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Pluralism in Regional Health Planning: An Analysis of Public Engagement in Ontario's Local Health Integration Networks

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Abstract: This study set out to identify and explain variation in the choices of public engagement methods across Ontario's Local Health Integration Networks, in order to inform the policy space these organizations operate in with respect to enabling citizen participation in regional health planning decisions. The websites of all 14 Local Health Integration Network were searched for three key documents that detail their past and future public engagement method choices. Drawing from the literature, a multi-metric qualitative scoring framework was designed to explore patterns of variation in public engagement method choices across each region. The findings demonstrate that there is minimal variation in the choices of public engagement methods across Local Health Integration Networks, but suggest that variation in regional characteristics provide different justification for the same methods being chosen across multiple jurisdictions. The study concludes by outlining opportunities for public engagement practitioners in Ontario and other jurisdictions to improve the rigour of the proposed framework and potential use as a predictive tool of public engagement method choice dependent on variation in regional characteristics.

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1 Introduction

Ontario's 14 discrete Local Health Integration Network (LHIN) regions have each uniquely different contexts including: demographics, geographic, infrastructure, and economic. As such, it is important for policy makers and public servants to understand the mechanisms (e.g. recruitment methods) and motivations (e.g. legislative requirements, professional ethics, pluralistic values) which have shaped public engagement efforts for regional health planning in Ontario LHINs to date. Providing insights into the determinants of successes, failures, and leading innovations of public engagement for regional health planning, will help identify gaps in the legislative framework and pan-LHIN policies and procedures.

The goal of this study is to explore public engagement activities across Ontario's LHINs and theorize on the reasons for variations in their methods to inform the policy space LHINs operate in with respect to the choice of public engagement methods. Specifically, this study will view LHIN public engagement activities in the context of regional health planning through a framework of four lenses: (i) community characteristics (ii) acceptance criteria, (iii) process criteria, and (iv) the extent of engagement methods. It is acknowledged at the outset that LHINs also exist to implement broader provincial policy and as such will necessarily exercise limits on the scope and depth of public engagement on some topics. An appropriate extension of this study for public engagement practitioners would be to assess whether the framework can be used reliably to predict public engagement methods choices in regional health planning in Ontario and other jurisdictions.

2 LHINs and Local Governance

LHINs are Ontario's expression of Regional Health Authorities (RHAs), are created and wholly under the authority of the provincial government, and exist as regional special-purpose bodies in the space between the provincial government and the health services provider organizations across the regions. Service providers in turn are accountable to the LHINs. The primary objective of LHINs (and RHAs) "is to enable regional community leaders rather than provincial bureaucrats to develop mechanisms for local health institutions, especially hospitals, in order to use resources more rationally" (Sancton, p.61-62). In their quest to bring a local voice to regional health planning LHINs necessarily employ public engagement activities, but as will be discussed this is also a legislated requirement.

2.1 History of Ontario's LHINs and Implications for Citizen Participation

While authority for healthcare in Canada falls to the provincial governments, in the 1990s, all provinces except Ontario began devolving this authority with the establishment of RHAs in a bid to "contain costs and improve service integration" (Lomas(1), p.1). It was not until 2006 that Ontario took "small steps toward regionalization" (Elson, p.7), passing the *Local Health System Integration Act, 2006* (LHSIA) which created LHINs which share some similarities with the other provinces RHAs, while retaining distinct differences. These differences range from the lesser funding and planning powers than those granted to RHAs, and a lesser degree of oversight than RHAs exercise over the operations of local service providers. While the devolution of provincial health authority to RHAs was primarily focused on the

attainment of pecuniary and operational efficiencies, there have been implications for citizen participation in regional health planning, specifically in the Ontario context.

From its inception, the RHA movement in Canada was motivated primarily by a political agenda of cost cutting and streamlining healthcare, coinciding with the emerging focus on scientific management and instrumental rationalism in the public sphere. That remained just as true more than a decade later as Ontario moved toward regionalization, similarly focusing on implementing a means to "increase the effectiveness and efficiency of the health system", and also to respond to growing demand for "increased accountability and public input" (Lewis, p.15). These objectives are complementary if local citizens are effective at exercising participation, and the system is fair, then participation can be a key driver of allocative efficiency (Sancton, p.19) (i.e. matching provided health services with what people want locally). Furthermore, participation serves as a necessary response to "calls for greater accountability of economically-pressed health resources" and has long been recognized as "a key tenet of community development" (Frankish, p.1472). But more fundamentally, the opportunity for direct participation (e.g. board membership) helps avoid a situation in which the state controls everything to the detriment of local or individual needs. In the case of RHAs, any degree of autonomy ensures a source of local power that serves as a counterpoint to central authority, and represents a shift toward pluralism. But regionalization alone is not a sufficient condition to promote participation; indeed, "from a local perspective, it can represent the loss of power and influence; from a provincial or national perspective, it can be seen as a process of decentralization" (Elson, p.9). To date, the political changes embodied in the

implementation of RHAs have indeed had mixed results, sometimes diluting and sometimes strengthening citizen participation.

A hallmark of regionalization in the 1990s was the elimination of service provider corporations (e.g. hospitals) and their boards. "Literally hundreds of organizations ceased to exist" (Elson, p.6) as a multitude of service providers were merged under RHA corporate structures. Any perceived gains in participation through decentralized provincial authority, were immediately dwarfed by the offsetting concentrating step of removing thousands of service provider board members from the picture. This elimination of innumerable public spaces set the stage for ever increasing demand for new citizen participation opportunities in RHA planning.

In support of public accountability, most provinces envisioned fully elected boards for RHAs at the outset, but invariably all were set up with provincially appointed boards to expedite implementation. Some provinces, Alberta and Saskatchewan among them, subsequently experimented with electing boards, but eventually reverted to appointed boards. Provinces adopted the view that given the complexity of health care, it was increasingly evident that board membership "requires an enhanced level of information that may be difficult to achieve" (Frankish, p.1472). Thus the provinces all moved to their own "rigorous skill and merit-based selection process" (www.lhins.on.ca) in making board appointments. As a result RHA board membership has not provided a backdrop for wide spread participation of lay citizens.

Turning to Ontario, LHIN board members are government appointed, which gives rise to the "problem […] that they lack democratic legitimacy" (Sancton, p.62). But

to strike some balance, the legislation that created LHINS requires that "board meetings are open to the public" (www.lhins.on.ca). Furthermore, the initial legislation that established LHINs sets out requirements for community engagement. These requirements serve as a meaningful counterpoint to the absence of public input into board appointments.

In contrast to the other provinces, service provider boards were not dissolved with regionalization in Ontario. Leaving LHIN boards without the power to direct the budgets and decision making of service providers, LHINs were instead charged with achieving their objectives by having service providers sign off on balanced budgets, accountability and performance agreements as a condition of funding. To some extent this relegated LHINs to the role of regional health planners, albeit with more authority given service providers still require LHIN approval of their decisions. On the other hand, the trade-off of this de facto three-tiered system may result in a stronger local voice, distinctly different from the other provinces, invariably preserving greater participation and pluralism in Ontario health care.

