives in FLS and Aboriginal Health Needs. All LHINs are continuing to work with their respective French Language Planning Entity to identify the needs of the francophone populations in their regions (CELHIN, 2016g; WWLHIN, 2016e; NSMLHIN, 2016a; TCLHIN, 2016). They are also working with Aboriginal organizations in their regions to understand the needs of Indigenous peoples and to involve them in planning, implementation and evaluation of health outcomes. In addition to this, all of the LHINs have made cultural competency training programs to provide appropriate care for Indigenous peoples to HSPs (CELHIN, 2016g; WWLHIN, 2016e; NSMLHIN, 2016a; TCLHIN, 2016).

The information on community engagement further emphasizes the variation in approaches by these organizations in this region, in observing the range of methods taken in seeking input. Emphasizing community engagement in the production of IHSPs creates a system where collaboration between different organizations is built in. However, it is worth noting that collaboration with other levels of government or government organizations do not receive this same level of attention in the IHSPs.
Table 7: Summary of LHIN Community Engagement

<table>
<thead>
<tr>
<th>LHINS</th>
<th>Consultation for IHSP</th>
<th>FLS</th>
<th>Aboriginal Heath Needs</th>
</tr>
</thead>
</table>
| CELHIN: | • Collected input of patients and their family and caregivers, residents, health care system workers, and partner organizations.  
• Methods: planning partner engagement sessions (Health Link community planning tables, Health Interest Networks, etc); surveys; and presentations to municipal councils. | • Offer training to HSPs on culturally and linguistically appropriate services for francophones. | • No additional specific initiatives outlined. |
| TCLHIN: | • Input from consumers of health services, the public, HSPs and their boards, and marginalized populations.  
• Recruited participants for focus groups through community agencies. | • Offer training to HSPs on culturally and linguistically appropriate services.  
• Working with Reflet Salvéo, Entity 4, and the Central and Central East LHINs on mental health and addictions continuum of care for francophones. | • One of the member organizations of the Toronto Indigenous Health Advisory Circle which is currently developing a five-year strategic plan to identify gaps and Indigenous health priorities. |
| NSMLHIN: | • Patients and their families, HSPs, health care leadership and local board members actively participated.  
• A focus on including both rural/urban communities, seniors, Francophones, First Nations, Inuit and Metis. | • Partnered with Entité 4 to deliver workshops on “Language in Patient Centre Care”, training francophone health workers in Mental Health First Aid in French, and enhancing the data on the HSPs offering FLS. | • Funding a System Coordinator to work with the Health Links.  
• Aboriginal Patient Navigator position has been developed with First Nations communities, associations, and community health centres |
| WWLHIN: | • Community stakeholders not specifically identified.  
• Conducted a telephone survey and multiple focus groups with the community and gathered information from HSPs. | • As a result of the last IHSP, provided seniors’ exercise programs and mental health counselling over video in French. | • Created: the Aboriginal diabetes education program, and Aboriginal health and wellness promoter.  
• Hospice services available for culturally specific needs of Aboriginal residents. |

Note. Data for the Consultation for IHSP, FLS, and Aboriginal Health Needs for the CELHIN from CELHIN (2016g), for the NSMLHIN from NSMLHIN (2016a), for the TCLHIN from TCLHIN (2016), and for the WWLHIN from WWLHIN (2016e).

4.5 Discussion

4.5.1 Regionalization and Integration

As explained in 4.1 Establishing LHINs, the main difference between the regionalization processes that occurred in Ontario versus the rest of the country concerns the consolidation of
services, in that many existing organizations were retained in Ontario, rather than consolidating them. While the Ministry avoided much of the political confrontation that other provinces faced due to the dismantling of governance structures, LHINs are challenged in their regular operations and service integration by the vast number and diversity of organizations individually reporting to them, as noted by Elson (2009, p. 8). While other provinces restructured to have a two-tier system, Ontario created a three-tier system which is much more complicated in addressing their system management and integration role (Elson, 2009). This complicates efforts to integrate services. As an ideal, integration is intended to ensure better service for all residents and promote easier navigation of the system, which can be interpreted as limiting the system barriers to access. As mobile populations may experience system barriers in particular, difficulties in achieving integration goals may present structural barriers to LHINs addressing mobility and access.

However, as Fenn (2006) argues, beginning regionalization by changing bureaucratic structures slowed the reform process in the rest of the country. By first establishing local-level planning and funding processes, it was possible to appropriately divide tasks between the Ministry and LHINs and move forward with the health care agenda unencumbered (Fenn, 2006). However, this came at the cost of impairing integration efforts. Elson (2009) explains that LHINs have two competing agendas – having to manage finances (including staying on budget, and maintaining accountability and performance agreements with HSPs) while simultaneously attempting to foster system-wide integration. Each LHIN is accountable for specific deliverables under their accountability agreements, while integration requires the blurring of boundaries to focus on continuity of care between organizations (Elson, 2009). As a result, it is likely that the financial interests of each individual organization will take priority over efforts to integrate services, particularly with pressures to cut costs (Elson, 2009).

Moreover, there is an absence of clear expectations for the integration efforts of LHINs in the legislation, despite the LHSIA granting LHINs the responsibilities for integration. There is no model of a working template for integrated health care meaning that, as Fierlbeck (2011) states, “[i]ntegrated systems will have to work out relationships of collaboration and accountability just as painfully as regionalized systems did.” (p. 85). The lack of guidance may have led to integration becoming a more passive goal for LHINs. I observed in the meeting minutes that
most of the integration initiatives were proposed by members of the HSPs in question and these voluntary efforts were simply seeking approval from the LHIN Boards.

The way that Ontario has restructured the health care system has hampered integration efforts from the onset of regionalization and likely for future integration efforts. Without consolidating services at the beginning of the regionalization process, the health care system has become complicated for LHINs to manage. Despite the decision to retain most of the existing organizations, LHINs were charged with integrating services in the legislation. Moreover, LHINs’ individual responsibilities of financial management contrast their integration goals, as the latter would involve overcoming the individual interests of organizations. Limiting integration efforts represents a barrier in promoting the navigation of care for patients as, without integration, the ease of navigation through the system may not improve. Thus, any system barriers that mobile populations face may be difficult to address considering the restrictions on integration efforts.

4.5.2 Mobility and the Funding System

This sub-section considers the funding system and reforms and any implications for health care access for mobile populations. First, I consider how the funding system may appropriately address mobile populations. The HSF R offers more structure to the provision of funding. The previous dependence on historical funding amounts through global budgets did not reflect the volume or type of services patients received nor the quality or performance of HSPs (Chalk et al., 2014). Hypothetically, in the event of a significant increase in the demand for services for any given reason, HSPs should track this utilization and be reimbursed for any discrepancy between projected and actual usage. The responsibility to plan for the nuances of service delivery is on the LHIN-level, so any given variation in service demand should be addressed by LHINs under this funding formula. The procedures to collect data on mobility are in place, as patient residence is recorded in multiple service utilization databases. Therefore, patient residence information is available to inform health planners on any hypothetical changes in service demands due to the mobility of residents within and between regions. Tracking and using such data in health planning presents an opportunity to better allocate funding based on where mobile people are travelling to use services.
However, a significant portion of health care funding remains based on historical funding amounts through the global budget and as part of the calculations in involved in HBAM (Sutherland et al., 2013). Continuing to rely on historical funding amounts disincentivizes the development of new care models (Sutherland et al., 2013). Providers are unlikely to strive for innovation if their current procedures result in the same, traditional funding levels (Sutherland et al., 2013). In addition to this, Sutherland et al. (2013) raises concern over achieving various goals of the HSFR simultaneously as some goals may conflict in practice, for example increasing volumes of services, promoting efficient use of services, and decreasing spending.

Further to this, the difficulty in meeting all of the LHINs’ goals could be exacerbated if the historical funding amounts are no longer sufficient for the population currently residing in a region or the population using services in a region. Thus, careful, geographic consideration in setting the HBAM funding and the global budget appears to be a necessity. Without proper allocation, funding pressures may cause risky health system behaviour. Chalk et al. (2014) provides an example of such behaviours: hospitals may choose to focus on the QBPs (which are funded at a set price) over acute or complex patients (most of which fall under global budgets) because QBPs provide a greater opportunity to create funding surpluses in comparison with complex patients.

A broad perspective should also be taken in considering how the funding system may hypothetically disadvantage certain regions. Supposing that there are regions with greater capacity to provide QBPs than other regions, such a LHIN would be able to reap the benefits of the funding system. If people tended to travel to that LHIN to access specialized QBP services, the volume that other LHINs conducted these procedures would decrease. Thus, the LHINs with less capacity to provide QBPs would not be able to benefit from QBP funding to the same degree as the LHIN with greater capacity to provide these services. In an extreme situation, those regions that provided fewer QBPs would receive far less funding, nor would they be able to gain the expected funding surpluses from these procedures.

Further to this, the indirect expenses of service provision could also be a source of pressure within this funding system. It is unclear in the health system information available to the public where the additional important health care goals such as community engagement or facilitating transportation to services are budgeted. It can be assumed that it falls under the global budget,
since HBAM is based on direct service provision. If these services are allocated under the global budget, there is an even greater importance in determining appropriate global budgets for the current health system. The literature also points out risks for the global budget. The indirect costs of services funded under the QBP allocation, such as equipment and overhead, are cut out of the global budget, by using utilization data to determine the amount of the indirect costs (Sutherland et al., 2013). Sutherland et al. (2013) argues that, while “conceptually ambitious”, there are no international examples of using data this way, nor is there evidence to support the feasibility or effectiveness of this method (p. 16).

In summary, there are some concerning aspects of the funding system and reforms considering a mobile and dynamic population. From the information that is available, it appears that, if the funding is not very carefully allocated, this funding system could overly benefit those regions that historically receive high levels of funding or have higher capacity to provide QBPs. This means that some LHINs may become overly reliant on their global budgets or suffer from lack of resources.

4.5.3 The LHSIA and the Provincial Focus on Patients

This section concludes the discussion of the structure of the regionalized health care system by examining both the province’s most recent action plan, Patients First, to understand the provincial direction for the health care system in the next coming years, and the health care system’s relevant legislation to mobile populations. The Patients First initiative emphasizes patient experience in the context of an aging population, and, thus, there is a focus on strengthening home and community care (MOHLTC, 2015a). It is clear from an overview of the LHIN IHSPs that this perspective is reflected in their strategic plans for the next three years. This is most apparent in the CELHIN and WWLHIN plans, while the TCLHIN and NSMLHIN seem to be concentrating on the improvement of system design, and building capacity and coordination. There appears to be little effort directed to addressing mobile populations in planning, although securing transportation in accessing services is mentioned in the IHSPs for the CELHIN and TCLHIN. The other LHIN IHSPs did not comment on transportation. It can thus be concluded that, while the broader challenges in accessing the health care system are
recognized by some, mobility is of little consideration for the current provincial and LHIN strategic planning.

Despite the lack of planning initiatives for mobile populations, there are pieces of legislation and these strategic plans that concern mobility. The LHIN boundaries were designed with some level of mobility in mind. As stated at the beginning of the chapter, the localization indices (LIs) for LHINs ranged between 59.1 to 97.2 percent according to Ardal et al. (2006a). The range of LIs means that there are variations in the degree that the LHIN barriers encapsulate the utilization of services by residents of an area. It is noteworthy that residents in Ontario are using services outside their region and, for some regions, the degree of mobility in using health care services is significant. Further, there is has been no indication that these barriers will be regularly updated, and one gets the sense that these boundaries are not meant to be dynamic. The mobility in usage of services highlights the necessity of properly addressing mobile populations and continuity of care at a larger scale. The LHSIA explicitly protects travel to health care services by restricting LHINs from entering into agreements that will prevent individuals from receiving services based on their residence, although any procedures to assist such patients in getting to facilities is not outlined.

However, home care is considered in planning and it can be inferred from the recent initiatives for providing home care that the province, and therefore LHINs, are attempting to limit the distance individuals must travel for health care. While focusing on home care acknowledges mobility and the logistics in using the health care system for non-ambulatory residents, home care efforts do not address potential access issues related to such mobility as commuting and seasonal travel. Provincial-level planning is, therefore, limited in its consideration of mobility to improving home care as a way to specifically increase access for seniors, rather than discussing mobility between LHINs or the mobility required by all Ontarians to navigate the health care system. The latter would involve services that reduce the opportunity cost and improve the ease of using services for all Ontario residents, in addition to those that require home care.

Moreover, it is important to note that community engagement is loosely defined in the LHSIA, which means that there is some variety in the degree to which LHINs consult their residents, their community engagement methods, and the amount of information they distribute. The regional variation in the ways goals of the health care system are conceptualized and decided
upon described earlier in this section may be reflective of lacking a clear definition of community engagement tasks. Further, it is not a specifically mandated goal of LHINs in the LHSIA to consult other government agencies or municipalities within their region. Thus, LHINs may be limited in their ability to coordinate health services with other social services to facilitate health care access should LHINs refrain from collaborating with other government agencies.

Preliminary conclusions can be drawn from this section’s secondary research on some aspects of the structure of the health care system that may limit how mobility can be accounted for in health planning. While utilization and place of residence data is collected, there do not appear to be specific mechanisms for using such data. There are limited guidelines for LHINs in conducting services in terms of collaboration and integration, and mobility is not accounted for specifically in funding, with the assumption that simply accounting for demand is nuanced enough on the provincial-level. This may result in an over-reliance on HSPs’ global budgets. Proceeding from the discussion on the structure of the health care system, I will present the research of the interviews with LHIN participants to understand how this system works for mobile populations and how they would characterize the impacts of mobility on health planning and health care access.
Chapter 5
Mobility and Geography Factors to Access

5.1 Introduction

The previous chapters of this thesis have laid the foundation for understanding health care access for mobile populations by reviewing the literature on regionalization and factors of access, in addition to presenting the results of the secondary research on the structure and legislation of the health care system. The following sections in this chapter present the results of the semi-structured interviews with the LHIN and BCHC participants. As the interview with the WWLHIN participant was significantly shorter than other LHIN interviews, and the BCHC interviews were conducted with a different interview guide, there is less data used from these sources.

