Ontario Health Coalition Summary & Analysis of Minister of Health's White Paper on Health Care Reform

Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario
Discussion Paper issued by the Minister of Health & Long-Term Care, December 17, 2015

Process & Timelines

The process of public consultation for this proposed reform is an improvement on we had seen under the previous Minister of Health. There is a "White Paper" (a discussion paper) and there is a process for input. But there are a few problems. The Minister released the discussion paper just before the last weekend prior to the winter holidays. Many people were on vacation or leaving for vacation. We note that the Ministry of Health released its plans to bring in private clinics two years prior at the exact same time of year. Many organizations that would like to be involved in giving input lost weeks of time before they could even begin their internal processes to give input. Many missed the release of the document and only found out about the proposals in the last few weeks as the LHINs' announced their public consultations. The timing of the release guaranteed that there would be virtually no media coverage of the proposals.

In addition, the government has delegated the Local Health Integration Networks to conduct public consultations across the province. Thus, the LHINs are leading the consultation on expanding their own powers. This is an obvious conflict of interest. We have received many complaints from people asking how they are supposed to give input on their experiences with the LHINs when the LHINs are the ones conducting the consultations. Many have expressed distrust that the LHINs are compiling their input. Several people have complained to us that the written summary was hidden from the people and groups giving input, or that the summary did not reflect their input. In addition, in several communities, we have been told that by the time the LHINs got done their presentation, they ran out of time to consult.

There should be a proper process of on-the-record consultation done prior to implementation of the wide-ranging reform proposed in this report. A model to follow could be the process that was used in the creation of the Long-Term Care Homes Act (2007) in which Minister of Health George Smitherman had Monique Smith conduct consultations and develop the policy from a White Paper.

It is widely rumoured that the government intends to bring in new legislation in March. This would mean that the legislation was written before the public was consulted. Therefore, it is not clear whether there is any opportunity for meaningful public input at all. The deadline for input is Monday, February 29, 2016.

Summary

The Minister's plan is to expand the powers of the Local Health Integration Networks (LHINs).

1. **Change in Scope of What is Covered/Not Covered by the LHINs**

Currently the LHINs have powers over the following:

- Public hospitals
- Long-term care homes
- Community Care Access Centres
- Mental health facilities
- Home and community care providers
- Community Health Centres
- Community mental health and addictions non-profits

Currently the LHINs do not have powers over family doctors, chiropodists, dentists, optometrists, independent health facilities, labs, public health and certain corporations of health professionals.

Under this proposal, the LHINs' new powers would include:

- Take-over and elimination of CCACs. Case managers would be transferred to be employees of the LHINs and LHINs would take-over of contracting out of home care. CCAC Boards would be eliminated.
- Take-over of what the Minister is calling "planning and performance management" in primary care (primary care is the ground floor of the health care system – family doctors or health teams, nurse practitioners, Community Health Centres etc.)
- Take-over planning and performance management for Public Health Units.

Therefore, under the new plan, LHINs would provide case management and care coordination and possibly some direct care provision for home care/community care that used to be under the CCACs. The LHINs would have some sort of governance role in primary care, but the exact powers they would have and how these compare with the current powers of the College of Physicians and Surgeons/Nurses are not defined in the paper. The LHINs would have some governance role over Public Health Units but there are competing or contradictory parts of the report regarding what role municipalities/Public Health Boards would have and what role the LHINs would have. (Currently municipalities fund 25% of public health and public health is run by Boards of Health that are made up of municipal representatives.)

Under the new plan, purview of the LHINs still would not include chiropodists, dentists, optometrists, independent health facilities, labs, public health and certain corporations of health professionals.

2. Change in What LHINs Do

a. LHINs no longer a purchaser, but also a service provider taking over CCACs, case management and care coordination

LHIN legislation currently prohibits the LHINs from providing any health service directly. The LHINs are supposed to follow a model that has been called "the purchaser-provider split". LHINs are required to forge "Accountability Agreements" with providers under their purview. These providers actually provide health care services. The LHINs do not. The Accountability Agreements set out performance measures and funding levels. The LHINs are supposed to oversee these. (See the section on analysis for more on this. There is no real accountability or enforcement for many performance measures set out in the accountability agreements, and while some of the measures are in the public interest, a number of the measures are problematic.)