2.2 Legislative Requirements for Public Engagement in Ontario's LHINs

The legislative authority that created the LHINs and defines their functions and powers arises from the LHSIA. Specific to public engagement, this act establishes the requirement that LHINs "engage the community […] on an ongoing basis […] about the integrated health service plan and while setting priorities" (2006, c. 4, s. 16 (1)), where the methods of public engagement "may include holding community meetings or focus group meetings or establishing advisory committees" (2006, c. 4, s. 16 (3)). While the

wording with respect to methods of public engagement indicates discretionary choice of methods on the part of the LHIN, recent amendments to the LHSIA enacted under *Bill 41, Patients First Act* (2016) added a prescriptive requirement that LHINs "shall establish one or patient and family advisory committees" (2016, c. 30, s. 15 (1)).

The LHSIA also identifies the requirement to engage Indigenous planning entities (2016, c. 4, s. 16 (4a)), and French language planning entities (2016, c. 4, s. 16 (4b)), and it defines the scope of "community" as including "patients and other individuals" in the LHIN (2006, c. 4, s. 16 (2a), health service providers and any other person or entity that provides services" in the LHIN (2006, c. 4, s. 16 (2b)), and any "employees involved in the local health system" (2006, c. 4, s. 16 (2c)). But the legislation otherwise provides no explicit direction as to how LHINs should ensure representativeness of the "community" within the LHIN boundary, nor for that matter any specific requirement that the public boards of LHINs should be representative of the "community". Clearly, much is left to the determination of the individual LHINs, and as such it is reasonable to expect that other than in the absence of collaboration across the LHINs, the form and results of public engagement activities will vary across LHINs. It is within this context that this study will endeavor to explore and help understand how variation in the extent and success of citizen participation across LHINs arises from legislative authority and differences in local LHIN policies and procedures.

3 Literature Review

The literature review focused on theories on public engagement, both in general and specifically as it relates to the regional health planning context, in three key respects: (i) what the theory has to say about the benefits and risks of public engagement, (ii) what the theory has to say about the ideal conditions for public engagement, and (iii) what the theory has to say about evaluating public engagement initiatives. Lessons from the literature were used to propose a framework for categorizing the public engagement activities observed, and identifying the factors contributing to variation, across Ontario's LHINs.

3.1 Benefits and Risks of Public Engagement

In general terms, Irvin and Stansbury (2004) identify "two tiers of benefits to consider (process and outcomes) [...] in evaluating the effectiveness of the citizen-participation process" (Irvin and Stansbury, p.56) (see table 1 below). With respect to many of the risks, they suggest they can be mitigated by process choices. For example, the representation problem can be mitigated at the process level by employing a citizen jury approach (e.g. randomly selected participants from the population) rather than a volunteer approach.

Table 1 Benefits and Risks of Public Engagement

Process Benefits	Outcome Benefits
• Citizens and government learn from each other • Citizens have opportunity to influence • Government has opportunity to build trust • Citizens build activist skills • Government gains legitimacy of decisions	• Improved social outcomes • Empowerment of citizens • Reduced probability of litigation • Better policy and implementation choices
Process Risks	**Outcome Risks**
• Time consuming and costly • Build mistrust if recommendations ignored	• Representation problem • Loss of government control • Bad decisions

Note: Reproduced from Irvin and Stansbury (2004), p. 55 and p. 57.

Specific to the regional health planning context, the uneven redefining of the RHA public space for participation across Canada arises largely from a lack of consensus on why there should be citizen participation in regional health planning. There are accepted theoretical reasons for citizen participation, including "that health needs and health services should be more closely matched [...]; that people have the right to participate in planning [...]; and that community empowerment can be fostered so that community members will have a sense of contribution and of power or place within the system" (Frankish, p.1472). There are also practice-based reasons, including the belief that untapped community resources can bring new perspectives to health planning, and correspondingly increase potential for decisions that are more cost-effective and more efficiently deliver services (Frankish, p. 1472-1473). And there are political reasons, including providing a means to "gaining broad-based citizen support" (Frankish: 2002, p.1473) at a time when there is suspicion and loss of faith in decision making in the public sphere. But "the creation of lay health authorities involves a

significant change from the traditional physician-dominated system" (Frankish: 2002, p.1473), which gives rise to tensions among health professionals threatened by the spectre of dilution of their influence, and the implicit uncertainty of their legitimacy as the apex of decision makers on all things health care related.

Given the complexities of healthcare, the apprehension of health professionals to citizen participation inescapably expresses itself in barriers in decision making practice, and ultimately in influencing the how RHA decision making public spaces are defined, though perhaps not always in the way they had hoped. And their resistance is not surprising given the complexities of health care depend on the professional knowledge and skills of health professionals, and the tendency for professionals to "assume that the kind of knowledge they possess … outweighs … the knowledge ordinary people have" (Stivers, p.144). Correspondingly, some RHAs have placed explicit limits on the numbers of health professionals relative to members of the general public in their decision making bodies, to balance these tensions.

But RHAs have also recognized in kind that clear delineation of the roles and responsibilities of citizen participants is paramount. Furthermore, this has stimulated broader discussion on the knowledge and skills of citizen participants reasonably appropriate to serve on RHA decision making bodies. By no means is it the view that citizens be expected to become technical experts, nor possess the equivalent knowledge of health professionals. But their contributions are clearly suited to identifying "local preferences to be reflected in treatment choices and decisions" (Frankish, p.1477) when assessing needs and setting priorities.

In general and in the context of regional health planning the focus of benefits seems to be predominantly on consideration of allocative efficiency, on making "better decisions and a more effective, efficient health system" (Frankish, p.1478). But given the general expectation by the public that services align with their preferences, there is an implicit overarching objective that public engagement in regional health planning is equally about generating legitimacy. The primary expected risks of public engagement include: representation problems, heightening tensions and mistrust, reliance on citizens lacking in sufficient technical expertise, and costs. These are risks that can be mitigated by process choices, and as such evidence of differences in process choices could account for variation across LHINs.

3.2 Ideal Conditions for Public Engagement

Jabbar and Abelson (2011) evaluated public engagement frameworks to "assess their relevance to the LHIN context" (Jabbar and Abelson, p.59), and concluded a general failure to "capture all aspects of the LHIN context" (Jabbar and Abelson, p.68), in particular, noting that public engagement frameworks "should include evaluative features related to organizational capacity" (Jabbar and Abelson, p.68). This is consistent with the generic findings of Irvin and Stansbury who caution with respect to public engagement the "potential wastefulness of the process if it is employed in a less-than-ideal community" (Irvin and Stansbury, p.63). They categorize the ideal conditions as being a combination of low-cost and high-benefit factors (see Table 2 below).

Table 2 Ideal Conditions for Public Engagement

Low-Cost Factors	High-Benefit Factors
• High citizen interest • Low geographic dispersity • No cost/income impact on participants • Homogenous community • No master of complex technical information required	• Involvement needed to break gridlock • Community validation needed • Process led by credible facilitator • Issues are high interest publicly

Note: Reproduced from Irvin and Stansbury (2004), p.62.

Given the geographic breadth of diverse communities within each LHIN, many would fail to meet several of the low-cost factors. The non-ideal scenario is marked by some combination of low-cost and high-benefit conditions not being met, as well as decisions outcomes that are likely to be no different than in the absence of public engagement, or likely to be ignored.