All of the factors discussed in the interviews concern mobility and geography to different degrees. As a result, the data from the interviews are organized into two main patterns of health care access factors. The first of these are defined by mobility and the movement of individuals, so I will use the term “movement-based” to refer to these factors. The other set of factors emphasizes geographical contexts of access and are called “place-based” factors. The chapter directly pertains to the research objectives of documenting the factors to health care access for mobile populations identified by the participants and understanding how health care access for mobile populations is addressed by the regionalized health care system. Presenting the results will also provide insight on how the participants characterize health care access for these populations, but this will be continued in the next section, the discussion, alongside the interpretation of the interview and secondary research results with the literature and legislation.

5.2 Movement-based Factors to Access

This section contains the results of the interviews with the LHIN and the BCHC participants that are emphasizing the mobility of residents and accessing health services in southern Ontario, thus presenting the movement-based factors identified by the participants. The interview questions directly asked participants about how commuters use the health care system and how the health care system addresses commuters, as it represents a mobile population in the study area. As a
result, the first sub-section presents the participants perspectives on the considerations for health care access for commuters as a mobile population. Here I use the term “logistics” in navigating the health care system to refer to such practical aspects of using and scheduling services at health care facilities, such as office hours.

However, the participants raised access to transportation as a factor in residents effectively seeking out appropriate health care without initial prompt. Thus, the interview data on access to transportation as a factor in the health care system has been presented in the second sub-section. The last sub-section describes two themes within the mobility interview data. The first theme is the funding system, which was a reoccurring aspect in the interviews, albeit with a great degree of variety of opinions on how well it follows the mobile populations. The second is the choice in where residents seek health care, commonly referred to as some variant of “the right to patient choice”. The LHIN participants commonly presented the commuters’ use of the health care system as ultimately the choice of the patient, maintaining the necessity to protect this right.

5.2.1 Health Care Access for Commuters

There are some patterns that emerge in the responses from the LHIN participants on commuting and access to health care. The CELHIN, NSMLHIN and WWLHIN participants suggested that commuting was somewhat concerning but not enough to prioritize it in health planning. The CELHIN participant stated that they consider commuting a cost to the health care system and patient in both time and money. The cost for the patient is mentioned as a possible reason one might not be able to maintain a relationship with a physician after moving and their reasoning for characterizing commuting as a “planning consideration”:

I’d say [commuting is] an active issue for our LHIN given that we are outside of the city of Toronto and we have growing suburban areas, actually Durham region is going to be our highest growth area in the next 20 years. And plus implicated by that would be development in Durham Region and beyond into our North East cluster of transportation routes like the 407 as well as extension of GO Trains service. [CELHIN participant].

The NSMLHIN participants also raised concerns with commuting and health care access. Firstly, they argued that the funding is not following people who commute through the system:
we have a large percentage of our population not only commuting within the LHIN and part of the challenge that this presents particularly as HSFR and HBAM aren’t fully functional is that money isn’t following the patient and so we have a number of people who are potentially presenting in Downtown Toronto when they could get care closer to home or we have people who are referring out of LHIN because they are working in Toronto and would just like to have that continuity of care closer to work. So it is challenging if funding isn’t following the patient entirely. [NSMLHIN participant].

Secondly, the logistics of commuting are characterized by the NSMLHIN participants as having a large impact on patients as they may have to take a day off work, possibly without pay, to arrange an appointment. Thirdly, the “rostering” system was suggested as a challenge for residents travelling to use services and was used as just “one of a number of examples exists in health care that make it difficult to access services outside of what you’re connected to” [NSMLHIN participant] within a regionalized system. They later suggested that the main concern with travelling to see a doctor in another LHIN is that it prevents an individual from accessing the connections a doctor has within the LHIN of residence. Fourthly, they described commuting as a factor that limits the choices patients with chronic conditions have in receiving care. In their example of a diabetic or hypertensive patient, they argued managing those illnesses is more difficult as a commuter, which will not change unless the health care system somehow comes to them. They, as health workers, are unsure of how to do this as patients sometimes cannot access care at home because of the hours of operation and cannot access some services in Toronto because they do not live there.

Despite the concerns, the LHIN participants did not characterize commuting as a priority in health planning. The WWLHIN participant explained that health planning considers many broader social aspects of health and that commuting, as just one of many component pieces of the community, does not warrant priority over other considerations. Similarly, the NSMLHIN participants maintained that they have not set aside commuters as a special population within their region. It is implied that singling out commuters in health planning would be an exceptional consideration in programming services, such as the focus on facilitating health care for seniors in Patients First (see 4.4.2 Aligning to the Provincial Plan – Patients First). A NSMLHIN

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3 As described by the College of Family Physicians of Canada, the patient rostering system “is a process by which patients register with a family practice, family physician, or team.” (p. 1) and facilitates accountability and long-term relationships with health care providers (College of Family Physicians of Canada, 2012).
participant indicated that commuting is an aspect of the population that is considered alongside other aspects of the community in saying that, “commuting is certainly an issue and just adds to the community profile for us is just as it does many LHINs.” [NSMLHIN participant]. In other words, the NSMLHIN participants considered commuting as a factor for the entire population of the LHIN rather than, for example, creating specific programming to address commuters. The NSMLHIN participants predicted that the population within their LHIN’s jurisdiction will always have a large number of people commuting into the city and that it is an issue larger than their LHIN in how they address it. Similarly, the TCLHIN participant stated that commuting is not something that has been specifically discussed in health planning. This is despite the TCLHIN participant’s statement that the population in Toronto increases dramatically during the day and that some of these individuals may choose to seek their health care services in Toronto. However, while they believed the mobility of patients and clients is a factor health planners are aware of, they conceded that “it’s hard to know” [TCLHIN participant] if commuting has been an issue:

… but so far I don’t think it has been. (…) I think that if our healthcare is flexible enough to adjust to demands as they rise and fall (…) that should offset the variability of demand driven by commuting. (…) whether they are resident population or commuting population or visitors to the area, they [health service providers] still have a responsibility to try and meet the needs of those clients and patients that come to their door, right? [TCLHIN participant].

This statement explains that it is difficult to foresee commuting’s future role in health planning, although the participant presumed that the health care system is flexible enough to adjust to wherever patients’ demands occur. Similarly, two of the BCHC participants were only able to guess at commuting’s impact on access. One of these participants assumed that there were logistical challenges commuters faced in accessing care but made it clear they were extrapolating from their understanding of the health care system and had not considered commuting in this way before. The other said that, while the Centre does not address commuting in organizing their services as they have long-term relationships with clients, they assumed that those providing and managing acute care would feel more of the impact of commuters’ demand for services. To summarize, some of the participants were more inclined to consider commuting an issue than others – the CELHIN participant portrayed commuting as a consideration, the NSMLHIN participants suggested it was a concern that did not require specific programing in planning, the TCLHIN participant was cautious in predicting the importance of commuting to access, and the
BCHC participants presumed that commuting was a challenge without having considered it seriously before.

The use of digital data and after-hours clinics were raised by some participants as ways to mitigate any logistical issues commuters may face in accessing health care services that the participants raised. Digital data and the eHealth initiative were referred to in two related ways: the use or collection of digital data for electronic medical records (EMR) and telehealth services. Both the CELHIN and NSMLHIN participants focused on the former, as participants stated that the eHealth initiative should have ensured that EMRs travel with the patient but this is not a reality yet. For example, electronic networks are mentioned several times in the interview with the CELHIN participant, who suggested that the use of electronic networks with video conferencing will connect people with specialists and eliminate the need for travel. For the latter, the BCHC and TCLHIN participants stated that telehealth services should negate the need to travel to health care services, in that travelling to see specialists would not be a necessity for patients in remote areas with further integration of telehealth services. One BCHC participant in particular strongly held this conviction, who also argued that a telehealth connection to Toronto specialists will be necessary as securing an appropriate number of specialists based in Barrie is unlikely given the small population size of the city in comparison to other areas in the province. They further implied that it is beneficial to make “it easier for people to live in a less expensive area (...) or a place that’s that they want to live as opposed to having to relocate to where what their medical needs are (...)” [BCHC participant].

After-hours care was mentioned by NSMLHIN, CELHIN, BCHC, and TCLHIN participants. The NSMLHIN participants stated a strong interest in providing more flexible hours to care, and that they would like to provide services beyond the typical work day hours for those commuting (or doing shift work) and plan to provide these services in an innovative way. This perspective was also prevalent in the BCHC interviews. One BCHC participant believed that the health care system must change “to meet the needs of the commuters” by “having flexible hours” [BCHC participant]. They expanded on this perspective:

(…) I think it’s only going to get worse the commute and not worse in the sense that commuting is bad but I think the distances that people have to travel and they … the number of people that have to commute to go to their job or to get jobs is going to only increase and –and because of the GO train and transportation services like that it means
that people can live much further outside the city and work a great distance away, (…) [BCHC participant].

However, the TCLHIN participant best characterized the main perspective on after-hours care:

(…) It’s been a greater push [to have more off-hours services available] - it’s been a greater push in terms of our primary care strategy where [we want] to ensure that physician offices, health care teams (…) have extended hours for those individuals that need those extended hours. It is generally understood that if people really need to see a doctor and they can’t get to their physician they’re going to go to emergency department and that’s really probably not the best place for them to get their primary care. First of all you’ll be waiting for hours and essentially (…) it’s probably a need that can be met with a visit to their family physician so it’s also an inappropriate use of a hospital. (…) so more recently our focus has been on ensuring that the health care system is responsive to the needs of our patients and clients when they need the service so we’re looking at extended hours as I said … [TCLHIN participant].

The LHIN participants largely suggested care after business hours as a way to reduce unnecessary ED visits which are seen as less efficient use of resources. It should be noted that commuters were implied to contribute to these ED visits by the participants.

The LHIN participants aside from the WWLHIN participant, walked through hypothetical examples of commuters accessing health services, all of which suggested there could be logistical challenges in navigating the system. These hypothetical examples provided insight on how the LHIN participants characterize access and in documenting how the health care system addresses access for mobile populations. For example, the CELHIN participant, when asked to explain how commuters might use the health care system and how that would be taken into account in health system planning, they elaborated on their thought process:

Well one way is thinking about where people go for their services - so folks who live in Durham region for example, they’re commuting to downtown Toronto - do they have a primary care physician that’s downtown Toronto? Are they using walk-in clinics downtown Toronto? Sometimes people want to consume their services closest to where they work during the daylight hours or even evening hours rather than where they are at home. [CELHIN participant].

In this statement, they suggested that commuters may access the system in a number of ways, including walk-in clinics or rostering with a primary care physicians in Toronto to use services during regular office hours. However, the CELHIN participant did not expand on any planning initiatives on commuting or how these considerations would factor into planning. Further to this, when asked if commuting affects the access of different types of care, they answered that,
“Mobility is certainly a concern” [CELHIN participant] and went on to explain that seniors consider mobility “front of mind” when thinking of moving residences. They related this to commuting as it also uses various methods of transportation, such as driving and public transit, and argue that lacking transportation to care, such as a driver, is a factor for senior patients and their family caregivers.

Similarly, the BCHC participants also spoke to these logistical challenges. One BCHC participant explained that the community is changing with the GO Train and GO Buses in that it is making it easier for people to commute to work in Toronto, thus increasing the population in Barrie. Such commuters may be accessing health care in Toronto as “(…) some people (…) - that live here [in Barrie] and work in Toronto they get a lot of their health care in Toronto because they spend more time in Toronto than they do here…” and, because of this, they believe that the health care system has to change to “meet the needs of the commuters.” [BCHC participant].

However, the CELHIN and TCLHIN participants highlighted a surprising health system data procedure concerning mobility - LHINs do not use data that track place of residence versus place of receiving care, although their HSPs do track this and are presumed by LHINs to have an understanding of related patterns. When asked where do they believe residents of their region are using health services (either close to home or work), the CELHIN participant stated that, “We don’t have a way of tracking that other than our health service providers would when they’re servicing people - they would understand where their place of residence was.” [CELHIN participant]. The TCLHIN participant explained that the patterns in the data are hidden to them:

The service providers (…) they collect information around place of residence. As a health care planning organization, we don’t get client-specific data so we don’t know so (…) we don’t see health client-specific, patient-specific location or profiles. We just get the rolled up numbers so it’s a hard question for us to answer yeah. [TCLHIN participant].

When providers speak to LHINs as funders about this, it is implied that HSPs do not volunteer what utilization proportions are from a resident population and a commuting population. The TCLHIN participant stated that they do not necessarily ask them about utilization and resident locations and only fund based on volume, wait time and other such factors. According to the TCLHIN participant, LHINs do not use individual-level data for health planning in general, meaning that in order for LHINs to have an understanding of such patterns on mobility, HSPs
must present utilization data to them. As stated in 4.3 The Funding System and Reforms, it can be confirmed that HSPs track place of residence for a number of different databases. Thus, it can be inferred that HSPs must not be raising commuting as an issue to LHINs. However, it is likely that HSPs would provide their general thoughts on the impacts of commuting if directly asked.

In summary, the CELHIN, NSMLHIN, and TCLHIN participants suggested that there are some concerns for health care access for commuters but did not present commuting as a major factor to access to health care for residents in southern Ontario. The CELHIN and NSMLHIN participants were aware of the large commuting population in their regions and the NSMLHIN participants in particular raised a number of logistical challenges for commuters in accessing care. The NSMLHIN participants spoke to challenges related to the health care system including the complications of the rostering and funding systems. The participants also spoke to the opportunity costs of access for commuters (e.g. having to take off time from work) and additional logistical challenges for those with chronic conditions. However, the participants were not certain if and what impacts commuting has on access for this mobile population, especially because individual data on residents (including place of residence) is not used in health planning by LHINs.