Contrary to the current prohibition against LHINs providing direct services, under this new plan, LHINs would directly provide the case management/care coordination functions for home and community care that used to be provided by the CCACs. In some areas, the CCACs also provide front-line care services such as physiotherapy. It is not clear whether the direct care employees such as physiotherapists that are employees of CCACs in some areas are to also be transferred to the LHINs. The change to enable LHINs to directly provide care would require new legislation and regulatory changes.

b. New powers regarding primary care unclear

It is unclear in the discussion paper what role the Ministry would take and what role the LHINs would take regarding primary care. On page 14, the paper states that the Ministry would retain its role in health workforce planning. Elsewhere it states the LHIN would take over "primary care human resources planning" (for example, see pp. 5). The paper proposes that the Ministry will more methodically measure patient "outcomes" in primary care to understand the patient experience in accessing primary care including same-day and after-hours care. [It is not clear whether the point is to measure outcomes or access or both]. But there seems to be duplication here also. The paper states that LHINs, too, will collect and assess performance indicators for primary care at a sub-region level and share that info with health providers and managers (sharing this information with the public is not mentioned).

It appears that the proposal is for the LHINs to be responsible for recruitment planning for primary care and linking new patients with doctors and nurse practitioners. Elsewhere in the paper, it is proposed that LHIN sub-regions would link patients with providers.

The primary care proposals include language respecting a team-based approach to primary care. Patient choice in primary care is to be respected. This is repeated throughout the paper.

c. New powers over Public Health Units unclear

Under the plan, the LHINs would create accountability agreements with public health units. Accountability agreements are fundamentally a funding mechanism. But the paper also states that local boards of health would continue set budgets. These two proposals are in conflict with each other. The plan also calls for the creation of an expert panel to be established to recommend how to "deepen the relationship". This seems to indicate a plan for further reform and more LHIN powers over public health.

The paper states that Boards of Health and land ambulance services continue to be managed at municipal level.

The plan includes the creation of some kind of formal relationship between Medical Officers of Health and each LHIN, empowering MOHs to work with LHIN leadership to plan population health services.

d. LHINs' restructuring powers would be expanded to cover primary care and public health

The primary function of the LHIN legislation is to give the LHINs and the Minister of Health extraordinary powers to overrule existing Boards of Directors for health care providers under the LHIN legislation's purview, to order them to provide certain services or levels of service, and to force restructuring. In the LHIN legislation, "integration" is actually defined to include extraordinary restructuring powers including: ordering service providers to increase or decrease volumes of service; requiring service providers to start providing a service or to cease providing it; powers to merge or amalgamate non-profit providers of services (like hospitals or community agencies); and powers to order providers to cease operations and dissolve entirely. Unlike the restructuring legislation passed under the Mike Harris government that gave the Health Minister extraordinary powers to order hospital restructuring, there is no end date for these extraordinary powers. (The Harris legislation had a sunset clause that ended restructuring after several years.) The LHIN legislation proposes to restructure in perpetuity.

The new sectors – public health and primary care -- given over to the LHINs under the Minister's proposals would be subject to those restructuring powers.

The Minister's discussion paper proposes to make the LHINs responsible for improving access to care. To do this, the LHINs would need to make a priority of planning the capacity and services to meet population need for care. In the long list of things LHINs can do under their legislation, there is mention of measuring and planning to meet population need for health care in their regions. But the LHINs do not actually do this. In fact, there is no capacity planning in Ontario's health care system. The LHINs generate an impressive array of health and population data. But it is not used to create a plan to meet need. The last hospital bed study was done in 1994 – 1995. The planning for long-term care beds was done in the mid-1990s and is at least 20,000 short. There is no home care capacity planning and home care wait lists have never actually been measured since different CCACs simply cease to admit whole classifications of patients onto wait lists when funds are short. (For example, those with moderate or lighter needs are simply cut off and not waitlisted when CCACs are short of funds.)

Currently the LHIN legislation requires them to find opportunities to integrate (restructure) as a priority. It would be a most positive change if the LHINs were actually required, as their priority, to measure and plan to meet population need for care in their regions.

3. **Creation of Sub-Regions**

The Minister's discussion paper proposed that the 14 LHINs create new sub-regions potentially aligning with the Health Links regions. It also notes that adjustments to the LHIN boundaries may be made.

Currently the CCACs have different sub-regions than Health Links. It appears that if the LHINs were to take over and eliminate the CCACs, those sub-regions would be restructured along the lines of the new proposal. This impacts the sub-regional offices and also likely the scheduling and traveling distances for the home care workforce.

Currently there are 36 Public Health Units. There is no reference to what will happen to those regions under this proposal, but there are concerns that this will lead to a restructuring of the Public Health Units and their regions. This will impact all the municipalities and Boards of Public Health and their workforces. It would also, presumably, impact municipal funding for Public Health Units.