Anecdotally, while it is doubtless that LHINs are likely to derive high benefits from public engagement, it is also likely that LHINs are predisposed to high public engagement costs, and as such may not fit the mold of ideal cost conditions. Notwithstanding conditions may not be entirely ideal, recalling that LHINs are legislatively required to engage, it then becomes a question of how LHINs choose to balance the depth of public engagement that can be supported by available resources. Indeed while "some communities are poor candidates for citizen-participation initiatives [some of these problems] may be overcome by effective structuring, if resources permit" (Irvin, p.58). In any case, consideration of the ideal conditions for public engagement could serve as an effective framework to predict the disposition of LHINs to be successful at public engagement, in particular, whether any LHINs are

decidedly advantaged or disadvantaged in terms of conditions that might account for variation.

3.3 Models of Citizen Participation

Timney (2011) proposes a fundamental continuum of citizen participation models from passive -"government for the people", to collaborative - "government with the people", to active - ("government by the people") (Timney, p.91). Within this continuum, Timney proposes a scorecard differentiated by 10 levels (see Table 3 below). Levels 0 through 7 span the passive end of the spectrum, where government controls the process and remains the ultimate decision maker. At higher levels decision-making becomes increasingly influenced by the public. At level 8, partnership between the government and the public exists in the form of increasingly structured committees and events, with decision-making not shared but strongly influenced. At level 9, collaboration exists, with not only decision-making but also power being shared. And finally at level 10, both decision-making and power are fully delegated to the public.

Timney suggests that the ideal level is 9, collaboration, since it brings government and the people together, avoiding the opposite extremes where one side or the other is perceived as the enemy, and implicitly acknowledging that "government administrators are also citizens and that their expertise has value in the decision-making process" (Timney, p.95). Timney's scorecard provides an effective framework to categorize the depth and breadth of public engagement achieved by LHINs, helping "to evaluate the ways that they involve citizens in projects that affect their communities" (Timney, p.99).

Table 3 Models of Citizen Participation

Passive: *"Government for the people"*	**Collaborative:** *"Government with the people"*	**Active:** *"Government by the people"*
0 Non-communicating (process closed to citizen participation) **1 Informing** (e.g. public disclosure of decisions already made) **2 One-way feedback** (e.g. public surveyed for preferences) **3 Segmented consultation** (e.g. advisory groups, participants pre-selected) **4 Formal procedures** (e.g. public hearings, participants self-selected) **5 Feedback through media** (e.g. informal surveys, participants self-selected) **6 Scientific feedback** (e.g. structured surveys, participants randomly selected) **7 Interactive** (e.g. structured focus groups, participants pre-selected)	**8 Partnership** (e.g. advisory groups, participants selection shared, decision making not shared but strongly influenced) **9 Collaboration** (i.e. iterative processes, participants selection shared, decision making shared)	**10 Delegated Power** (i.e. decision making delegated to public groups, participants selected by the public)

Note: Reproduced from Timney (2011), p.93.

Ontario's pan-LHIN community engagement guidelines (June 2016) propose a spectrum of engagement, which when aligned with Timney' scorecard offers a more simplified mapping of engagement methods, reduced from ten to only five discrete levels of engagement. Timney's passive levels map into two levels: (i) "inform", corresponding to levels 0 through 2, and (ii) "consult", corresponding to levels 3 through 7. Timneys' collaborative levels also map into two levels: (i) "involve", corresponding to partnership, and (ii) "collaborate", corresponding to collaboration. And lastly, Timney's active level maps to "empower".

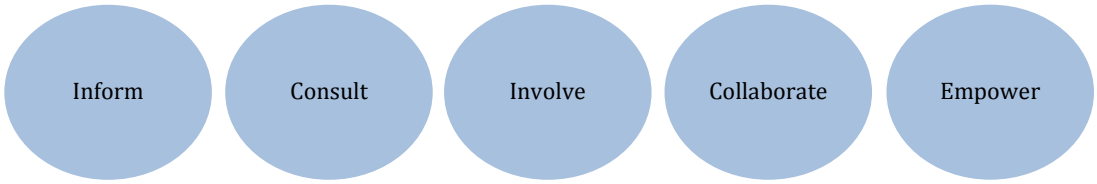

Figure 1 Levels of Public Engagement

3.4 Evaluation Criteria

Rowe and Frewer (2000) highly regarded foundational work suggests a "comprehensive set of criteria for determining whether a public participation mechanism is successful" (Rowe and Frewer, p.4) (see Table 4 below), differentiated by acceptance criteria, related to evaluating the effectiveness of the engagement initiative, and process criteria, related to evaluating the potential public acceptance of the engagement initiative. They used these criteria to evaluate common engagement methods, and when overlayed with Timney's scorecard, their results provide deeper insights into the nature of tradeoffs that occur moving through Timney's continuum of citizen participation models.

Table 4 Evaluation Criteria

Acceptance Criteria	Process Criteria
• Representativeness • Independence • Early Involvement • Influence • Transparency	• Accessibility • Task Definition • Structure Decision Making • Cost Effectiveness

Note: Reproduced from Rowe and Frewer (2000), pp. 19-20.

In terms of process criteria, engagement methods across the passive end of the spectrum tend to rank lower, generally associated with lower quality decision outcomes, and rank increasingly higher moving toward the collaborative and active

ends of the spectrum. In contrast, acceptance criteria do not necessarily rank increasingly higher moving from engagement methods at the passive end of the spectrum toward collaborative and active methods. Early involvement is not dependent on engagement methods selection, and generally ranks uniformly positive across the spectrum of methods. Whereas for influence on the final policy, engagement methods across the passive end of the spectrum tend to rank lower, generally associated with lower quality decision outcomes, and rank increasingly higher moving toward the collaborative and active ends of the spectrum. And for independence of participants and transparency of the process, engagement methods across the passive end of the spectrum tend to rank higher, and can rank increasingly lower moving toward the collaborative ends of the spectrum. In the case of independence, unskilled and ineffective facilitators in more collaborative methods can hamper participation. And in the case of transparency, while outcomes across the spectrum tend to be communicated evenly, the mechanics of the process are visible to fewer participants as group sizes shrink moving toward collaborative methods. And though perhaps counter intuitive, representativeness of participants is low at the passive end of the spectrum, increases moving toward collaborative methods, and then decreases. But this gains face validity when one considers that representativeness grows stronger as participant selection shifts from self-selection to random selection, but then weakens again due to reduced numbers of direct participants, which can create representativeness challenges, particularly in diverse communities.

While Timney's work is more recent, recalling Rowe and Frewer's earlier work highlights that there is some nuance missed in Timney's scorecard. Added dimensions

of criteria seem appropriate to include in a framework for evaluating public engagement in LHINs in recognition that gains from using deeper methods of engagement may imply tradeoffs in acceptance criteria.

3.5 Domains of Public Engagement

The work of Abelson et al. (2015) designed a generic tool for evaluating public engagement activities in a wide range of health system organizations, in part building on Rowe and Frewer's foundational work. They identified four core domains of public engagement principles, and developed a set of measureable outcomes for each domain (see table 5 below). These measures were used to propose evaluation questionnaires targeted at three respondent groups: (i) citizen and patient participants, (ii) managers and sponsors, and (iii) organizational leaders. These core principles provide the basis for separate domains the researchers incorporated into a generic PPE evaluation tool with the goal of addressing gaps observed in existing rudimentary PPE evaluation tools for use in health system organizations. This work provides a substantial foundation of key determinants of effective citizen participation to be explored in my research, and while the scope of this study is expressly not considering outcomes, these perspectives may assist with interpreting the causes for variation of public engagement in the LHINs.