In spite of this uncertainty, the TCLHIN participant suggested that the health care system should be flexible enough to accommodate for commuter’s use. In addition, the use of digital data and after-hours clinics were raised by the participants as ways to mitigate logistical issues in accessing health care services for commuters, despite arguments that telehealth services are not sufficient yet. While telehealth services and extended hours were offered as solutions, none of the LHIN participants stated that there were planning initiatives for commuters or how this mobile population may be factored in planning, although they were able to provide hypothetical examples on how they much navigate the system. Thus, there are a variety of perspectives on commuting, but the participants appear to agree that it is not a major factor impacting health care access for the residents of southern Ontario.
5.2.2 Transportation to Health Care Services

The commuting issues raised by LHIN participants were often related to other mobility and geography concerns in health planning, the most common of these being transportation to health care services. This sub-section details the participants’ perspectives on transportation and health care access for mobile residents, who presented transportation as a factor in accessing health care in southern Ontario. In particular, the BCHC, CELHIN, and NSMLHIN participants focused on transportation barriers in answering the interview questions on mobility and health care access. The BCHC participants presented transportation as a parameter around health care access and status. One participant described the difficulties for patients in accessing transportation and even accessing transportation services offered by the health care system.

For the CELHIN participant, transportation was a prime focus in regards to mobility, even suggesting that further recruitment for this study should be framed around transportation planning or development in southern Ontario. They listed a number of services for patients facing “certain conditions” “who have routine need for transportation to an area [or] a community outside of their own” [CELHIN participant]. Some services are funded by the LHIN while others are privately-funded, non-urgent transportation services (the patient is usually charged for the latter although some providers bury this cost). Volunteers help run some services but the participant did not provide details. Eligible patients for these services appear to be those receiving treatment for chronic conditions such as kidney disease services, cancer services, chemotherapy and radiation. Despite the services available, they alluded to issues in ensuring patients are transported home, within or outside the geographic boundaries of their LHIN after appointments or procedures, as their HSPs consistently report public transit and transportation pressures for clients. The participant explained that, because the CELHIN is geographically large, transportation planning is “something that [they are] always aware of” [CELHIN participant]. They considered urban development, population growth, and the expansion of transportation routes as important factors in health planning due to their role in increasingly providing “the opportunity for people to live out farther from the city core.” [CELHIN participant].

The participants from the NSMLHIN did not focus on services to alleviate transportation concerns for residents, but did outline the struggles of transportation access in their region. The
participants explained that there is a high level of mobility generally required for residents outside of the GTA to access providers. The NSMLHIN participants maintained that some form of transportation is necessary to access health services, even with community hospitals located in the sub-geographic areas of their LHIN, which they imply should be a sufficient number and distribution of hospitals. They said that the necessity to secure transportation means that it may be difficult for residents even just a kilometre outside of a main centre to access services, as some communities do not have a public transport system or a community organized transportation provider. The NSMLHIN participants further characterized the idea that people are mobile and ambulatory as assumptions of the health care system. An example they brought up to complicate this assumption of the health care system was weather, as they suggest that extreme weather events occurring in the region (mostly referring to snowfall) “profoundly” affect the ability of people requiring health care to find a provider, leave their house, or arrange for services to come to their home.

The NSMLHIN participants argued that transportation services are needed on multiple levels, including public transportation and facilitated transport, and maintained that one mode of transportation will not meet all of the needs of the community. There is the need for a coordinated approach, which the NSMLHIN is endeavouring to incorporate, but are challenged by lack of resources. The NSMLHIN participants brought up the LHIN’s community engagement sessions a number of times when they discussed how transportation issues are addressed in the health care system, appearing to use these sessions to gain feedback on planning from their patient-family caregiver advisory council and learn how to best leverage the limited resources in the community.

In contrast, the TCLHIN participant discussed transportation to a lesser degree, although they recognized that transportation services are lacking for certain populations and listed a few services to combat this. For instance, there are community support services which primarily target the elderly for transportation to medical appointments and there are other transportation services that will ensure that clients are getting to appointments, regardless of their place of residence, which are funded, presumably by the LHIN. They discussed the necessity for transportation as an implicit factor in the system, in that individuals will travel for the services they prefer or are referred to. Much of the information related to transportation from the TCLHIN participant interview is indicative of the assumption that people will travel to receive
health care. The participant stated that LHINs assume that people will try to find health care where they live but understand they are not limited to that: “Hospitals obviously (...) have leaders in cancer and transported so they, their physicians will refer to the specialized services so whether it’s by choice or whether it’s by referral you know people will move right?” [TCLHIN participant]. Because of this, individuals will be mobile depending on what their needs are and where their provider is. The TCLHIN participant said that the TCLHIN is “keenly” aware of the mobility of patients, and stated that “people will go (...) where the services are”, meaning that they will seek out the services that best meet their needs. Because of this, if there is a service in Toronto that the patient anticipates will best meet their needs, according to the participant, the TCLHIN believes the patient will travel. However, whether that trip is a specific visit to access health services or a secondary goal of the trip (e.g. the patient goes downtown for work and accesses health services there while on a lunch break) is “something we really haven’t thought of” [TCLHIN participant].

This sub-section has provided the results pertaining to transportation and access. Transportation was presented as a factor in health care access for southern Ontario, most prominently by the BCHC, CELHIN, and NSMLHIN participants. Transportation is thus characterized as important in regional health care access by the participants. It should be noted that a number of the participants stated that transportation issues in health care access have been exposed in the process of engaging with their regions’ communities and HSPs, a fact that they often used to support the idea of transportation as a factor for access. In particular, the CELHIN participant characterized transportation as a prime focus for mobility and access in the interview. They outlined services to aid patients in getting to and from appointments, thereby providing evidence on how this region addresses some related issues. The CELHIN participant also linked transportation challenges to population growth and increasing transportation infrastructure. The NSMLHIN participants discussed the necessity of transportation to access services in their region, due to the remoteness of some residents and challenges presented by weather conditions. These participants argued that a coordinated approach is needed to address these issues, for example arguing for improvements of transportation services on multiple levels. The TCLHIN participant discussed transportation to a much lesser degree and, while recognizing that transportation services are lacking for certain populations, they largely assumed that people will travel to receive the health care services they would like.
5.2.3 The Funding System, Patient Choice, and Mobility

While there were two main factors to mobility raised in the interviews, there were two additional reoccurring aspects to these discussions: 1) the funding system in Ontario and the related idea of “costs” to the health care system and patients, and 2) the Ontario residents’ right to access health care in the location of their choice. These patterns within the data are important in understanding the ways that the participants characterize access for mobile populations in southern Ontario. They provide context to the two main mobility factors summarized in the previous sub-sections. In addition to the context, the results in this sub-section will be incorporated in interpreting the mobility-access factor results in the Chapter 6.

First, I will describe the participants’ variety of perspectives on the funding system, as well as the type of information raised on the topic in terms of mobile populations. Both the NSMLHIN participants and the TCLHIN participant discussed how they believed the funding system works for mobile populations, although with opposite perspectives. The TCLHIN participant expressed a firm belief in the strength of the funding formula in accommodating for the population, because funding builds with population growth. However, the participant asserted that funding is not solely based on population growth, otherwise commuting could be a concern, and stated that “[t]he funding formulas do have sort of have that mobility factor built in (…)”. They explained that, “we [LHINs] just fund based on drivers of volume, wait time, that kind of thing.” [TCLHIN participant], proposing that the funding follows residents’ utilization of the system because of volume-based measures. In direct contrast, the NSMLHIN participants argued that funding is not following the patient. It is interesting to note that the NSMLHIN participant specifically references the HSFR and HBAM not being fully functional yet in their statement before explaining the challenges related to patients referring out of the LHIN (see the quote in 5.2.1 Health Care Access for Commuters). It is unclear what stage the implementation of the HSFR is in, but the differences in perspectives between the participants from these two LHINs could be related to the progress on the reforms.

The NSMLHIN participants presented a further challenge of the funding system. When asked about the LHIN’s ability to deal with these mobility-access issues, one NSMLHIN participant said:
because we can’t hold all the funds around transportation because that is offloaded to
the municipalities. We can only do that in collaboration with [the municipality] right and
so we have a very good working relationship with the county of Simcoe and the District of
Muskoka and you know we certainly involve them in our planning processes (...) and
hopefully involving them, they consider that information when they’re doing their own
planning around transportation. [NSMLHIN participant].

This statement indicates that, because LHINs do not have funding for transportation, they must
work with other organizations or the municipalities to facilitate access in consideration of the
broader factors of access, while hopefully maintaining a healthy working relationship to continue
these efforts. Both the NSMLHIN and CELHIN participants offered increased collaboration with
municipalities as a solution to mobility-access issues discussed in the interviews. In particular,
the CELHIN participant highlighted the lack of a consistent framework for collaboration which
would assist in their work. The other participants did not specifically address the funding
system. For example, the CELHIN participant did not address how the funding system works for
mobile populations but did characterize transportation and commuting as costs for both the
patients and the health care system and discussed funded and unfunded services to mitigate these
costs.

The second theme in the interview data on mobility and access documented in this sub-section is
the right to patient choice. The importance of protecting patient choice in accessing health care in
any location in Ontario without geographical barriers was often implicit in the statements made
by participants on mobility and access. However, the participants’ perspectives on patient choice
were not always consistent. For example, the CELHIN participant affirmed their belief patient
choice in using services regardless of location a number of times, while at the same time
maintaining that “(...) equity doesn’t mean equal services” [CELHIN participant]. Expanding on
this:

(...) you should have primary care for sure close to home, you may have an emergency
service, you may not have the rehabilitation that you need so it will all depend on what’s
available and – how far field you’re able to travel to receive that service if it’s not available
in an – alternative format – like Telemedicine. [CELHIN participant].

In other words, the CELHIN participant explained that not all health care services will exist in
every location and that users of the health care system may need to use alternative methods in the
event they do not live within reasonable travel distance of facilities. The distribution of services
in the region is related to cost, as the CELHIN participant suggests that there are “logical,
economies of scale for services” [CELHIN participant] but also said that LHINs consider the time residents have to drive to services.

While the CELHIN participant characterized patient choices as having some practical limitations in the system, the right to individual choice in health care is strongly represented in the TCLHIN interview, and this perspective appears to be related to their opinions on commuting and transportation access. The TCLHIN participant emphasized the idea that people will travel to seek out services they want, stating that “for all services if there’s - a client that lives somewhere else and they know of services in Toronto that can best meet their needs we know that they will travel. …” [TCLHIN participant]. For commuters, “the expectation is that if that [Toronto] is the right place of care for that individual then that’s where (…) the services ought to be made available.” [TCLHIN participant]. In the case of chronic conditions, where patients would like their care delivered is handled by the patient and “(…) they’re going to have to make those arrangements right?” [TCLHIN participant], suggesting that patients enter into a conversation with their family doctor to discuss their preferences for where to manage their care. However, they stated that if the patient suffers from an acute condition, they will be taken to wherever makes medical sense and will be discharged when medically safe to do so.

Similarly, the WWLHIN participant strongly asserted that the regional jurisdictions of LHINs are not barriers and patients have the choice and right to use what services they prefer. They recognized that clients may be accessing services in a variety of locations, in that “(…) it could be near [where] you live[,] it could be near your work, it could be in neither of those and you choose to continue to have that primary care provider - for a variety of very good reasons” [WWLHIN participant]. They maintained that there are no barriers between LHINs for health care access and that it is an individual’s choice where they can receive services. They reaffirmed that:

Health care is in an open public system and so no matter where you live or work certainly your access to urgent care clinics, your access to – well clinics of any nature for that matter, to hospitals et cetera is not impeded in any way by … by moving around the province. [WWLHIN participant].

In arguing that there are no “boundary issues related to the delivery of health care”, they stated that because the public health system is open to the broader public, “(…) regardless of where you live or work you should have access to this public health system, so it’s … transferable.”
Individuals must be able to access services when they need it, so the participant explained that this is taken into consideration as part of “good planning.” [WWLHIN participant].

In contrast, the NSMLHIN participants were notably conflicted on the role of patient choice, as they raised suggested that individuals are not always presented with extensive options for health care due to the logistics of their schedules and the health care system. They emphasized that having flexible services is necessary for accessibility, stating that:

(…) we can’t just think of Monday to Friday, 9 to 5, because that’s not the most accessible for everybody so if (…) you don’t have the flexibility to be available when people need you to be available it certainly would impact acute or chronic health care management. [NSMLHIN participant].

The idea of “demands for greater flexibility” are referenced a number of times in the focus group, as the NSMLHIN participants explained, without flexibility, people may use care that is not the most appropriate for their needs. They acknowledged that people have choice in where they receive their health care, as “in some cases you know, or we have people who are referring out of LHIN because they are working in Toronto and would just like to have that continuity of care closer to work.” [NSMLHIN participant]. However, there is a growing number of individuals becoming chronically ill and commuting is a logistical concern in receiving their care. Therefore, commuting limits their choices to some degree, as they suggested some concerns with this:

(…) the large group of people that commute to the GTA every day for work, (…) if they’re diabetic or hypertensive and they’re not managing those illnesses well like, they haven’t had their bloodwork done so they have no idea how well or unwell they are, that isn’t going to change unless we somehow come to them, right? And so - I don’t know how to do that, that if they can’t access health care at home because the hours of operation are poor and they can’t access some in Toronto because they don’t live there. [NSMLHIN participant].

The latter assertion that there are services that non-residents of Toronto cannot access may be referring to primary care services from a GP as a result of the rostering system. This statement contrasts with the narrative that patients may choose to access services wherever it suits them by raising the logistical issues for those with chronic diseases. It is also inconsistent with the idea that LHINs do not present patients boundaries in health care.
The BCHC participants had additional comments on the funding and patient choice themes in the mobility and access interview data. However, it is important to position these participants’ perspectives as primary health care workers from an organization on the receiving end of LHIN funding, in contrast with the LHIN participants who are involved in health planners. The majority of the statements from the BCHC participants on funding were positive, in that they generally spoke to the benefits of the LHIN’s larger scope in removing the “silos” of funding. However, one participant described that it is exceedingly difficult to measure prevention in terms of funding for chronic disease self-management (which is a focus for the province). They provided a hypothetical example to expand on this:

(…) how do you prove that this program saved this many dollars in the end because these people with diabetes didn’t end up going to the emergency room because they stabilized and their diabetes is under control because they’ve learned to exercise – [BCHC participant].