Additional Analysis and Notes

There are progressive ideas and values reflected throughout the Minister's proposals. The discussion paper proposes to "address structural issues that create inequities", to "truly integrate the health system", and provide patients the care they need no matter where they live. It promises to improve access to primary care (the front door of medicine -- family doctors, nurse practitioners, community health centres and the like); standardize and strengthen home and community care, and strengthen population and public health. It supports interdisciplinary teams in primary care and proposes to improve performance and access across a wide section of the health care system.

All of these ideas are positive and we support them.

But there is nothing in the paper that would actually accomplish these. Simply moving the CCACs to the LHINs is unlikely to achieve any improvement in home care, though it will create massive upheaval. The same applies to Public Health Units. It is not clear how the LHINs could create any meaningful accountability for primary care providers. Moreover the LHINs themselves are not accountable to the public. They have only had discretionary power over a very small slice of health funding to date. Primarily LHINs have been used to force through cuts and restructuring.

The Minister's proposals are founded on two assumptions that are not true:

1. That the main problem is lack of integration, not lack of planning and appropriate resources to make those plans real.
2. That the LHINs have shown themselves to be capable of making the proposed improvements.

1. **Lack of planning**

   There is no doubt that lack of integration is a problem in Ontario's health care system. But at least equally problematic is the total lack of any normal planning functions. There is no capacity planning. There is no attempt to measure and meet population need for health care and then provide the resources to implement the plans. Infrastructure planning is not attached to any actual planning to meet community's needs for care. Service levels are not based on population need for care. Normal planning processes used in other jurisdictions with public health care systems (and have historically been used here in Ontario) have been abandoned.

   The first job of a public health care system is to measure and meet population need for health care. But this report does not recognize the lack of planning. It does not make any recommendations that would address this problem other than to propose that LHINs improve access to care. Without better planning and resources (human and financial) based on measurement and planning to meet population need, access will not improve in many areas of health care.

In fact, the LHINs' requirement to endlessly restructure has taken needed resources away from care and bred an army of consultants, technocrats and PR firms that are not improving access to care. The system needs to be reoriented to focus clearly on planning and appropriately resourcing the health care system to meet need.

2. LHINs' record of performance

The Minister's discussion paper starts with the premise that the LHINs have proven themselves to be "the right structure to enhance service integration, accountability and quality". This contention is not supported by the evidence.

We must recognize that there are highly talented, committed and well-meaning Board and staff members in a number of the LHINs. But their best efforts cannot change the flaws in the LHINs legislation and mandate, and the priorities that they have been given to enforce.

Under the LHINs legislation, the LHINs were supposed to be subject to review. The review was delayed until after a provincial election, and then later it was started but not completed. This was a legislative requirement and it is not clear how or why the government has failed to comply.

Under the new proposals, the Minister plans to eradicate the CCACs and hand them over to the LHINs. But the LHINs have many of the same problems that plagued the CCACs. The movement of the CCACs to the LHINs will not create a public non-profit home care system. In fact, the plan is to continue the contracting out of home care to a majority of for-profit chain companies. The duplicate administrations, profit taking and all the problems inherent to this structure will continue. Inequities in access to care are as grave in the LHINs as they are in the CCACs. Further, there is no proposal to ensure that Ontarians have the right to access home care, that need will be measured and met, or that funding will be based on an evidence-based assessment of need.

The Ontario Health Coalition has decades of experience in health care advocacy prior to and since the creation of the LHINs. We have observed how decision-making over vital health care services has changed under the LHINs. There have been many very serious problems. Among them:

- LHINs do not measure and plan to meet population need for care. LHINs have Integrated Health Service Plans (IHSPs) for their regions but these are not capacity plans and they do not measure or try to meet health care needs across the continuum of care. These IHSPs have varied greatly from region to region and their goals have ranged from concrete proposals that would likely improve access to care if implemented to trendy and largely meaningless "biz speak". Moreover, though some of the Integrated Health Service Plans contain laudable goals, in reality LHINs neither have the power to implement many of the goals they set, nor do they operate under any accountability system that would hold them to meeting these goals.

- Since the LHIN legislation was enacted, decisions to cut, close and curtail health care services have been inequitable and ad hoc. Sound planning, evidence-based decision-making and proper process in health care has been largely abandoned. Decisions to close and move services have been made without any regard for patients' access to care.

- The LHINs have played a very damaging role in cutting needed hospital services and cutting funding for important community care and support services. These decisions are totally disconnected with population need, and, in many demonstrable instances, are not cheaper.