Table 5 Principles and Outcomes of Public Engagement

Integrity of Design and Process	Influence and Impact
• Participants are representative • Support are provided to enable participation • Process includes clear two-way communication	• Planning and decision making is influenced • Participants gain knowledge • Process builds confidence and trust
Participatory Culture	**Collaboration and Common Purpose**
• Organization promotes public engagement in strategic planning • Organizational leaders are trained in public engagement • Public engagement is implemented in service and policy work	• Organization and public plan and work together

Note: Reproduced from Abelson et al. (2015), p. 1822.

3.6 Influence of Public Participants

The work of Boivin et al. (2014) designed a framework which accounts for how variations in both the method of public participation and the participants' ability to influence, affects collective health care improvement and policy decisions. The study findings demonstrated that the public participants' ability to influence the groups increased with their credibility, legitimacy and power. The publics' credibility, legitimacy and power were framed and strengthened by: (i) recruitment of a balanced group of participants, (ii) structured training, (iii) opportunities to draw from others' experiences, and (iv) a blend of broad public consultation with small-group deliberation. Furthermore, the engagement of key stakeholders in the design and implementation of participation interventions helped build policy support for public involvement. This work identifies key ingredients for ensuring effective public participation, and specific criteria that could lead to more effective public engagement

processes and strengthen the public's influence on health care improvement and policy decisions, which accounts for how variations in both the method of public participation and the participants' ability to influence affects collective health care improvement and policy decisions, which will further provide context for discussing variation in LHIN public engagement activities.

3.7 Regional Health Context

The work of Thurston et al. (2005) designed a framework for understanding public participation in the context of regionalized health governance. The findings of the study identified a number of important themes: (i) public participation is a process that occurs before, during and after the particular point in time that the actual participation initiative occurred, (ii) governance decisions and operational decisions should be considered separately when evaluating the impact of public participation initiatives, (iii) the social context of the participants, rather than the participants themselves, determine their level of influence and representativeness of specific population groups or the broader population, (iv) "health" is broadly regarded by participants to include more than the absence of disease, it was seen as a balance of social, physical, emotional, spiritual, and social determinants. The outcome of the study included four key interdependent implications for evaluating participation initiatives: (i) participation is a temporal process, not just a point of time initiative, (ii) there needs to be clarity on the intended effects of participation, (iii) the mechanisms of participation need to be clearly specified, and (iv) when the effects are expected to appear needs to be understood. I will use this work as a foundation for categorizing the overarching themes to summarize findings from my research.

The findings provide important insights into the perceptions and beliefs behind public participation. The outcome provides a theoretical framework consistent with current theory on policy environment and processes, and extends it to the health policy context. This framework will be used as the basis for categorizing the overarching themes summarized in this study.

4 A Framework for Evaluating LHIN Public Engagement

Drawing from the literature, this study proposes a multi-lens framework to qualitatively measure how LHINs public engagement activities compare across several key dimensions: (i) community characteristics, (ii) acceptance criteria, (iii) process criteria, and (iv) the extent of engagement methods. For each dimension, a separate rubric has been constructed to visually represent a gradient for scoring each metric so that each LHINs overall evaluation can be analyzed across metrics in relative rather than absolute terms.

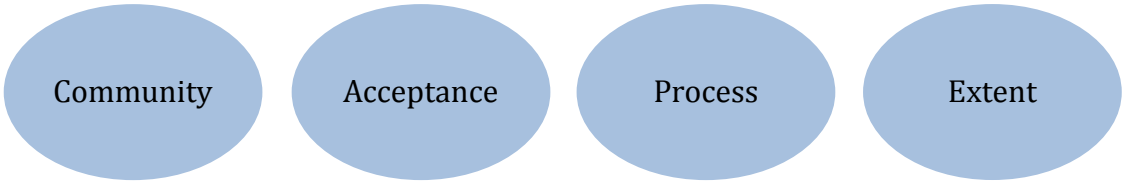

Figure 2 Framework for Evaluating LHIN Public Engagement

4.1 Community Characteristics

To provide some insight into variation in the choice and mix of engagement methods, two factors from Jabbar and Abelson's ideal conditions, geography and demographics, will be use to measure whether each LHINs characteristics are expected to influence their engagement strategies. The geography factor will evaluate three metrics as the basis for assessing whether each LHIN is geographically diverse or

disperse: the per cent of the LHIN population living in rural settings, small urban settings, or large urban settings. The demographics factor will evaluate 3 metrics as the basis for assessing whether the population of each LHIN is homogenous or heterogenous: the per cent of the LHIN population that is French first language, Indigenous identity, or visible minority. For each metric, the LHIN values will be transformed to quintiles based on the distribution of all values, with each LHIN's quintile scored as shown in Table 6 below.

Table 6 Community Characteristics - Rubric

	0th to 20th Percentile	21st to 40th Percentile	41st to 60th Percentile	61st to 80th Percentile	81st to 100th Percentile
Geographic Diversity and Dispersity	○	◔	◑	◕	●
Population Diversity	○	◔	◑	◕	●

4.2 Acceptance and Process Criteria

Overlaying Rowe and Frewer's evaluation criteria onto Timney's scorecard, modified to the levels of participation from Ontario's pan-LHIN community engagement guidelines to ensure alignment with terminology used in LHIN engagement strategies, acceptance criteria will be measured using five metrics, and process criteria will be measured using four metrics. It is noted up front that all LHINS engage the public actively at standard at least above the level of informing which ensures that every LHIN will score at least at the second level. As such, engagement activities at the lowest level will not be included in scoring. Furthermore, no LHINs engage with broad-based

delegated decision-making power, so nor will any LHINs be expected to score at the highest level. As we know from the literature, there are tradeoffs to different levels of engagement methods for acceptance criteria, and as such scores will not necessarily improve linearly as the levels of engagement methods increase. For each LHIN, the engagement methods used will be mapped to discrete levels of engagement using Table 3 above, and then each LHIN will be scored based on the highest level achieved as shown in Table 7 and Table 8 below. It is to be expected that some LHINs will use methods from multiple levels, which will be captured in the final scoring dimension discussed in the next section.

Table 7 Acceptance Criteria - Rubric

	Inform	Consult	Involve	Collaborate	Empower
Representativeness of participants	n/a	◔	◑	◔	n/a
Independence of participants	n/a	◕	◕	◑	n/a
Early Involvement	n/a	◕	◕	◕	n/a
Influence on the final policy	n/a	◔	◑	◕	n/a
Transparency of the process to the public	n/a	◑	◑	◔	n/a

Table 8 Process Criteria - Rubric

	Inform	Consult	Involve	Collaborate	Empower
Resource accessibility	n/a	◔	◕	◕	n/a
Task Definition	n/a	◔	◕	◕	n/a
Structured Decision-Making	n/a	◔	◑	◕	n/a
Cost-effectiveness	n/a	◑	◑	◑	n/a

4.3 Extent of Engagement

The extent of engagement will be measured using 2 metrics of each LHINs overall public engagement strategy. The number of discrete levels of methods used at least once will be scored as shown in Table 9 below. And the highest discrete level of methods used will be scored as shown in Table 10 below. LHINs that engage both broadly and deeply will be considered to have the greatest extent of engagement. As we know from the literature, there are tradeoffs to different levels of engagement methods, and as such engaging with multiple as well as deep methods can compensate for any such tradeoffs, ensuring a more robust public engagement strategy.