Another BCHC participant implied that it is challenging to address broader factors of health, using the example of services to mitigate transportation barriers to health care:

… it’s always problematic however (…) when you’re funded for health services (…) we want to mitigate all barriers to accessing [services] and transportation is a huge one for many people on even within the city of Barrie but we can’t pay for transportation although that’s often the ask. [BCHC participant].

It can be inferred from this statement that the Centre would prefer to employ a more comprehensive approach to health care but the funding system does not allow for such a perspective. Interestingly, this sentiment was echoed by the NSMLHIN participants earlier, with their statement on the necessity to collaborate with other organizations to address transportation issues in health care access. Further, this BCHC participant also suggested that the current funding model will have ramifications for certain kinds of patients in their area:

(…) I think perhaps (…) the capitation model doesn’t really lend itself to necessarily wanting to have large (…) patient rosters with individuals with lots of complexity, so young families absolutely you move to region, you’ll probably [going to] find a family practice but if you are of an older age cohort or you know you have – mental health or addictions problems, it’s more problematic. [BCHC participant].

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4 The capitation model (or blended capitation model as referred to by Health Force Ontario) is “based on a defined basket of primary care services provided to enrolled patients based on age/sex of each patient.” Physicians also receive capitation payments for all enrolled patients on a monthly basis and there are additional payments for
Because of the funding system’s difficulty in addressing complex patients, this participant believed that the community health centre model is the best way to handle such issues, implying that more funding would better equip the Centre to addressing more complex patients.

A BCHC participant also had a noteworthy point regarding patient choice, with expressing a strong belief in seeking care within one’s community:

(...) with (...) the broader concept of health including all of the social determinants of health, in terms of the sense of community belonging while being specific engagement, there would be a huge cultural shift or shift in our culture if that were the case [if people used care outside their community]. And I think individuals become less of a, this is a bad word, user of the system and become part of the planning and care yeah that would be a paradigm shift for sure. [BCHC participant].

While it is possible that the different perspectives on individual choice may be simply a result of differing personal opinions or values, the contrast between the preference of this participant who is part of an organization providing primary care and the TCLHIN, WWLHIN, and CELHIN participants’ statements promoting patient choice is intriguing.

In summary, there were a range of opinions on the funding system. The NSMLHIN and TCLHIN participants had contrasting perspectives on how the funding system addressed mobile populations. The TCLHIN participant presumed that funding based on volume should suffice in accounting for whatever and wherever health care services are used by commuters. On the other hand, the NSMLHIN participants stated that the funding is not following the patients, which may be related to delays in implementing the HSFR (planned to be completed by 2015 to 2016). The CELHIN participant did not discuss the funding system directly, but did broadly characterize transportation and commuting as costs for the patient and the health care system. As recipients of LHIN funding, the BCHC participants were mostly positive about the broader scope afforded by the LHINs. However, they suggested that it is difficult to measure efficiency saving efforts, to mitigate broader factors to health care access, and to address complex patients within the current funding system. The results from the interviews on the participants’ perspectives on funding provide more information on how the health care system works for mobile populations (or how it

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rostering, New Patient Fees, bonuses, premiums and “special payments” for services including “chronic disease management, preventative care, pre-natal care and home visits for enrolled patients, and for hospital visits, obstetrical care and palliative care for all patients.” (Health Force Ontario, 2016)
addresses these populations), even though there is conflict between the narratives presented by the participants.

There were more similarities between the perspectives on the theme of patient choice in the mobility and access discussions. The TCLHIN and WWLHIN participants represented a belief in the importance of allowing for patient choice in where to access health care services. The NSMLHIN participants were more conflicted about patient choice as they noted that individuals were not always presented with extensive options in health, due to the logistics of navigating care. Moreover, one BCHC participant strongly believed in the importance in seeking care within one’s community. The perspectives on patient choice are important in understanding how the participants characterize health care access for mobile populations. From these results, it has been observed that the participants portray choice for patients as important for mobile populations accessing health care services, although sometimes limited by the realities of the health care system.

5.2.4 Summary

This section has presented the movement-based factors to access identified by the participants and how the health care system addresses such concerns in access for mobile populations. The interview results with the participants indicate that some aspects of routine travel are factored in health planning. While commuting is not portrayed as a priority by LHINs, how residents travel to health services is considered in health planning to varying degrees. These participants do not necessarily characterize access as poor for residents facing difficulties in accessing transportation, but maintain that transportation is a requirement to navigate the system and acknowledge the difficulty in doing so without a readily available transportation method.

There are two major themes within the interview data related to mobility. Firstly, there are a variety of opinions on the funding system. For example, the TCLHIN participant suggested that the funding system accommodates for mobility of residents by funding based on volume while the NSMLHIN participants stated that funding is not following mobile patients in southern Ontario. Secondly, the LHIN participants generally asserted the importance of preserving residents’ choice to access services where they would prefer. However, the CELHIN and
NSMLHIN participants did discuss some complications to the ideal of allowing for complete agency of the patient, in that not all services can be provided unilaterally across the province and that some residents simply do not have as many choices as others (e.g. those with chronic conditions).

There are two particularly important details about the data in this section to note for the later analysis. While the participants mostly stated that the health care system allows residents to choose the services they wish to use, at the same time, there does not seem to be significant programming to specifically support such residents with their decisions to travel to their chosen health care services. Further, a BCHC participant and the NSMLHIN participants explained that it is difficult to address broader mobility factors to health care access within the funding system. Both of these points pertain to the objective of understanding how the health care system addresses mobile populations. These details suggest that system barriers, particularly related to mobility, may be challenging to alleviate given the current system.

5.3 Place-based Factors of Access

This section presents the study’s interview results on factors to health care access and the ways that residents may use the health care system within specific places, and thus emphasizing geography. The portrayals of access for residents in particular geographies will be investigated with this data and later interpreted alongside the literature. As this study focuses on access for mobile populations, the discussions of place still contain elements of mobility. For example, seasonal travelers are mobile populations, travelling to an area for a certain period of time, who may access services in that location. Within the section on population and urban growth, those who will travel to the city to use health care services are considered as well urban residents. However, the data are grouped as place-based aspects of care because they concern particular geographies.
5.3.1 Seasonal Mobility

The interviews sought to determine if seasonal travel is a factor in health care access in southern Ontario and how seasonal travellers access the health care system, so I will present the participants’ perspectives on access for this population. The results of the interviews on seasonal influx of demand for health care services reflects the diverse geography of the study area. The CELHIN and NSMLHIN participants had similar perspectives on seasonal mobility in comparison with the other LHINs, as cottagers and vacationers regularly visit these respective regions. According to the CELHIN participant, seasonal influx within the region is concentrated in rural, retirement, seasonal destination, and cottaging communities such as the Puerto Lakes-Lindsay area, Haliburton, and the rural areas of Peterborough and Northumberland County during the summer months. As the aging baby boomers are retiring, many are gradually taking up their seasonal properties as permanent residences according to the CELHIN participant. The participant stated that there was a high level of influx particularly in Haliburton. They confirmed that HSPs within the region collect data on the impact of seasonal influx (presumably with utilization data). The CELHIN participant explained that LHINs have the expectation that HSPs will work within their existing budgets to provide health services. HSPs must anticipate and plan for the seasonal influx within these budgets. If there is substantial need demonstrated over time, the CELHIN participant said the HSP can file a request for additional resources or a change in their resources to LHINs.

Similarly, the NSMLHIN participants said there are many people that visit the region during the summer months on weekends, evenings, and holidays given the NSMLHIN region contains popular vacation destinations (both of the Muskokas and the Collingwood-Wasaga Beach area). Seasonal residents generally contribute to health services demand through emergency department (ED) visits with accidents during activities such as skiing or boating. As a result, the participants said that some of the regional hospitals have higher rates of emergency room use depending on the season. The NSMLHIN has addressed this by communicating and directing the public to alternative methods and places for care aside from ED according to the participants. However, patients must be rostered with a primary care physician in the health care system, which the NSMLHIN participants implied prevents them from accessing primary care services in other locations. Thus, it is unlikely that seasonal residents of areas would be able to access a physician outside of ED services due to the rostering system, according to the NSMLHIN participants.
The TCLHIN participant suggested that seasonal mobility is more relevant for other LHINs, stating that there are no seasonal changes in demand related to travel within TCLHIN. They did raise the issue of the flu season which is associated with a high volume of utilization from approximately October to January. Likewise, the WWLHIN participant acknowledged seasonal mobility for recreation, but stated this affects other regions, such as the Muskokas and other northern areas, and not the WWLHIN region. When asked about examples of seasonal influx occurring within their region, the participant discussed the influx in student populations their region experiences as it contains three major universities and a major college. They stated that this has been taken into consideration in a number of ways as the university population has different needs. The WWLHIN partners with universities and colleges on initiatives such as suicide prevention and mental health issues.

All of the LHIN participants explained, or at the very least implied, the ways in which LHINs and HSPs accounted for these seasonal increases in demand. The CELHIN, TCLHIN and WWLHIN participants did not seem to characterize these increases in demand as challenges, while the NSMLHIN described some difficulties in arranging care for temporary residents as a result of the rostering system. It can be concluded from this data that there is increased seasonal demand within some of the LHINs but health planners feel that it is well understood and planned for, even from a funding and logistics point of view.

5.3.2 Urban Development and Population Growth

Urban development, intensification of infrastructure in urban areas, and population growth were other common points of the discussion in the interviews. In particular, urban development and population growth were of prime concern for the TCLHIN participant, while these factors were mentioned less often by the CELHIN and NSMLHIN participants. The TCLHIN participant explained the TCLHIN is beginning to see the impact urban development is having on their health care system. Reportedly, the organization has launched a research project to better understand the impact of urban development on the health care system, beyond “anecdotaly” noting that increasing rates of commuting are affecting demand [TCLHIN participant]. According to the participant, those at the LHIN hypothesize that urban growth, whether in the
city or in areas surrounding the city, leads to a higher density of individuals and a greater population, which in turn increases the demand for health care services within the TCLHIN.

The CELHIN and NSMLHIN participants did not characterize urban growth as a main concern for health care access. The NSMLHIN participants mentioned that health planners take time and consideration in examining the trends and population growth to plan, using this to determine some of the trends of illness in the region (e.g. a concentration of seniors in a particular geographic area). Further, the NSMLHIN participants presumed that, given the prices of houses in the GTA, more people will come to live in the North Simcoe Muskoka region.

The CELHIN participant raised a few points concerning urban development and population growth. They described the development of a particular area north of Pickering, in Durham Region, and that it is expected to draw many people to move there (implying they would migrate from outside the region). For the CELHIN participant, urban development was also linked with transportation and commuting. They stated that more people are moving to the Central East region, with the goal of moving farther away from Toronto, because the improved transportation routes allow them to easily commute to work downtown.

In summary, urban intensification and population growth are factors considered in planning by the LHIN participants. However, the interview with the TCLHIN participant was unique, as the TCLHIN is in the process of understanding the demand implications between LHIN boundaries of broader regional growth. The CELHIN and NSMLHIN participants did not present urban and population growth as major concerns. However, the NSMLHIN and CELHIN participants predicted that populations in their respective jurisdictions will continue to increase with people moving away from Toronto while retaining their downtown jobs.

5.3.3 Summary

Place-based aspects to health care access for mobile populations were discussed by the LHIN participants in the interviews. The documented factors have been organized into the categories of seasonal mobility and urban development within this section. The CELHIN and NSMLHIN participants confirmed that their regions experience an influx in the population during the summer, as monitored by the HSPs within their boundaries. This mobile population, seasonal
residents, was not considered to face significant barriers to health care access. However, the
NSMLHIN participants explained that it is unlikely that seasonal residents will be able to access
health care other than ED services. Patients must be registered with a physician to access most
primary care under the rostering system. This detail on the rostering system provides insight on
how seasonal residents, as a mobile population, use the health care system.

Seasonal mobility was considered less relevant to the TCLHIN and WWLHIN by their
respective participants. However, the TCLHIN participant did express concern for urban
development and population growth, as the TCLHIN is embarking on a research study to better
understand increases in demand for services their region. The CELHIN and NSMLHIN
participants did not characterize urban growth and population growth within their regions as
current concerns. They presumed that their populations will grow substantially in the coming
years, with the implication that this may affect demand for services. The results of this section
suggest that the participants do not consider seasonal travel a major factor in health care access,
while they are concerned for the future impacts of urban development and population growth
within the area on demand.

5.4 Key Results of the Interviews

Chapter 5 focused on documenting the factors determining or impacting health care access for
mobile populations in southern Ontario and the ways any barriers are accounted for in the health
care system, as they were presented by the LHIN and BCHC participants in the semi-structured
interviews. Further, the importance in deciding health care access for mobile populations has
been summarized for each factor, which will be used in the discussion to investigate the
participants’ characterizations of access.

The factors discussed in the interviews emphasizing the movement of individuals were
commuting and transportation. The questions in the interview guide focused on commuting, due
to the increases in commuting in the study area, but the participants did not raise commuting as a
significant barrier to health care access for residents of southern Ontario. They proposed a
number of logistical barriers for commuters in accessing the health care system but this
population has not been specifically planned for in health care programming by the LHINs. On
the other hand, access to transportation in getting to health care services was presented as a factor in health care access. In particular, the CELHIN and NSMLHIN participants were proponents of this characterization of transportation.

In the interview data related to commuting and transportation affecting access, discussions of the funding system and upholding the right to patient choice were reoccurring elements. The TCLHIN and NSMLHIN participants had contrasting perspectives on how well the funding system addresses mobile populations, as the TCLHIN presumed that funding follows the patient in wherever they navigate the system, while the NSMLHIN participants stated the opposite. There was more agreement on the importance of patient choice, particularly between the CELHIN, TCLHIN, and WWLHIN participants. However, the NSMLHIN participants complicated the idea patient choice by suggesting that patients do not always have a myriad of options to choose from.