Table 9 Breadth of Engagement - Rubric

	0	1	2	3	4
Number of levels of engagement used	○	◔	◑	◕	●

Table 10 Depth of Engagement - Rubric

	Inform	Consult	Involve	Collaborate	Empower
Highest level of engagement used	○	◔	◑	◕	●

5 LHIN Public Engagement

As a central requirement of the LHSIA"LHINs were mandated to undertake 'community engagement' as part of their service planning […] in the early years this was clearly seen as a combination of stakeholder meetings and public information and consultation about local system priorities […] more recently though, the LHINs have become much more focused on patient experience and patient engagement and the creation of direct measurement of each" (Fooks, p.252). In support of these efforts, and to align LHIN interpretations of the LHSIA, the LHINs partnered with the Ministry of Health and Long-Term Care (MOHLTC) to develop a set of pan-LHIN community engagement guidelines (June, 2016) (PLCEG) which: (i) define community engagement, (ii) set principles for meaningful engagement, and (Iii) identify key engagement requirements.

The PLCEG provides needed clarity on the intended scope of "community" which the LHSIA mandates LHINs to engage. In broad terms, the PLCEG suggests LHINS should consider "anyone whose interests may be positively or negatively affected by a project or anyone who may exert influence on the project or its results" to be a stakeholder. And that all stakeholders must be identified and engaged appropriately (June, 2016).

This places a clearer expectation on LHINs that they seek out identifying all unique stakeholder groups when planning public engagement activities.

The PLCEG also identifies three key principles of meaningful engagement: (i) effective planning, (ii) effective execution, and (iii) effective facilitation. Thorough and inclusive planning is crucial, including attention to inclusion of demographic diversity, specifically including Francophone and Indigenous communities. And quality engagement is dependent on sustaining a participatory culture with emphasis on a commitment to learning, demonstrating trust and transparency.

The PLCEG outlines a common standard for key engagement requirements across the LHIN. First, each LHIN should document a Community Engagement Plan (CEP), which outlines planned public engagement activities, target audiences, and goals and methods, as well as ongoing LHIN engagement structures and processes. In addition, this plan should form a part of each LHIN's Annual Business Plan (ABP), which should be posted publicly to the LHIN websites. Second, each LHIN should maintain an inventory of all public engagement activities, including details of the purpose, format and outcomes of activities. This inventory should form part of each LHIN's Annual Report (AR), which should also be posted publicly to the LHIN websites. A third key annual document prepared by each LHIN and posted publicly to the LHIN websites is the Integrated Health Services Plan (IHSP), which sets out the strategic directions and plans for each LHIN which are often the subject of public engagement activities. Individually, these three documents provide either prospective or retrospective details of LHIN public engagement activity, but used in combination they provide a balanced

overall perspective. All three documents for each LHIN were accessed from their public facing websites.

With the creation of the PLCEG, it is to be expected that public engagement activities across LHINs will be better aligned and uniform, and in that respect may reduce variation at least in terms of the choice and use of engagement methods. On the other hand, there may still be variation in the extent of public engagement achieved across LHINs given their success in accounting for challenges unique to each LHIN and in ensuring representativeness, of their stakeholder groups, as well as their effectiveness in planning, executing, and facilitating public engagement.

5.1 LHIN Integrated Health Services Plan (IHSP)

The Integrated Health Services Plan (IHSP) sets out the four-year strategic directions and plans for each LHIN, including how the LHINs intend to plan, fund, integrate and monitor the local health care system. Central to the planning process is broad-based public engagement is to ensure the resulting plan represents the priorities of all stakeholders in each LHIN. The 2016-2019 IHSP's of each LHIN were scanned to identify the public engagement methods and stakeholders who were engaged for input into the plans. A summary is provided in Appendix B.

There was some variation in IHSP specificity and details on public engagement methods and stakeholders, highlighting potential limitations in using IHSPs for this purpose. In order to fill in any gaps, supplementary information was gleaned from press releases and other on-line communications specific to each LHINs IHSP. In general a wide range of public engagement methods was used to consult LHIN communities, with

minimal but still some variation noted across LHINs. Methods ranged across all key levels of participation: consult, involve, and collaborate. For example, all of the LHINs used surveys and focus groups to *consult* with their communities. In contrast, the common characteristics of LHINs that used public session to *involve* their communities were those with a mix of rural, small urban, and large urban communities. The LHINs dominated by large urban communities did not mention the use of public sessions. The implications of this observed pattern of variation across LHINs will be explored in later discussion of IHSP scores. And finally, most LHINs used advisory committees to *collaborate* with their communities. There was no apparent pattern to the LHINs that did not reach the collaboration level.

5.2 LHIN Annual Business Plan (ABP)

The Annual Business Plan (ABP) for each LHIN sets out how it will operationalize its IHSP, including details of each LHIN's Community Engagement Plan (CEP). The 2016-2017 ABPs of each LHIN were scanned to identify the public engagement methods and stakeholders identified in each LHINs CEP. A summary is provided in Appendix C. The CEP for every LHIN was generally consistent with the list of public engagement activities identified in the IHSPs, with the notable exceptions of the absence of references to the use of surveys and public forums in most LHINs. It is clear from the IHSPs that open and self-selecting methods like public forums for public engagement are common used across the LHINs. But it is not clear whether these methods are truly excluded from use outside of IHPs, or if it is simply an artifact of the ABP structure being predominantly focused on highlighting public engagement activities related to iterative closed and pre-selected methods.

5.3 LHIN Annual Report (AR)

The Annual Reports (AR) for each LHIN details its achievements for the prior year, including an inventory of each LHIN's public engagement activities for that year. The 2015-2016 ARs of each LHIN were scanned to identify the methods and stakeholders of public engagement activities in the year prior to the current ABP. These are expected to overlap extensively with the current ABP, and serves to supplement the scoring of both the IHSPs and ABPs. A summary is provided in Appendix D. Not unexpectedly, given the retrospective nature of ARs, the public engagement activities identified in the ARs for every LHIN overlapped with their IHSPs and ABPs, and as such provided no few additional insights, and were not scored.

6 Community Characteristics of Ontario's LHINs

6.1 Geographic Diversity and Dispersity

Ontario's geography is quite varied with the populations of some LHINs more densely concentrated than others (see Appendix A). For example, 69.3% of Ontario's population lives in large urban communities, ranging from a high of 100% in the Toronto Central (TC) LHIN, to a low of 19.3% in the North East (NE) LHIN. And while only 14.1% of Ontario's population lives in rural communities the range across LHINs is wide, from a low of 0% in the Toronto Central (TC) LHIN to a high of 44.8% in the Southeast (SE) LHIN. These differences in geographic diversity and dispersity have implications for whether some LHINs might be more challenged than others in engaging the public, not only in terms of ensuring representativeness when there is greater geographic diversity, but also in terms of the resulting increased costs and time of the

LHINs and participants invested in public engagement activities when there is greater geographic dispersity. Responding to these differences may account for differences in public engagement strategies across the LHINs.

Scoring the percentages of population across community types in each LHIN according to the rubric in Section 4.1, there appear to be three general profiles of geographic diversity and dispersity, within which evidence of similarities in public engagement strategies may be expected, all other things being equal. First, there are the LHINs in the Toronto and surrounding regions that are small in physical area relative to total population and are dominated by large and densely populated urban communities (CW, MH, TC, and C shaded in green in Table 11 below). Second, there are the LHINs that are large in physical area relative to total population and are dominated by sparsely populated rural and small urban communities (ESC, SW, SE, NSM, NE and NW shaded in blue in Table 11 below). And finally, there are the LHINs that lie in between that are moderate in physical area and comprised of a diverse mix of rural, small and large urban communities (WW, HNHB, CE and CH shaded in pink in Table 11 below). LHINs in the third group may be the most challenged in terms of ensuring representativeness in public engagement activities given the greater geographic diversity of their communities. In constrast, LHINs in the second group may be the most challenged in terms of mitigating organizers and participants costs and time given the greater geographic dispersity of their communities.

Table 11 Geographic Diversity and Dispersity - LHIN Scores

	ESC	SW	WW	HNHB	CW	MH	TC	C	CE	SE	CH	NSM	NE	NW
Population in Rural Areas	◑	◕	◔	◔	◔	○	○	○	◑	●	◕	●	◕	●
Population in Small Urban Areas	●	●	◔	◑	○	◔	○	◔	◑	◕	◔	◕	●	◕
Population in Large Urban Areas	◔	◔	◕	◕	◕	●	●	●	◑	○	◑	○	○	◔

Note: See glossary of LHIN acronyms. LHIN display order is geographically from southwest to southeast, then from northeast to northwest.

6.2 Population Diversity

Ontario's residents are very demographically diverse with the populations of some LHINs more heterogenous than others (see Appendix A). For example, 25.9% of Ontario's population is visible minorities, ranging from a high of 57.3% in the Toronto Central (TC) LHIN, to a low of 1.8% in the North East (NE) LHIN. And while only 4.4% and 2.4% of Ontario's population is French first language or Indigenous identity, the range across LHINs is wide, from lows of 2.3% and 1.0% respectively in the TC LHIN to high respectively of 23.2% in the North East (NE) LHIN and a high of 18.3% in the North West (NW) LHIN. These differences in population diversity have implications for whether some LHINs might be more challenged than others in engaging the public, not only in terms of ensuring representativeness, but also in terms of the resulting increased costs and time invested in public engagement activities. Responding to these differences may account for differences in public engagement strategies across the LHINs.

Scoring the percentages of population across community types in each LHIN according to the rubric in Section 4.1, there appear to be three general profiles of population diversity, within which evidence of similarities in public engagement strategies may be expected, all other things being equal. First, there are the very diverse LHINs in the Toronto and surrounding regions that have a high rate of visible minorities and the northern regions that have high rates of French first language and Indigenous identity (CW, MH, TC, C, CE, NE and NW shaded in green in Table 12 below). Second, there are the more homogenous LHINs that have very low rates across visible minorities, French first language and Indigenous identity (SW shaded in blue in Table 12 below). And finally, there are the LHINs that lie in between that have moderate rates in one or more of visible minorities, French first language and Indigenous identity (ESC, WW, HNHB, SE, CH, and NSM shaded in pink in Table 12 below). LHINs in the third group may be the most challenged in ensuring representativeness in public engagement activities given the greater population diversity of their communities.

Table 12 Population Diversity - LHIN Scores

	ESC	SW	WW	HNHB	CW	MH	TC	C	CE	SE	CH	NSM	NE	NW
French First Language Population	◑	○	○	◔	○	◔	◔	○	○	◑	○	◔	●	●
Indigenous Identity Population	◔	◔	○	◔	◑	○	○	○	◔	◑	◔	◑	●	●
Visible Minority Population	◑	◔	◑	◑	●	●	◕	●	◕	○	◕	◔	○	○

Note: See glossary of LHIN acronyms. LHIN display order is geographically from southwest to southeast, then from northeast to northwest.

7 Acceptance Criteria

Scoring the acceptance criteria in each LHIN according to the rubric in Section 4.2, there appear to be three profiles of public engagement used to inform IHSPs. First, the majority of LHINs engage at the highest level (ESC, SW, WW, CW, MH, C, CE, SE, NSM, and NW shaded in green in Table 13 below). Second, there are minority of LHINs that engage at the second lowest level (HNHB, CH and NE shaded in pink in Table 13 below). And lastly, there is the single largest LHIN that appears to only use the lowest level of engagement, which seems suspect and is likely a data anomaly (TC shaded in blue in Table 13 below). It is expected that the majority of LHINs will engage at the highest level so that processes are effective at ensuring participants have meaningful influence on decision-making. But given it is understood that there are tradeoffs in terms of reduced representativeness and transparency, it should be common practice to observe LHINs engaging using multiple methods to satisfy these. Evidence of using a broader extent of methods will be assessed in Section 9.

Table 13 Acceptance Criteria - LHIN Integrated Health Services Plan Scores

	ESC	SW	WW	HNHB	CW	MH	TC	C	CE	SE	CH	NSM	NE	NW
Representativeness of Participants	◔	◔	◔	◑	◔	◔	◔	◔	◔	◔	◑	◔	◔	◔
Independence of Participants	◑	◑	◑	◕	◑	◑	◕	◑	◑	◑	◕	◑	◕	◑
Early Involvement	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕
Influence on Final Policy	◕	◕	◕	◑	◕	◕	◔	◕	◕	◕	◑	◕	◔	◕
Transparency of the Process to the Public	◔	◔	◔	◑	◔	◔	◑	◔	◔	◔	◑	◔	◑	◔

Note: See glossary of LHIN acronyms. LHIN display order is geographically from southwest to southeast, then from northeast to northwest.

Scoring the acceptance criteria in each LHIN according to the rubric in Section 4.2, there appear to be no variation in for details of CEPs outlined in ABPs. All LHINs scored at the highest level of engagement (see Table 14 below). Given the forward focused nature of ABPs, it is to be expected that all LHINs will endeavour to draw connections in their plans to the use of higher level engagement methods recommended by pan-LHIN interpretations of LHSIA requirements.

Table 14 Acceptance Criteria - LHIN Annual Business Plan Scores

	ESC	SW	WW	HNHB	CW	MH	TC	C	CE	SE	CH	NSM	NE	NW
Representativeness of Participants	◔	◔	◔	◔	◔	◔	◔	◔	◔	◔	◔	◔	◔	◔
Independence of Participants	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑
Early Involvement	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕
Influence on Final Policy	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕
Transparency of the Process to the Public	◔	◔	◔	◔	◔	◔	◔	◔	◔	◔	◔	◔	◔	◔

Note: See glossary of LHIN acronyms. LHIN display order is geographically from southwest to southeast, then from northeast to northwest

8 Process Criteria

Scoring the acceptance criteria in each LHIN according to the rubric in Section 4.2, there appear to be three profiles of public engagement in for details of CEPs outlined in ABPs. First, the majority of LHINs engage at the highest level (ESC, SW, WW, CW, MH, C, CE, SE, NSM, and NW shaded in green in Table 15 below). Second, there are minority of LHINs that engage at the second lowest level (HNHB, CH and NE shaded in

pink in Table 15 below). And as discussed previously, there is the single largest LHIN that appears to only use the lowest level of engagement, which seems suspect and is likely a data anomaly (TC shaded in blue in Table 15 below). It is expected that the majority of LHINs will engage at the highest level to ensure processes lead to sound decision-making, generally accepting the trade-off of reduced cost-effectiveness in terms of time and expenses for both the LHINs and participants.