The place-based factors in the interviews were seasonal travel and urban development or growth. The former was more important in the interviews with participants from LHINs in areas with “cottage country”, i.e. the NSMLHIN and the CELHIN. The participants from these LHINs affirmed that there is seasonal influx in the use of health care services during the summer months, but did not characterize this as a barrier for seasonal residents or as a pressing concern for health planning. Seasonal influx was characterized as a feature of demand in these regions that is understood and monitored by the HSPs. The HSPs, in turn, are charged with the responsibility of managing their budgets to account for the influx.

Urban development and population growth were more concerning for the TCLHIN participant, who stated that the LHIN is looking to conduct a research study on the impact of migration to the city and surrounding areas to better understand increases in demand for health care services. The NSMLHIN and CELHIN participants expected that there will be population growth in their regions, and largely those who commute, but did not present this as a current issue for the health care system. These key findings from the interviews will be considered alongside the secondary data and the literature from the review for interpretation of the variation in perspectives of the participants and to expand on the factors to access for mobile populations raised in the study.
Chapter 6
Discussion of Interview and Secondary Data

6.1 Introduction

The discussion brings together all of the results (interview and secondary data) of the study to achieve a number of the research objectives, organized into the three major themes of the data. Further, the interpretations have been connected to the literature outlined in the literature review in Chapter 2 where possible, in addition to highlighting where the literature is lacking.

One of these themes of the data was the structural limitations of the health care system for addressing access for mobile populations. This section draws on the results of the secondary research on the structure of the health care system from Chapter 4 and the literature on Canadian regionalization from 2.2 Regionalization in Canada. The secondary research included an overview of provincial and regional governance structures, including the regionalization process in Ontario, the legislation presiding over the LHINs (the Local Health System Integration Act), the funding system and reforms, and the organizational structure and goals of the LHINs. This chapter drew preliminary conclusions that will be expanded in the discussion with support from the interview data, to explore the restrictions on addressing broader geographies and social factors, and the concerning aspects of the funding system for mobile populations.

Next, I focus on the logistical challenges for the mobile populations focused on in this study (commuters and seasonal residents) in accessing the health care system. The interview data on commuting and seasonal travel are interpreted using the health care access literature in 2.3 Access to Health Care to investigate how the participants characterize access for these populations and to better understand their perceptions of access and mobility. The results of the semi-structured interviews and a focus group with the BCHC, CELHIN, NSMLHIN, TCLHIN, and WWLHIN participants were presented in the previous section, Chapter 5, which documented mobility and geography factors of health care access and the ways these are considered by the health care system. The interview guide focused on questions regarding commuting and seasonal travel but these kinds of mobility were not considered significant barriers to access by the participants. Additionally, commuters and seasonal residents do not appear to be not specifically planned for in programming, although seasonal influx in utilization
is budgeted for. The participants continually defended patients’ right to choosing the location of services used, despite practical limitation to choice for residents, and these perspectives and the literature have further been used to explore the participants’ thoughts on commuting and access.

Lastly, I discuss the system barriers participants raised from Chapter 5. The participants characterized the need to secure transportation to health facilities as a feature of the system that complicates access for residents, particularly by the NSMLHIN and CELHIN participants. Moreover, urban development and population growth were portrayed as future concerns for the LHINs (especially the TCLHIN participant), with the idea they would cause increases in demand for services. These two factors have been considered in reference to the literature on system barriers in 2.3.3 System Barriers to Health Care Access, particularly the impacts of lacking transportation to services and the studies on urban- and rural-specific challenges to access. This section contains further interpretation of the participants’ conceptions of access for mobile populations, by revisiting the framework by Aday and Andersen (1974) and the concept of “reasonable access”. The discussion concludes by outlining the limitations to the study.

6.2 The Structure of the Health Care System Affecting Access

This section revisits and expands on the preliminary interpretations of the secondary research presented in 4.5 Discussion, which raised some potential concerns related to the structure of the health care system for mobile populations’ access. I have grouped these concerns into those related to the regionalization of the health care system and to the funding allocations. The structuring of the health care system around the regional-level has limited the scope of planning efforts and integration of services. The literature from 2.2 Regionalization in Canada on regionalization in the rest of the country and the interview data on collaboration have been used to support the interpretations of the secondary data. The next sub-section brings together the secondary research and the interview data from Chapter 5 on the funding system to suggest that mobile populations are not well accounted for or considered in the funding system and health planning, which may put financial pressures on LHINs who may not benefit from the volume-based funding reforms.
6.2.1 The Limitations of Regional Structures

Regionalization is important in the structures of the Canadian and Ontarian health care system, and describing this process has been used to provide context to the legislation presiding over the provision of health care for mobile populations. To continue this exploration of the regionalized health care system, the literature on the Canadian regionalization process, the secondary research on the LHIN IHSPs and Board meeting minutes, and the interview data are brought together to suggest some ways in which the structure limits the capacity of health care organizations to address mobile populations.

The processes of regionalization across the country faced many challenges, including: rocky implementation of regional authorities, often leading to reduced local ownership (Lewis & Kouri, 2004); and striving to achieve ambitious and sometimes conflicting goals, given the minimal power regional authorities were generally granted (Lewis & Kouri, 2004; Fierlbeck, 2011). By observing the regionalization process in other provinces, Ontario reforms generally avoided conflict and disenfranchisement with the health care system by adding a third level of administration, rather than consolidating local health providers (Elson, 2009). However, while the LHSIA charged LHINs with system integration (LHSIA, 2006), LHINs are limited in achieving their integration goals because of the numerous organizations retained through the reforms (Elson, 2009).

Further, as discussed in 4.5.1 Regionalization and Integration, the LHINs have been given responsibility for the two competing agendas of financial accountability and system integration (Elson, 2009). The accountability agreements set out the expected performance for LHINs and their HSPs in exchange for funding, which requires these organizations to deliver specific volumes of services (LHSIA, 2006). On the other hand, integration efforts focus on continuity of care and involve blurring boundaries between organizations (Elson, 2009). Elson (2009) says that, given the financial pressures on LHINs and this system’s focus on individual organizations’ goals, it is unlikely for integration to be a priority. The LHIN Board meeting minutes also reflect integration as a passive goal, as most of the integration initiatives discussed were proposed by members of the HSPs and these voluntary efforts were simply seeking approval from the Boards. In fact, the meetings largely focused on managing the process of refreshing, extending, and amending the accountability agreements for the next year and discussing the Patients First plan.
Thus, it can be inferred that the structure of the health care system, focusing on LHIN-specific deliverables, does not facilitate improvements in continuity of care within and between regions. Further, as none of the interviews or the secondary data have indicated that the boundaries of LHINs will be updated or have been adjusted since their establishment in 2004, it does not seem they were intended to be dynamic. Reluctance to regularly update LHIN boundaries would be understandable, as presumably it would be an administrative challenge; reassigning HSPs to different LHINs would involve creating new funding agreements and forging new LHIN-HSP relationships. However, the population is changing and becoming more mobile, which may not be reflected in the current LHIN jurisdictions.

The regional variation of the LHIN’s three-year plans are also reflective of this LHIN-specific focus of the health care system. The significant amount of regional variation in the presentation of each organization’s goals in their planning documents, most importantly in the structure of the LHIN’s goals, may be in part a result of a lack of framework encouraging a cohesive understanding of planning requirements, as noted in 4.5.1 Regionalization and Integration. The IHSPs read in this study had three different structures of goals: 1) the NSMLHIN and CELHIN chose to have a small number of general priorities and a number of more specific goals and indicators for each of these; 2) the TCLHIN had two different kinds of broad goals in addition to more specific tasks, indicators, and predicted impacts; and 3) the WWLHIN had fairly broad goals and a small number of fairly general tasks intended to closely follow the Patients First plan. The IHSPs also included varying levels of detail on environmental scans of their respective areas (or a similar report on regional demographics referred to as a variety of terms), although, overall, the TCLHIN provided the most detail and the WWLHIN the least. While regional variation in the IHSPs may lead to the production of tailored plans to the various geographical contexts of the province, it further reinforces the practice of each separate entity planning for their resident population, rather than a comprehensive plan to accommodate a mobile population.

The kinds of and degree to which the IHSPs used data appeared to be more similar than the structure of their goals; all the IHSPs drew on information from their HSPs and community engagement sessions but there were some variations in how the listed priorities were justified. The WWLHIN and the TCLHIN IHSPs emphasized their community engagement process and use fewer population statistics in describing their priorities, which may imply that the production of these documents emphasized qualitative data. Here it should be noted that, aside from
Francophones and First Nations groups, which community members that LHINs engage with do not appear to be mandated, as there are slight differences between the consultation processes as summarized in Table 7. The regional variation in the IHSPs in terms of data may indicate the use of different levels of granularity in setting goals and targets, which may in turn affect the degree to which LHINs can plan for a specific population, such as the mobile populations of relevance to this study.

In addition to this, the necessity of inter-organizational collaboration in health planning similarly suggest that the structural approach of health care presents challenges to addressing broader barriers in access. The LHIN participants were largely concerned with the lack of provincial-wide commitment to collaboration between LHINs and other government organizations. The participants from the CELHIN, TCLHIN and NSMLHIN participants all portrayed collaboration as an important part of their work and that, while they maintained they have good relationships with the municipalities, there need to be some changes in their involvement. For example, the TCLHIN participant mentions that city and municipal planners do not always consider health care as a factor in planning. It can be inferred from this portrayal by the LHINs that the relationships between municipal governments and LHINs are not easily maintained or initiated.

However, inter-organizational collaboration is key in addressing broader social factors in access. The NSMLHIN participants indicated that LHINs must work with other organizations or the municipalities to comprehensively facilitate access, as LHINs do not have jurisdiction over and funding for such factors as transportation. Further, a BCHC participant spoke to the fact they can only indirectly address the lack of transportation to health services because of the structure of the funding system. Thus, the reliance on collaboration to address such factors is a concerning aspect of the structure of the health care system, particularly with the implication that these relationship are difficult, and seems to imply that the health care system is limited in addressing these issues.

In summary, the structure of the regionalized health care system, with the focus on regional scale in planning and necessity of inter-organizational collaboration, restricts health planning for the mobile population in southern Ontario. The lack of a clear integration mandate in the LHSIA and the accountability agreements governing the health care system limit the integration of services in practice. Similarly, the focus on LHIN-scale planning of the IHSPs may also prevent the consideration of those using services across LHIN boundaries in health care programming.
Further to this, the LHIN participants raised the issue of lack of standardization for collaboration with other organizations. The LHIN participants stated that their organizations address broader factors through collaboration with other organizations, and lacking a specific, cohesive mandate for maintaining inter-organizational relationships may affect how the health care system can address system barriers.

6.2.2 The Funding System and Mobility

The results from the interview data on funding showed that there was diversity in the perspective of the LHINs on the funding system. There are some discrepancies between what the participants said about the funding formulas and what was found in the secondary data. For example, the TCLHIN participant said that the LHINs fund based on drivers of volume, wait time, and more, without mention of the various kinds of demographic and geographical data HBAM is reportedly based on, although this was likely a simple oversight. In addition to this, the TCLHIN participant presumed that funding, given the volume-based methods for allocation, is following commuters wherever they use services. The NSMLHIN participants’ perspective was in complete contrast as they said that funding is not following the patients who are presenting at Toronto health facilities. A NSMLHIN participant specifically referred to HBAM, which funds based on the expected volume of services to be provided. This specific mention of HBAM may, thus, indicate that the reason funding is not following patients is somehow related to the volume of services provided. They also suggested that the HSFR is still in the process of being implemented, but it is unclear if the HSFR is gradually being rolled out from the data available to the public. It may be the case that the HSFRs have been implemented in the TCLHIN and not in the NSMLHIN, and in such a situation, patients accessing services between these two regions would understandably be challenging.

However, even assuming that the HSFR is uniformly being implemented, one of the NSMLHIN participant’s statement that funding is not following the patient seems to suggest that the regionalization strategy may create structures in the funding that are “troubled” by commuters and mobile populations in general. Most obviously, it is unclear how the costs of patients seeking treatment outside their LHINs are factored into the health care system, especially since they are not allocated for directly in the funding system. The HSFR appears to solely focus on funding
organizations based the expected costs of providing specific volumes of services to be utilized by residents. While HBAM uses a range of information to predict the expect costs of providing care (including demographic and socioeconomic information) (Chalk et al., 2014; MOHLTC, n.d.-a), there is no information available on how this is factored in for decisions on funding amounts. Within the focus on the volumes of services, and thus utilization, it is not clear how factors of accessing services are funded for. Specifically, the secondary research on the system of allocating funds from the federal and provincial levels to the LHINs shows that no funding allocations specifically consider mobility. This may imply that the opportunity costs to using services are not addressed in the funding system, which fails to recognize the impacts this may have for this highly diverse and mobile population.

Further, the funding formula may benefit some organizations or regions over others. Hypothetically speaking, if the TCLHIN has more demand for services and provides a greater volume of services than the other LHINs, this means that their funding would be significantly higher due to the volume-based HBAM and Quality-Based Procedures (QBPs) funding. It may be the case that the TCLHIN benefits disproportionately from this arrangement with economies of scale or better capacity to provide QBPs, and would thus be better equipped to produce funding deficits. Further, should the TCLHIN have increased capacity to provide QBPs services, this may attract patients from other regions to use health facilities in the TCLHIN, which would increase the volume of these services they provided, exacerbating how much more funding the TCLHIN receives in proportion with other LHINs. There was no discussion in the interviews or in the secondary data on the structure of the health care system on sharing utilization data between LHINs, which, considering the regional dynamics of accessing health care, could complicate the provision of QBPs. With the information available to the public, it is not clear if the TCLHIN is better equipped to provide QBPs or benefit disproportionately from the funding system, as determining these would require access to granular data on funding allocations.