Table 15 Process Criteria - LHIN Integrated Health Services Plan Scores

	ESC	SW	WW	HNHB	CW	MH	TC	C	CE	SE	CH	NSM	NE	NW
Resource Accessibility	◕	◕	◕	◕	◕	◕	◔	◕	◕	◕	◕	◕	◕	◕
Task Definition	◕	◕	◕	◕	◕	◕	◔	◕	◕	◕	◕	◕	◕	◕
Structured Decision-Making	◕	◕	◕	◑	◕	◕	◔	◕	◕	◕	◑	◕	◑	◕
Cost-Effectiveness	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑

Note: See glossary of LHIN acronyms. LHIN display order is geographically from southwest to southeast, then from northeast to northwest.

Scoring the acceptance criteria in each LHIN according to the rubric in Section 4.2, there appear to be no variation in for details of CEPs outlined in ABPs. All LHINs scored at the highest level of engagement (see Table 16 below). As noted previously this is not unexpected give the forward focused nature of ABPs, and it should be no different with respect to all LHINs drawing connections in their plans to the use of higher level engagement methods recommended by pan-LHIN interpretations of LHSIA requirements.

Table 16 Process Criteria - LHIN Annual Business Plan Scores

	ESC	SW	WW	HNHB	CW	MH	TC	C	CE	SE	CH	NSM	NE	NW
Resource Accessibility	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕
Task Definition	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕
Structured Decision-Making	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕
Cost-Effectiveness	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑	◑

Note: See glossary of LHIN acronyms. LHIN display order is geographically from southwest to southeast, then from northeast to northwest.

9 Extent of Engagement

Scoring the extent of engagement in each LHIN according to the rubric in Section 4.3, there appear to be three profiles of breadth and depth for public engagement used to inform IHSPs. First, there are the LHINs in the Toronto and surrounding regions that are predominantly densely populated urban communities (WW, CW, MH, TC, and C shaded in pink in Table 17 below). Second, there are the LHINs that are predominantly sparsely populated rural and small urban communities (ESC, SW, CE, SE, NSM and NW shaded in green in Table 17 below). And finally, there is a mix of LHINs with no obvious commonalities (HNHB, CH, NE shaded in blue in Table 17 below). LHINs in the second group would be expected to be the most challenged in terms of ensuring representativeness in public engagement activities given the greater geographic diversity of their communities, which perhaps accounts for their use of a broad range of

engagement methods, to complement the use of the deepest engagement methods. In contrast, LHINs in the first group may be the most challenged in terms of managing the scale of open engagement methods, which perhaps accounts for their use of the deepest engagement methods, but a tendency to limit their choice methods to those that are more deliberative.

Table 17 Extent of Engagement - LHIN Integrated Health Services Plan Scores

	ESC	SW	WW	HNHB	CW	MH	TC	C	CE	SE	CH	NSM	NE	NW
Breadth	◕	◕	◑	◑	◑	◑	◔	◑	◕	◕	◑	◕	◑	◕
Depth	◕	◕	◕	◑	◕	◕	◔	◕	◕	◕	◑	◕	◑	◕

Note: See glossary of LHIN acronyms. LHIN display order is geographically from southwest to southeast, then from northeast to northwest.

Scoring the extent of engagement in each LHIN according to the rubric in Section 4.3, there appear to be three two profiles of breadth and depth for details of CEPs outlined in ABPs. But ultimately, the only difference between this is passing references to the use of town hall engagement methods by only three LHINs (CW, TC, and SE shaded in green in table 18 below). As noted previously this is not unexpected give the forward focused nature of ABPs, and it should be no different with respect to all LHINs drawing connections in their plans to the full breadth and depth of engagement methods recommended by pan-LHIN interpretations of LHSIA requirements. That said, it is noteworthy that evidence that LHINs make extensive use of open public forums, in their planning documents they provided definitive plans for their use of more deliberative methods of engagement, and otherwise perhaps assume that the use of other tools is a apparent without need of mention.

Table 18 Extent of Engagement - LHIN Annual Business Plan Scores

	ESC	SW	WW	HNHB	CW	MH	TC	C	CE	SE	CH	NSM	NE	NW
Breadth	◑	◑	◑	◑	◕	◑	◕	◑	◑	◕	◑	◑	◑	◑
Depth	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕	◕

Note: See glossary of LHIN acronyms. LHIN display order is geographically from southwest to southeast, then from northeast to northwest.

10 Further Study

There are two clear limitations of this study that present future opportunities for research by public engagement practitioners in Ontario and other jurisdictions. First, its reliance solely on publicly reported LHIN documents, where definitional consistency is not assured, is problematic. Proposing additional metrics could provide a deeper understanding of variation in LHIN public engagement method, but the consistency and reliability of comparator data gleaned from publicly available non-standardized documents may vary unpredictably. As such, one improvement for further study and development of the proposed framework would be to expand data gathering with a survey component requesting specific measures, and provide standardized definitions to ensure comparability. Second, the findings suggest that there may be a predictive relationship between LHIN characteristics and public engagement methods choice in terms of mitigating issues of acceptance criteria (e.g. representativeness, transparency, etc.). In contrast, the findings also suggests that the relationship between LHIN characteristics and public engagement methods choice in terms of mitigating issues of process criteria are more consequential than predictive. As such, another area of improvement would be expanding the metrics defined for acceptance criteria lens, and

eliminating the process criteria lens. With increased rigour from future research, the proposed framework for evaluating public engagement activities in LHINs could eventually provide a predictive tool of public engagement method choice dependent on variation in regional characteristics.

11 Conclusions

Two observations from the review of the LHIN's planning documents are noteworthy. First, while the new LHSIA requirements with respect to patient and family advisory committees were in part a motivation for this study, only two LHINs include direct references to them in their forward focused annual business planning documents. This may be an issue of timing, with some LHINs choosing to be early adapters while other LHINs prefer not to formalize any changes into their business plans until there is an opportunity to better understand the implications and intent of the legislation with respect to public engagement method choice. Second, while the LHINs community engagement plans include details for French and Indigenous public engagement, an explicit requirement of LHSIA, several LHINs frequently reference with equal importance the need to capture the voice of visible minorities, yet none of these LHINs has created a targeted strategy for engaging these segments of their communities. Both of these are worthy considerations for a response from expanded pan-LHIN community engagement guidelines.

This study set out to identify and explain variation in the choices of public engagement methods across Ontario's Local Health Integration Networks, to inform the policy space these organizations operate in with respect to enabling citizen

participation in regional health planning decisions. The general finding is that the majority of LHINs appear to engage to a similar depth, which follows given pan-LHIN public engagement guidelines were developed with participation from all of the LHINs. However there is evidence of modest variation in the extent of engagement method choices aligning with variation in the characteristics of LHINs, suggesting LHIN characteristics are important determinants of public engagement method(s) choice. This key finding has significant policy implications. Specifically, a clearer understanding of the differences in LHIN characteristics provides important context for justifying the choice of individual methods, as well as the widespread use of a mixed methods approach. Indeed, the importance of engaging deeply to provide opportunity for meaningful public involvement in decision-making is widely accepted. However, given the consequential tradeoff of representativeness in favour of deliberativeness, the complementary use of open and self-selecting methods is equally important in order to generate legitimacy of decision-making.