Further, as discussed in 4.5.2 Mobility and the Funding System, those regions that do not properly benefit from the funding system due to lack of service provision volume, may have to rely on their global budgets. As the global budgets are based on historical funding allocations, there is no guarantee that this allocation in the budget is representative of the funds they would need for the provision of services and promotion of health care access. If the HSPs within the current TCLHIN geographic region historically received more funding than other HSPs, this
would likely have carried over from the creation of the LHINs and the implementation of the HSFR. LHINs and HSPs may be in a difficult position in general if they do not receive guidance on how to streamline service provision, particularly within a system where these organizations are rewarded based on creating efficiencies.

The population in southern Ontario is dynamic and highly mobile and these factors of the funding system and the reliance on collaboration to address broad social factors, it seems to portray LHINs as ill-suited to dealing with the broader factors of access for the fact that they are regional entities created through regionalization. Thus, it can be inferred that the funding system provides some barriers for LHINs in addressing health care access for mobile populations. Funding allocations based on volumes may put some regions at a disadvantage, if they are unable to benefit from the efficiencies expected by the province in the funding reforms, as they may be more reliant on their global budgets. Relying on global budgets may be associated with some level of risk since they are not necessarily well calibrated to the needs of the population. This analysis is limited by the level of detail on funding reforms available to the public, but these inferences drawn from considering mobile populations suggest, if a significant portion of the funding is based on service volumes, the spatial dynamics of the population should be reviewed in funding allocation decisions, particularly for those regions not able to benefit from creating efficiencies.

6.3 The Logistics of Access for Seasonal Residents and Commuters

The interview guide focused on understanding how the health care system operates considering commuting and seasonal travel as different kinds of mobility. In this section, the interview results regarding access for these kinds of mobile populations are explored and connected to previous work on health care access wherever possible. Health care access for these types of mobile populations has not been extensively studied in the literature, nor did the participants portray these as integral factors in programming. Nonetheless, commuting and seasonal mobility remain distinct themes in the results and the participants’ statements can be used to draw conclusions on the characterization of access for mobile populations in the regionalized system.
6.3.1 Seasonal Residents of “Cottage Country”

There are not many linkages to be drawn between the results on seasonal influx in southern Ontario from the interview data and the literature, which limits the degree to which this type of mobility can be examined in this discussion. Considering the studies on the “snowbird” phenomenon (Northcott & Petruik, 2011; Marshall et al., 1989), it can be assumed that there are increasing numbers of seniors living in Canadian “cottage country” and using health care services there. The interview participants from “cottage country” LHINs (CELHIN and NSMLHIN) suggest that seasonal mobility does impact demand for services, but that the HSPs are expected to accommodate for and anticipate the influx in utilization of health care services. The increase in demand does not present significant challenges, according to the planners’ perspectives. The lack of concern for the impacts of seasonal residents is surprising, given the restrictions of the rostering system, as seasonal residents may be restricted from using a vast range of health care aside from emergency room services. Moreover, their perspective on seasonal mobility seems inconsistent considering that reducing unnecessary ED visits is a priority described in the NSMLHIN IHSP.

In addition to this, while the literature characterizes decisions made by rural residents on utilization as complex (Wong & Regan, 2008), the interview data from this study emphasizes peri-urban and vacation destinations which appear to involve different considerations from those permanently residing in rural areas. For example, as seasonal residents are only able to access emergency services outside of physicians they are rostered with, they have the option to either remain in the area to use ED services or return home to their GP. In contrast, remote rural residents may not have the option to use health care services in their area (e.g. if they are not available locally) so there are a number of factors such rural residents may consider in deciding to use health services, such as how seriously they view the need for care and whether they have the financial or transportation means to access services (Wong & Regan, 2008). Thus, this study puts forward two gaps in the Canadian health care access literature: 1) the considerations in decision-making for health services utilization of seasonal residents, and; 2) the impact of seasonal influx in “cottage country” on the health care system.
6.3.2 Commuters, Utilization Data, and Choice

The results of the interviews on commuting suggest that this type of mobility is not a threat to reasonable access, as the participants presented minimal challenges for commuters accessing services. It should be noted that it is not always clear what kinds of services that the participants were referring to in discussions on the impacts of commuting. For example, the NSMLHIN participants stated that there are services that non-residents cannot access in Toronto while other participants (notably the WWLHIN participant) maintained that there were no geographic barriers to health care. These participants may be referring to different kinds of services in these statements. For instance, the NSMLHIN participant may have been referring to primary services because of the challenges associated with the rostering system, while the WWLHIN participant may have been considering health care more broadly.

The participants’ hesitation to characterize commuting as an issue for health care access, despite the logistical challenges described in the interviews, is surprising given how important regional travel and utilization patterns were in establishing the geographic boundaries of LHINs (as seen in 4.1 Establishing LHINs). There are a few aspects of the health care system’s data collection procedures that may be linked to the participants’ caution in presenting commuting as a challenge. Firstly, as the TCLHIN and CELHIN participants stated, LHINs do not use individual data in health planning and thus do not have insight on patient residence versus the location of services accessed. As a result, the LHINs do not have evidence to quantitatively prove that commuting is an issue for access. The aspects of mobility and geography raised by LHIN participants in the interviews were based on information their HSPs had presented to the LHINs, as part of their negotiated accountability agreements. Because they rely on HSPs to bring forward any patterns from the individual-level utilization data, the members of LHINs may feel uncomfortable speculating how mobile populations navigate the system.

Secondly, the types of data that HSPs collect on the health care system (i.e. data documented in the databases listed in Table 5) seem to be limited in their ability to gather information on the kinds of decisions residents make in accessing health care, particularly regarding where individuals seek treatment and the opportunity costs associated with utilization care from specific locations. For example, the data may illustrate how far individuals will travel for health care services but does record how patients managed to get to health care services. It could even be
argued that the data collection system compounds the ideas of “access” and “utilization”, rather than utilization as a dimension of access.

On the other hand, the health system information available to the public does not contain details on what kinds of questions LHINs ask in their community engagement sessions. Consulting with residents could be an avenue for LHINs to learn about such “micro-decisions” made in navigating the health care system. However, given that the TCLHIN participant stated that whether or not a visit to access health services is the primary or secondary goal of the trip is not something that has been considered (see 5.2.2 Transportation to Health Care Services), it seems unlikely that the LHINs would actively seek out qualitative information on utilization and commuting.

The participants consistently recommended telehealth services to aid in any logistical challenges they raised for commuters, as telehealth potentially offers a way to access health care from remote locations. The most obvious complication with the telehealth solution is that the services referred to in the interviews (i.e. video conferencing) are not widely available currently. The participants characterized the current use of digital data in the health care system as insufficient, which implies it may take a long time to fully implement telehealth services. The second complication is that the use of telehealth services does not necessarily remove the opportunity costs to access services. For example, residents may still need to take work off if a specialist does not offer after-hours care. Lastly, it is unclear how telehealth services will be further implemented into the health care delivery system. For instance, the participants did not provide insight or predictions on how telehealth services will be arranged under the rostering system, or if, perhaps, there will be separate registries for telehealth patients. Also, facilitating individuals to access the health care services in Toronto could lead to shifts in the arrangement of physicians in southern Ontario, which may drain health care services from surrounding areas.

The reference to the idea of ‘patient choice’ was a pattern in the interview data on commuting. The participants’ emphasis on patient choice could be related to the provincial vision, as detailed in the Patients First plan (see 4.2.2 Aligning to the Provincial Plan – Patients First), which stresses the improvement of services based on improving “patient experience” (to use the document’s terminology). The LHIN participants may have intended to keep their statements in the interviews consistent with the Patients First plan and, thus, the CHA.
As reviewed in 2.3.1 Frameworks Defining Factors of Access, Mol (2008) offers a particularly useful extension of this line of discussion on patient choice through her distinction between the “logic of choice” and the “logic of care”. These concepts can be used to better understand the importance placed on patient choice by the participants, while at the same time suggesting limitations. The logic of choice promotes individual autonomy and equal opportunity for individuals to make their own choices in receiving care (Mol, 2008). On the other hand, Mol argues that the logic of care focuses on viewing care as a practical, open-ended process, and on providing the best treatment possible for the patient, even over preserving individual choice (2008).

The participants’ emphasis on patient choice map somewhere to the logic of choice. Within the context of a universal health care system, Canadians should have many choices in accessing health care. From the perspective of some LHIN participants, those that travel regularly must be free to make their own choices about where to use health care (i.e. services close to home or work), what services to use (largely between having regular doctor or using ED services), or whether to use the health care system at all. However, they were also interested in providing the best quality care. For example, the TCLHIN participant suggested that, while treatment for chronic conditions has to be negotiated by the patient depending on their preferences, medical necessity takes priority in acute conditions over their choice in location. The CELHIN participant recognized the limitation in the dispersion of health care facilities, despite the fact that individuals have the right to reasonable continuity of care. Also, the NSMLHIN participants directly discussed the restrictions of accessing care for commuters with chronic conditions, thereby recognizing the practical limitations to patient choice. These discrepancies could also be interpreted as a conflict between providing health care in theory and service provision in practice.

However, the assumed level of autonomy in the interviews did not always seem realistic. If chronic care is to be negotiated, as the TCLHIN participant suggests, their options are likely limited by the fact that not all services exist everywhere. In addition to this, a BCHC participant suggested that the best care for patients is within their own communities, but, given the general hours of operation for health facilities, this does not seem practical for all residents, especially for those who commute. For some residents, their options are to seek care far away from home or to not receive care at all. In addition to this, while the participants generally stated that the health
care system allows residents to choose the services they wish to use, there do not appear to be programs to support such residents with their decisions to travel to their chosen health care services. In fact, the majority of the transportation programs described by the participants are volunteer services, rather than funded (see 5.2.2 Transportation to Health Care Services).

The participant’s conceptions of access for commuters have been examined to better understand the relationship between access and this type of mobility. There were a number of surprising aspects of the results on commuting, in particular, the recommendation of telehealth services to mitigate the logistical challenges of access. The services they referred to are not currently available and they do not necessary eliminate opportunity costs to using services. It is also unclear how telehealth operates and will operate under the rostering system, or how this will affect the arrangement of health care services in southern Ontario should the use of telehealth services become widespread.

In addition, the participants’ hesitation to characterize commuting as a concern has been linked to a number of possible factors related to the data available in the health care system, particularly their unfamiliarity with individual-level data and lack of information available on the qualitative decisions commuters make in accessing the health care system. The use of information from community engagement sessions could help balance the quantitative utilization data, and may even provide a way for LHINs to measure any system barriers, but it is unclear what LHINs ask the community in the creation of their IHSPs.

Finally, the participants’ statements on commuting and health care access were entwined with their perspectives on patient choice, as noted in 5.2.3 The Funding System, Patient Choice, and Mobility. It seems likely that the LHIN participants sought to reflect the provincial focus on “patient experience”. Further, Mol (2008) is useful in understanding the impetus behind promoting individual choice, how this contrasts at times with their efforts to provide the best quality care to patients.

### 6.4 System Barriers

The main system barriers identified in the interviews were: access to public transportation; distance to health services or remoteness of residences in general; urban and population growth;
and difficulty in reaching health care providers during regular office hours. These factors particularly impact seniors or those with chronic conditions. The participants recognized the factors of transportation and urban growth as barriers to different degrees. It should be noted that the system barriers documented in this study are slightly different than those identified in the literature, such as waiting times, geographic distance, living in rural/urban areas, the population density, and the local availability of providers and services (Wellstood et al., 2006; Rosenberg & Hanlon, 1996), although they are similar. Moreover, the idea of the “health service environment” (see 2.3.3 System Barriers to Health Care Access and Rosenberg & Hanlon, 1996) can be extended to consider transportation and urban development. This section concludes by revisiting the framework by Aday and Andersen (1974) and the concept of “reasonable access” from the literature review to make general observations on how the participants considered access for mobile populations broadly.

6.4.1 The Necessity of Transportation

Transportation was a factor raised in the interviews to health care access and this sub-section connects the findings related to this factor to the literature on access and transportation. The participants’ statements on lack of a method of transportation as a system barrier appear to reflect the literature on this subject in general. Notably, Syed et al. (2013) states that transportation is particularly important for those with chronic diseases to receive proper treatment, evaluation, and changes to treatment regimens to reduce or prevent disease complications. The NSMLHIN participants described some of the logistical challenges those with chronic conditions who are also commuters in keeping up with their treatment. Also, the CELHIN participant implied that special transportation services were available for those with chronic conditions needing routine transportation to appointments.

Further, some of the participants’ statements echo Wallace et al. (2005) concerning the impacts of being transportation disadvantaged, a concept that recognizes the link between the inability to secure transportation due to low income, disability, and the inability to drive. Transportation disadvantage appears to be reflected in the participants’ consistent reference to the need for public transportation. The NSMLHIN participants in particular commented on the lack of public transportation services in remote areas, which they characterized as a challenge since securing
transportation is a necessity for health care access. Further, the CELHIN participant argues that lacking transportation or a driver to health care services is a factor for seniors and their family care givers. This is concerning as Wallace et al. (2005) found transportation disadvantage was associated with a higher prevalence of the medical conditions they studied.

However, while the literature distinguishes between the impacts of distance and transportation on access, the responses in this study somewhat compound these factors. The participants were asked in the interviews to talk about the mobility factors for access that they believed were important, and were not probed for answers pertaining specifically to distance versus transportation in accessing health care. The literature generally concludes that distance is less important than securing transportation (Syed et al., 2013; Arcury et al., 2005) but it is difficult to disentangle the participants’ perspectives on the impact of transportation from that on distance between residents and health care services, although they did discuss the former more frequently. In reality, challenges related to transportation and distance may generally coincide, as the participants from regions outside of Toronto (i.e. the NSMLHIN and CELHIN) spoke to transportation issues more than the participant from the TCLHIN. Regardless, the perspectives of the participants suggest the existence of barriers in the Ontario regional health care system related to getting to facilities, although there seems to be varying levels of interest in interventions. For example, the CELHIN listed a number of services for those who have routine need for transportation while the TCLHIN identified relatively few.