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Websites of Ontario Ministry of Health and Long Term Care (www.health.gov.on.ca), and Ontario's 14 Local Health Integration Networks (www.lhins.on.ca)

Glossary of LHIN Acronyms

C	Central
CE	Central East
CH	Champlain
CW	Central West
ESC	Erie St. Clair
HNHB	Hamilton Niagara Haldimand Brant
MH	Mississauga Halton
NE	North East
NSM	North Simcoe Muskoka
NW	North West
SE	South East
SW	South West
TC	Toronto Central
WW	Water Wellington

Source: www.lhins.on.ca

Appendix A: LHIN Geographic and Demographic Metrics

LHIN	Geographic Metrics			Demographic Metrics		
	% Population Living in Rural Communities	% Population Living in Small Urban Communities	% Population Living in Large Urban Communities	% Population with French First Language	% Population with Indigenous Identity	% Population is Visible Minority
Ontario	14.1%	16.6%	69.3%	4.4%	2.4%	25.9%
ESC	19.3%	36.1%	44.6%	3.3%	2.5%	10.8%
SW	27.8%	32.6%	39.6%	1.3%	2.0%	7.6%
WW	11.0%	10.6%	78.4%	1.5%	1.4%	13.7%
HNHB	12.0%	15.9%	72.1%	2.3%	2.8%	10.3%
CW	6.5%	8.0%	85.5%	1.2%	7.0%	57.3%
MH	1.7%	11.3%	87.0%	1.8%	0.6%	40.7%
TC	0.0%	0.0%	100.0%	2.3%	1.0%	33.6%
C	4.5%	6.7%	88.8%	1.3%	0.5%	46.9%
CE	13.0%	15.1%	71.9%	1.5%	1.4%	37.2%
SE	44.8%	30.6%	24.6%	3.0%	3.9%	3.4%
CH	20.0%	15.1%	64.9%	1.0%	2.7%	17.7%
NSM	32.0%	30.1%	37.9%	2.8%	4.3%	4.1%
NE	30.2%	50.5%	19.3%	23.2%	11.0%	1.8%
NW	34.2%	19.8%	46.0%	3.5%	18.3%	2.2%

Source:Environmental Scan 2016-19 Integrated Health Services Plans www.lhins.on.ca

Appendix B: LHIN Integrated Health Services Plans Engagement Methods and Stakeholders

	Consult	Involve	Collaborate
ESC	Survey: Providers, Patients, Rural, Urban, French, Indigenous	Public session: Providers, Patients	Advisory Committees: Providers, Patients, Visible Minorities, Indigenous
SW	Focus group: Patients Survey: Provider	Public session: Providers, Patients	Advisory Committees: Providers, Patients, Indigenous, French
WW	Focus group: Providers, Patients, Rural Survey: Providers, Patients, French		Advisory Committees: Providers, Ptaients, Visible Minorities, Indigenous
HNHB	Focus group: Patients, French, Indigenous, Visible Minorities	Public session: Providers, Patients	
CW	Focus group: Patients Survey: Provider, Patients		Advisory: Providers, Patients, Indigenous, French
MH	Focus group: Patients Survey: Provider, Patients		Advisory: Providers, Patients, Indigenous, French
TC	Focus group: Provider, Patients, French, Indigenous, Visible Minority		
C	Focus groups: Providers, Patients Surveys: Providers, Patients		Advisory: Providers, Patients, French, Indigenous, Visible Minorities
CE	Survey: Providers, Patients	Public session: Providers, Patients	Advisory: Providers, Patients, French, Indigenous
SE	Focus groups: Providers, Patients Survey: Providers, Patients	Public session: Providers, Patients	Advisory: Providers, Patients. French, Indigenous
CH	Survey: Providers, Patients	Public: Patients	
NSM	Focus groups: Providers, Patients Survey: Providers, Patients, Rural, Urban	Public session: Providers, Patients	Advisory: Providers, Patients. French, Indigenous
NE	Focus groups: Providers, Patients, Rural, French, Indigenous Survey: Providers, Patients	Public session, Providers, Patients	
NW	Focus groups: Providers, Patients, Rural, French, Indigenous Survey: Providers, Patients	Public session: Providers, Patients	Advisory: Providers, Patients, Rural, French, Indigenous

Source: Integrated Health Services Plans of Ontarios' LHINs www.lhins.on.ca

Appendix C: LHIN Annual Business Plans Engagement Methods and Stakeholders

	Consult	Involve	Collaborate
ESC	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous
SW	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous
WW	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous
HNHB	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous
CW	Focus group: Provider, patient	Public session	Advisory, Provider, Patients, French, Indigenous
MH	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous
TC	Focus group: Provider, patient	Public session	Advisory, Provider, Patients, French, Indigenous
C	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous
CE	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous
SE	Focus group: Provider, patient	Public session	Advisory, Provider, Patients, French, Indigenous
CH	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous, Rural
NSM	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous
NE	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous
NW	Focus group: Provider, patient		Advisory, Provider, Patients, French, Indigenous

Source: Integrated Health Services Plans of Ontarios' LHINs www.lhins.on.ca

Appendix D: LHIN Annual Reports Engagement Methods and Stakeholders

Note: Differences from IHSP summary in Appendix B are shaded below.

	Consult	Involve	Collaborate
ESC	Focus group: Provider, patient Survey: Providers, Patients, Rural, Urban, French, Indigenous	Public session: Providers, Patients	Advisory, Provider, Patients, French, Indigenous
SW	Focus group: Patients Survey: Provider	Public session: Providers, Patients	Advisory Committees: Providers, Patients, Indigenous, French
WW	Focus group: Providers, Patients, Rural Survey: Providers, Patients, French		Advisory Committees: Providers, Ptaients, Visible Minorities, Indigenous
HNHB	Focus group: Patients, French, Indigenous, Visible Minorities	Public session: Providers, Patients	
CW	Focus group: Patients Survey: Provider, Patients	Public session	Advisory: Providers, Patients, Indigenous, French
MH	Focus group: Patients Survey: Provider, Patients		Advisory: Providers, Patients, Indigenous, French
TC	Focus group: Provider, Patients, French, Indigenous, Visible Minority	Public session	Advisory: Providers, Patients, Indigenous, French
C	Focus groups: Providers, Patients Surveys: Providers, Patients		Advisory: Providers, Patients, French, Indigenous, Visible Minorities
CE	Survey: Providers, Patients	Public session: Providers, Patients	Advisory: Providers, Patients, French, Indigenous
SE	Focus groups: Providers, Patients Survey: Providers, Patients	Public session: Providers, Patients	Advisory: Providers, Patients. French, Indigenous
CH	Survey: Providers, Patients	Public: Patients	Advisory, Provider, Patients, French, Indigenous, Rural
NSM	Focus groups: Providers, Patients Survey: Providers, Patients, Rural, Urban	Public session: Providers, Patients	Advisory: Providers, Patients. French, Indigenous
NE	Focus groups: Providers, Patients, Rural, French, Indigenous Survey: Providers, Patients	Public session, Providers, Patients	Advisory: Providers, Patients. French, Indigenous
NW	Focus groups: Providers, Patients, Rural, French, Indigenous Survey: Providers, Patients	Public session: Providers, Patients	Advisory: Providers, Patients, Rural, French, Indigenous

Source: Integrated Health Services Plans of Ontarios' LHINs www.lhins.on.ca