The CELHIN and NSMLHIN participants may have focused on transportation more than other regions as they are geographically large regions that are much more dependent on automobile use than Toronto (see Table 3 in the 3.5 Study Area). The extent of automobile use in these regions may indicate that those who do not have a car have difficulty in accessing health care services. It may be the case that public transportation from these regions is less convenient as an option in getting to appointments within or outside of the regions. Given the degree to which the NSMLHIN and CELHIN participants discussed residents from their respective jurisdictions seeking health care from other regions, it can be assumed that the NSMLHIN and CELHIN has more demand for referring patients out of the region than the TCLHIN, and thus, transporting these patients may be a higher priority for those affected LHINs.
Through this research, one gets a sense of the deep challenges in addressing mobility and the movement of people between regions. Implicit in the majority of the participants’ interview responses was the idea that mobility concerns were largely related to securing transportation to health facilities and that LHINs should arrange some kind of services to mitigate these issues. However, I question if LHINs currently have the capacity to address transportation and mobility issues.

Some transportation challenges arise from the unequal distribution of health care services throughout the province. However, rearranging health facilities would be a massive and economically infeasible undertaking. As stated in Arcury et al. (2005), transportation issues in sparsely populated areas are particularly difficult to resolve, as mitigating the problem would involve reducing residents’ distance to facilities to walking distance. The funding system is also not well suited to addressing transportation to health services, since it relies on LHINs to collaborate with municipal governments, and there are no specific funding allocations for system barriers.

However, there could be changes made to the funding system, such as adjusting the procedures for using data to include utilization location versus patient residence and creating a funding allocation for addressing system barriers. There would still be difficulties accounting for those travelling between regions because funding is distributed to each of the LHINs. As a result, there would need to be agreements made between LHINs on procedures for such situations. Another challenge is that simply equating mobility and access with transportation to services fails to recognize the possibility that the rostering system presents challenges for mobile populations between regions and other system barriers discussed in this study, such as hours of operation.

In summary, the LHINs may be able to deal with mobility issues but with structural changes. Currently, LHINs do not seem to have the capacity to address either transportation or greater mobility issues yet, and it is not clear how planners can consider system barriers in programming and organizing services. Planning at the regional-level is not an inherently flawed concept but this research suggests that there are characteristics of the population in Ontario that need to be accommodated for.

This sub-section presents the discussion on the findings of this study concerning transportation. The interview data on transportation to health facilities and access is reflective of the previous
work on broader factors to health described in the literature review. Notably, the LHIN and BCHC participants had similar perspectives on chronic conditions to Syed et al. (2013), and transportation disadvantage to Wallace et al. (2005). The study is not able to separately identify the impacts of remoteness and transportation; both were discussed in the interviews, although transportation was discussed more frequently. I argue that the NSMLHIN and CELHIN participants stressed the transportation factor more than the TCLHIN participant because the population in the former two regions are more automobile-dependent, so it may be more difficult to get to health facilities without a car there. Finally, the results have identified some challenges in accommodating for the mobility of the population with the current structure of the health care system.

6.4.2 Future Urbanization of the GTA

Urban development and population growth were raised as concerns for both access and the provision of health care by the LHIN participants. The literature review in 2.3.3.2 Urban-Rural Divide in Ability to Access Care contained the summary of the framework by Vlahov and Galea (2002), which is useful in distinguishing the aspects of participants’ concerns for these factors by comparing them to the dimensions of urban health. Urbanicity refers to the existence of common features of cities while and urbanization is the change in a city’s features, both of which may impact health care access (Vlahov & Galea, 2002). The participants (mostly the CELHIN and TCLHIN participants) generally raised aspects related to urbanization when discussing urban development and population growth as affecting demand for services, such as increases in transportation infrastructure and residential intensification of urban areas. For the TCLHIN, these contribute higher population density, an aspect of urbanicity.

Some participants portrayed urban development as more important than others and, while the literature does not provide a clear reason for this, the context of the study area may be related to the differences. Figure 2 from 3.5 Study Area shows that southern Ontario is experiencing population growth and some sections of the WWLHIN and the CELHIN are growing faster than the population in the TCLHIN. However, the TCLHIN participant may be more concerned with urbanization (i.e. population growth and infrastructure development) than the other participants if they are accounting for the growth occurring in all of southern Ontario, as the population in
surrounding areas is increasing at a higher rate than the national average. Given that people travel for health care to downtown Toronto and that the areas around Toronto are growing, the TCLHIN participant may be concerned this will result in significant increases in demand. Vlahov and Galea (2002) suggest that population growth tax the infrastructure of the health care system, thus affecting health care access. The TCLHIN may have decided to embark on the research study of urban development and demand to better understand the impact of these factors on utilization to plan for this population growth.

In summary, Vlahov and Galea (2002) demonstrate that the LHIN participants are largely concerned with urbanization (i.e. the process of urbanizing), rather than the current inherent qualities of the city. Further, it seems likely that the TCLHIN participant is more concerned for population increase due to the increases in the GTAs population, rather than just the City’s population change. It should be noted that the other LHIN participants did not portray urban development as a pressing health planning concern.

6.4.3 Theorizing access

The participants’ characterization of access for mobile populations has been considered throughout the thesis, but I will conclude this discussion by referring back to Aday and Andersen’s (1974) framework (see 2.3.1 Frameworks for Defining Factors of Access) for studying access and the concept of reasonable access (in 2.3.3 System Barriers to Health Care Access). The work by Aday and Andersen (1974) provides a model for examining health care access comprehensively, including the characteristics of the health care system within which services are provided, although it is generally used for quantitative work. For this study, the framework has been used to explore how health decision makers conceptualize mobility in the regional model using qualitative research methods.

Three aspects of this framework can be identified in the interview data: health policy, characteristics of the health delivery system, and characteristics of the population at risk. In general, the health policy that the participants discussed concerned the funding system. For characteristics of the health care system, they considered how commuters may navigate the system, suggesting that commuters may use primary care or walk-in clinics downtown. For
seasonal residents, the NSMLHIN and CELHIN participants explained that cottagers and vacationers tended to use ED services in the event they needed to access care. Lastly, the participants identified enabling factors, or an individuals’ means to access services, over the other kinds of characteristics of the population at risk. Given this information, it can be inferred that these health decision makers’ conceptions of access for mobile populations emphasize the importance of the organization of the health delivery system and enabling factors of the individual in their utilization of health services, both of which are affected by health policy related to funding. This is not overly surprising, as most of the participants are health planners, but these findings do reinforce the importance of the health system context in studying access. However, this study has extended this model, by focusing on how the health care system accommodates mobility and mobile populations, and, thus, supports the idea that mobility is important in studying access and should be integrated into future access research.

These factors to access for mobile populations and most of the system barriers identified in the interviews appear to fit broadly into the category of reasonable access, in that the LHIN participants consistently identified ways that residents in southern Ontario were able to navigate the health care system. Participants did not portray any access issues as barring individuals from “medically necessary” care by any of the definitions in the literature (see Charles et al., 1997). They suggested some aspects that presented challenges in accessing care, including the difficulty in securing transportation to health care services, the opportunity costs patients experience due to inflexible office hours, and the lack of telehealth services and digital data. Wellstood et al. (2006) and Birch and Abelson (1993), as reviewed in 2.3.3 System Barriers to Health Care Access, characterize opportunity costs as important in understanding utilization of health services. Mainly, the idea that there are indirect costs to taking time off work, which could be a significant barrier if not addressed by the health care system, is suggested as a problem by the NSMLHIN participants and the BCHC participants (see 5.2.1 Health Care Access for Commuters).

The participants’ observations on indirect costs indicate that they are recognizing some broader social factors in accessing health care services, rather than simply characterizing access as dependent on the ability to pay or level of need. As discussed in 6.2 Structure of the Health Care System Affecting Access, the degree to which the health care system reflects this broad perspective is debatable, particularly with the focus on utilization of health services. There is a
discrepancy between the inclusion of “reasonable access” in the legislation of the health care system and the way access is conceptualized by health planners. The literature generally criticizes the lack of an agreed-upon definition and the inability to recognize factors beyond level of need and ability to pay. This study contributes to the argument that changes need to be made to the conception of “reasonable access” as the LHIN participants’ characterizations of access did not even draw on this idea. Further, the results of this study encompass the additional complication of mobility, as it is unclear what “reasonable access” means for people routinely moving between the planning jurisdictions of the system and how can they be provided with such access. All of this suggests that there is a disconnect between the high-level policy on health care provision, the way it is planned for in practice, and residents’ complicated health care needs.

In summary, the participants’ conceptions of access for mobile populations in the regionalized model encompass broad factors of the health care system, including the policy and the organization of services. They also considered the means to facilitate access and the opportunity costs to using health services. Thus, the participants characterized the health care access that mobile populations experience as “reasonable” but they consider access more broadly than need and ability to pay.

6.5 Limitations

With regards to the participants, the first possible limitation of this study is that there were only nine participants. One of the greatest challenges of this study was securing participants from the health care system, particularly from the LHINs. This may have been due to the broad and qualitatively-based nature of this study conflicting with the perspective of health planners. Further, only members from one HSP were spoken to, so this data cannot be extrapolated to reflect other health service providers. All of this limits the generalizability of this study and the ability to make conclusive statements on the situation in the study area. However, even with the small number of responses, there are significant patterns in the data, as shown in the discussion.

Given the dynamic nature of health systems, finding concrete information on the structure of the health care system was difficult. While there is an abundance of information on the health care
system, not all of the publicly-available information is up-to-date or detailed enough for the purposes of rigorous study. For example, the current progress on the implementation of the HSFR is not currently available to the public, which limited the degree to which this study could address the funding system.
Chapter 7
Conclusion

In this thesis, I have focused on access for mobile populations in the regionalized health care system in southern Ontario, and there were a number of objectives to this effort achieved through this place-based study. I reviewed Canadian health care legislation pertaining to the provision of care for mobile populations in southern Ontario, particularly the LHSIA, as well as grey literature on the governance structure of the Ontario health care system, which were presented and interpreted in Chapter 4. These results were expanded in the discussion, Chapter 6, bringing together the regionalization literature and the interview data. There are two structural aspects of the health care system that may limit health planners’ ability to address mobility. First, the structure of the regionalized health care system impacts the degree mobile populations can be tracked and accommodated for, given the focus on the regional-scale of planning and the lack of legislative standardization of inter-organization collaboration. Second, the funding allocations are not suited to the dynamic, mobile population of southern Ontario and do not budget for broader system barriers to access.

The barriers to health care access for mobile populations and the ways such factors are addressed in health planning identified by health system key informants were documented. Semi-structured interviews and a focus group were conducted with staff members of LHINs and a health centre to gather qualitative data on mobility and access in southern Ontario. The results of these interviews (in Chapter 5) have been organized into movement- and place-based factors. Factors in the former category are commuting and transportation, and seasonal mobility and urban development in the latter. The interview questions emphasized commuters and seasonal residents but the participants suggested that these populations only face logistical access issues. Transportation was considered by most participants to be an important factor in navigating the system and receiving proper treatment. Urban development was a concern, particularly for the TCLHIN participant, in how it may affect future demand.

Investigating the participants’ characterizations of mobility and access with the interview data on health care access for mobile populations, particularly that on patients navigating services and the quality of services they experience, was expanded in the discussion, Chapter 6, considering the literature on access frameworks, opportunity costs, and “reasonable access”. Overall, the
participants did not characterize health care access and mobility within southern Ontario as a threat to “reasonable access”, even regarding the factors to access they identified in the interviews. Their conception of access for mobile populations encompassed broad factors of the health care system, including a consideration of policy, the organization of services in the health care system, and opportunity costs.

Finally, the interview data on mobility, geography, and access were interpreted considering the literature on system barriers to health care, reviewed in Chapter 2. Drawing on the results of the interview data from Chapter 5, Chapter 6 contains the discussion of the factors and characterizations of access for mobile populations. The logistics of navigating care for commuters and seasonal residents were not considered significant by the participants, which is surprising considering the restrictions of the rostering system. It is unclear how the rostering system accommodates for mobile populations, as there may be significant impacts, particularly if it restricts individuals from using primary care services outside of those they are rostered with. For example, people travelling daily may need to access primary care in multiple locations but the payment system for primary care is dependent on individuals being registered with one primary care provider.

The portrayal of commuting seems especially understated, as the regionalized health care system does not seem equipped to measure the impact and address such mobility within and between boundaries, with the apparent lack of appropriate data. Further, the suggested expansion of telehealth servicing would not remove opportunity costs without after-hours services. Allowing for patient choice for mobile populations is deemed important in health planning, but the distribution of services in the health care system limits choice in practice. The concern for urban development appears to be related to transportation infrastructure and population growth, especially for the TCLHIN participant with the rapid growth in areas surrounding Toronto. The challenge of providing necessary transportation discussed in the interviews was similar to the literature, particularly in identifying the intersections with chronic conditions and the inability to drive. The findings on transportation and distance are somewhat compounded, but these factors may coincide in southern Ontario.

This study contributes to the field of geography, particularly health geography, in a number of ways. The study’s approach brought together multiple fields of research, including health care
policy, frameworks of access, and mobility, to broadly encompass the complexities of health care access. Further, health care access for mobile populations is under-researched in the literature and the results suggest that understanding mobility and the decision-making factors involved in using health care services as an area for future research. The thesis has contributed to the study of health access by suggesting that the Aday and Andersen (1974) model be updated to encompass mobility. The methods of this study may provide guidance for further research on LHINs or other regionalized health care systems. This work supports the literature in arguing for the re-evaluation of “reasonable access” in health policy as well as work promoting system barriers in access research. Lastly, these results demonstrate that system barriers are important factors to consider in health planning.


Statistics Canada. (2012g). Toronto Central, Ontario (Code 3507) and Canada (Code 01), 2011 Census: Census Profile (Table). (Catalogue no. 98-316-XWE). Retrieved from


Appendices

Appendix A: Pilot Interview Guide

I am here today to conduct this interview at the [ORGANIZATION]. During the interview I would like to discuss health care, commuting, regionalization and integration within southern Ontario. With these topics in mind, I’d like to start by asking…

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<th>Main Topics</th>
<th>Additional Questions</th>
<th>Clarifying Questions</th>
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| Regional health issues and health care responses | • What are the core health concerns for your community?  
• Are there examples of specific programs that address these health concerns?  
• How has the regionalization of Ontario health care affected health care service provision in this region and community?  
• What aspects of the relationship between LHINs and health service providers (particularly CHCs) do you think works best?  
• Do you know of any populations within the community who are facing difficulties in accessing the health care system? | • Could you tell me about any successes or challenges of regionalization?  
• Who would you identify as the target groups of your programs?  
• IN GENERAL:  
  • CAN YOU EXPAND ON THIS?  
  • COULD YOU GIVE ME SOME EXAMPLES? |
| Regional and inter-regional dynamics and flows | • What role do flows and mobilization of patients and services play in the regional health care system?  
• What programs/services/sector are most affected by transfers, referral patterns, and/or the geographical distribution of specialists?  
• Are there challenges in services, funds and resources distribution for the region?  
• If so, who do you believe is most affected? | • By flows and mobilization I mean movements of patients and resources perhaps from one clinic to another. |
| Relationship between flows, integration of health services and regionalization | • How have LHINs promoted health care integration? Are there examples of how this has worked well with your CHC?  
• Does the health care system rely on increased integration in terms of transportation infrastructure and health networks to provide health care services? | • Do you find that patients and resources mostly stay within the region? |
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<th>Are these dependencies strengths or weaknesses?</th>
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<td>• If so, how and why has this occurred? Has this been a conscious goal of the regionalization of the health care system or a consequence of the funding and infrastructure circumstances?</td>
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<td>• Are certain populations within the region or community more likely to be affected by regional integration of health care services?</td>
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<tr>
<th>The effects of commuting and transportation integration on the health care system and vice versa</th>
<th></th>
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<tbody>
<tr>
<td>• Have you seen changes in the way that individuals use the health care system due to long and/or far work commutes?</td>
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<tr>
<td>• Have you found that increases in commuting and commuting time challenge health care either in the community or region?</td>
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<tr>
<td>• If so, has this affected the planning of health services for CHCS?</td>
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<td>• If so, what places and groups of people in the community are most likely affected by this?</td>
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<table>
<thead>
<tr>
<th>Future challenges</th>
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<tbody>
<tr>
<td>• Do you expect flows and mobilization of services and resources to be important factors shaping health care in the region and community?</td>
<td></td>
</tr>
<tr>
<td>• Do you believe that rises in commuting will have impacts on the health care system in the future?</td>
<td></td>
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<tr>
<td>• Do you believe that CHCs are equipped to deal with these issues?</td>
<td></td>
</tr>
<tr>
<td>• How would you recommend approaching other organizations like yours about participating in this study?</td>
<td></td>
</tr>
</tbody>
</table>

| Do you find that residents make use of services within their region? |  |
| Do some people consistently have to travel farther for health care? |  |
| (RELATED) does this affect their access to health care? |  |
### Appendix B: Interview Guide

During the interview I would like to discuss health care and commuting in the context of regionalization within southern Ontario. With these topics in mind, I’d like to start by asking…

<table>
<thead>
<tr>
<th>Main Topics</th>
<th>Questions and Talking Points</th>
</tr>
</thead>
</table>
| Patients navigating continuity and hierarchy of care. | • While I would like to focus on mobile populations, I would like to start with a discussion of the necessity of transportation in accessing health care.  
  • In your opinion, how – and to what degree – does the health care system assume or rely on some degree of mobility for people to receive adequate health care?  
    o Is this a consideration in planning for a coordinated health experience through continuity of care?  
    o Can you speak to some examples of how residents are supported in accessing health care that requires travel? |
| Understanding how and where mobile populations (focusing on commuters) use the health care system. | • From my research so far, it seems that there are three types of mobile populations that may have specific health care needs. I’ll be focusing first here on commuters given the extent of commuting in southern Ontario. Seasonal mobility and residential mobility are also of interest. Seasonal mobility includes people such as cottagers travelling more often at certain times of year, and residential mobility, refers to people who move residences often.  
  • In keeping commuting in mind: how does the regionalized health care system address the needs of a mobile population?  
  • How does mobility, especially commuting, affect the way an individual uses the health care system, and how is this taken into account in health system planning?  
    o If not, why isn’t it considered? [OR] what are the barriers to considering mobility in health system planning?  
    o Would you be able to comment on the effects of mobility for different kinds of conditions and care (e.g., acute vs. chronic, specialist vs general)?  
  • I’d like to go through a couple hypothetical examples of commuting and health care access:  
    o If I lived in [CITY] but worked in Toronto and had a chronic disease or illness, what kind of services do you think I would use and where and how would I access them? |
• How about if I had an acute condition while at working Toronto?

• For these situations, there may be a disconnect between the need to access services in one place and the wishes of the patient to be closer to another. For example, there may be the need to access services away from home in Toronto, but the patient may wish to be closer to home. Or someone with chronic issues may wish to access services closer to where they work. Is this considered in the coordination of health care? Why or why not?

• My first set of questions concerned planning assumptions in promoting continuity of care (e.g., requirements to travel for care). I’d like to draw on some of our earlier conversation on continuity of care to understand what factors affect continuity for a mobile population:

  • There has been the move to digital data for the health care data and information. How does this come into play for continuity of care and mobility?

  • How about other factors of continuity of care in the regional system: family doctor referral networks, hierarchy of care, different types of care and conditions etc.?

• How do increases in the number and distance of people commuting affect health care provision in the region?

  • Has the mobility of patients changed the demand for services within and/or between regions in southern Ontario?

  • How does this vary for different types of required care and conditions (e.g., changes in demand for services between acute vs. chronic; common vs. rare; requiring expert advice or treatment, etc.)?

• If there has been a notable change in pattern of demand, has there been a resultant change in location or distribution of supply of health care services?

  • In particular, has there been effects on supply or treatment options for those living farther away from Toronto? How does this vary for different types of care needed and conditions of patients?

  • If there has not been a change in supply, do you imagine that this could be a problem in the future for Ontarians?
Understanding the needs and effects of other kinds of mobile populations on the health care system.

- In reference to these other kinds of mobility, namely seasonal and residential, I’d like to go back to more hypothetical examples:
  - If I had a serious acute condition while at my cottage how would my services be coordinated?
  - How about for individuals who move tend to change residences often?
  - Is this kind of mobility considered in the coordination of health care?

- Again, do these types of mobile people raise issues of demand and supply of health care?
  - For instance, do you imagine that there any particular strain on health care services during the summer due to cottaging? How is this planned/accounted for by LHINs or HSPs?

Summary: thoughts of decision-makers on the importance of mobility in health care planning.

- Overall, would you consider increases in commuting currently to be a health planning issue for your region? Would you consider it to be a problem for other regions?
  - Do you believe that commuting could be a problem in the future for the planning of health care?
  - How about for the other kinds of mobility we’ve been talking about?

- Would you consider it to be a problem for the regionalized health care system if residents are not making use of health care services in their region of residence and why?

Conclusion

- Do you believe that rising mobility will have impacts on the health care system in the future?
- Which do you believe will bear the brunt of issues raised by rising mobility: primary care or secondary/tertiary care?
- Do you believe that your organization is equipped to deal with these issues?
- What kind of solutions would recommend to help with these issues?
- How would you recommend approaching other organizations like yours about participating in this study?
Appendix C: Shortened Interview Guide

Thank you so much for agreeing to this focus group session. During the interview I would like to discuss health care and commuting in the context of regionalization within southern Ontario.

<table>
<thead>
<tr>
<th>Main Topics</th>
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| Understanding how and where mobile populations (focusing on commuters) use the health care system. | • From my research so far, it seems that there are three types of mobile populations that may have specific health care needs. I’ll be focusing first here on commuters given the extent of commuting in southern Ontario. Seasonal mobility and residential mobility are also of interest. (I’m using these terms to refer to) Seasonal mobility includes people such as cottagers travelling more often at certain times of year, and residential mobility, refers to people who move residences often.  
  • In keeping commuting in mind: how does the regionalized health care system address the needs of a mobile population?  
  • How does mobility, especially commuting, affect the way an individual uses the health care system, and how is this taken into account in health system planning?  
    o If not, why isn’t it considered? [OR] what are the barriers to considering mobility in health system planning?  
    o Would you be able to comment on the effects of mobility for different kinds of conditions and care (e.g., acute vs. chronic, specialist vs general)?  
    • How do increases in the number and distance of people commuting affect health care provision in the region?  
      o Has the mobility of patients changed the demand for services within and/or between regions in southern Ontario?  
      o How does this vary for different types of required care and conditions (e.g., changes in demand for services between acute vs. chronic; common vs. rare; requiring expert advice or treatment, etc.)?  
    • If there has been a notable change in pattern of demand, has there been a resultant change in location or distribution of the supply of health care services?  
      o In particular, has there been effects on supply or treatment options for those living farther away from Toronto? How does this vary for different types of care needed and conditions of patients? |

| Understanding the needs and effects of other kinds of mobile populations on the health care system. | 6) Do the other kinds of mobility (seasonal and residential) raise issues of demand and supply of health care?  
- For instance, do you imagine that there is any particular strain on health care services in during the summer due to cottaging? How is this planned/accounted for by LHINs or HSPs? |

| I’d like to go through a few questions to summarize and be clear on your perspective. Summary: thoughts of decision-makers on the importance of mobility in health care planning. | Overall, would you consider increases in commuting currently to be a health planning issue for your region?  
- Would you consider it to be a problem for other regions?  
- Do you believe that commuting could be a problem in the future for the planning of health care?  
- [IMPORTANT] How about for the other kinds of mobility we’ve been talking about?  
- Would you consider it to be a problem for the regionalized health care system if residents are not making use of health care services in their region of residence and why?  
- I understand that there may be some structural changes coming for LHINs, focusing on a patients-first perspective. How do you think that will address some of the things we have talked about today? |
Appendix D: Invitation Letter Template

[Date]

To the Office of the [organization],

My name is Anna Fiume and I am a master’s student from the Department of Geography at the University of Toronto. I am writing to invite [organization] members to participate in my research study about regional health care access in Ontario. I have connected with other health care organizations within southern Ontario and believe that your organization would be a valuable resource for this study.

Would it be possible to pass on this invitation to the members? Anyone interested may contact me directly.

This study will focus on the relationship between increases in mobility (commuting, seasonal travel, and change of residence) and regional health care access. I am most interested in understanding how commuters’ use of the health care system affects regional health care provision and planning, and discovering if there are variations in these trends across the southern Ontario commuter belt. While there has not been a lot of research done on this, in my preliminary interviews, health care professionals have raised this issue, noting possible impacts on access and provision due to commuting in the southern Ontario region. I would like to hear the perspective of LHINs on this and mobility in general. Some questions I would like to explore in interviews include the following:

- How does the regionalized health care system address the needs of mobile populations, especially commuters?
- How do the different kinds of mobility affect the way an individual uses the health care system?
- How is health care coordinated for mobile people?
- To what extent are mobile populations considered in health planning?

If members decide to take part in this study, they will be asked to participate in an interview that is expected to take one hour. I would like to record audio and take notes for interviews. I intend to use information, recordings and notes gathered from interviews in writing my thesis. Names will not be used to identify individuals, though I may refer to the LHIN as well as the role of an individual (e.g., staff or board member) in my writing.

Taking part in this project is completely voluntary. If there are any members who would like to participate or have any questions about the study, please email or contact me at anna.fiume@mail.utoronto.ca or my cell phone (905) 505 0825.

Thank you very much,

Anna Fiume
Appendix E: Consent Form

[Integration, Regionalization and Health Planning in the Commuter Belt]

You are invited to participate in a study being conducted by Anna Fiume, a University of Toronto master’s student from the Department of Geography. You are being invited to take part in this study because of your position within the Ontario health care system. The study is not receiving funds from an external agency or sponsor. If you wish to participate, you will be asked to sign this form. Please take time to read this informed consent form carefully and keep a copy for your reference.

The project focuses on understanding regional health care access in Ontario. The researcher is particularly interested in what kinds of impacts increased mobility in the Greater Toronto Area has on regional health care and what challenges this presents health care provision and planning organizations in their region.

If you decide to participate, you will be asked to take part in an interview and audio will be recorded. Interviews will be conducted at a convenient time for you and should take one hour of your time. Interviews can be conducted over the phone or Skype at the participant’s request. Participation in this study is completely voluntary and you have the right to refuse to participate. If you decide to participate, you may still choose to withdraw from the study. If you decide to participate but later wish to withdraw from the study, data from your interview can be removed as long as you contact me prior to February 29, 2016.

Your confidentiality will be protected throughout the study although the researcher may refer to the organization you belong to and whether you are a staff or board member. Interviewees may be identifiable based on this information in the thesis or later publications. Audio recordings of interviews will be kept confidential and will not be heard by anyone but the researcher. All audio and notes will be stored in accordance with the University of Toronto’s data handling procedures for researchers. The data collected from interviews will be deleted at the completion of the project.

There are no anticipated benefits or risks to you as a participant, aside from helping the researcher in gaining a better understanding of regional health care dynamics in Ontario. The researcher will not be able to provide compensation to participants for taking part in the study. The researcher intends to publish this research and offers to provide a summary of research results in a way that is convenient to the participants.

If you have any questions about the research project, you can contact Anna Fiume at anna.fiume@mail.utoronto.ca or (905) 505-0825. Please contact the Office of Research Ethics at ethics.review@utoronto.ca or (416) 946 3273 if you have any questions about your rights as a participant.

My signature on this consent form means that I have read and understood the subject information and consent to participate in this study.
My signature may have been added at a later date, as I may not have been present at the time the participant’s signature was obtained.