- Small hospitals that were amalgamated to larger hospitals in the restructuring of the 1990s and are not considered to be entities under the LHINs legislation because they are not separate corporations. They have been subject to disproportionate cuts and their communities have had no voice in these decisions. In some cases they have been entirely closed down without any public input; entire towns have lost most or all of their local hospital care. Plans have been steamrolled through, despite massive community opposition. Amalgamation was never meant to be a carte-blanche to wipe out small and rural hospitals.

- In many areas, the forced cuts have facilitated the for-profit privatization of formerly public and non-profit health care services, particularly hospital care services and some community care, even though we were assured by the Health Minister at the time of the passage of the LHINs legislation that this would not happen and even though amendments were made to the LHINs legislation that were supposed to prohibit it from happening.

- We have experienced a number of instances in which some LHINs have deemed that their decisions are not "integration decisions" thereby circumventing any checks and balances on restructuring decisions. (Integration orders and decisions are required to follow a process. They require formal Board motions. They also require public notification, public input and consultation and the ability for the public to make an appeal to have the integration decision reviewed. Instead of doing this, the LHINs have simply claimed that major cuts that have offloaded public hospital services to for-profit clinics, for example, are not integration decisions. Thereby the LHINs have avoided all accountability and circumvented any process that would protect the public against health care privatization.)

- There are concrete performance measures for the LHINs are contained in the LHIN Accountability Agreements with the Ministry. It is unclear what actions the Ministry takes, if any, when the performance goals set out in these Accountability Agreements are not met. In any case, it is not within the LHINs powers to effect the changes necessary to meet a number of these performance indicators. For example, if as a result of decades of bed cuts, all local hospitals have too few beds to admit patients and the large town Emergency Departments are backlogged; the LHIN does not have the budget powers or the human resources to open and staff significant numbers of hospital beds to improve the situation. We have seen instances where LHINs have an incentive to turn a blind eye when hospitals create holding areas that they do not call Emergency Departments and simply move patients waiting for admission to these other units to wait, then can claim that they have met emergency department wait time reduction targets. Everyone knows this "gaming" is happening. For patients it means that there is no improvement in access to care while, at the same time, Ontarians are paying for an expensive multi-tier administrative system set up to make it look like someone is doing something.

- Some LHINs exploit a wide loophole in the requirement that they have open Board meetings to go "in camera" on issues that should be public. Some LHINs have refused to release information and reports that should, unquestionably, be in the public domain. For example, the Central East LHIN is currently refusing to release a consultant's recommending hospital cuts and restructuring in Northumberland Hills.

- LHINS decision-making processes involve multiple redundant reports and over-use of expensive consultants. Too often these reports are of poor quality and dubious methodology that are simply window dressing for pre-ordained conclusions. These reports have no public credibility. Worse, this process has given too much power to totally unaccountable consulting companies that often have an interest in privatization and restructuring because they offer possibilities for more consulting work. This system of self-justification through consultants' reports has undermined a professional public service that operates in the public interest.

- There is no consequence when LHINs ignore their own legislation.

- The LHINs' own accountability to the Ministry is convoluted and contains few performance measures – almost all of which are focused on hospitals – and which, in any case are unenforced or unenforceable.

The Minister's White Paper makes some claims regarding how the proposed change in scope for the LHINs will bring certain types of health planning "closer to home". In truth, The LHINs have centralized -- not decentralized -- decision-making. The LHINs are appointed by Cabinet (that is, the Ministers of the ruling political party in Queen's Park). Their Board Chairs and Vice Chairs are appointed by Cabinet. They are not accountable to local communities. There is

virtually nothing in the LHINs legislation that enables anyone in a local community to influence LHIN decisions. Even the provisions in the LHINs legislation that were supposed to allow community members to appeal LHIN decisions are, more often than not, ignored by the LHINs. The structure of the LHINs was set up purposefully for the LHINs to operate as a command-and-control body for the Ministry of Health to order and enforce restructuring. They have never been "decision-making close to home". In fact, the LHINs take power away from local Boards of Directors and local people as they have extraordinary powers to overrule local Boards of Directors for non-profit health care providers like community care agencies or local hospitals. They have only ever had discretion over a tiny slice of health funding. Funding levels are set centrally from Queen's Park in Toronto. The LHINs answer upwards – to the Ministry of Health, and through the Minister, they are accountable to Cabinet.

As we noted in our submission to the LHIN review that was never completed:

"LHIN Accountability Agreements contain a table of performance indicators with 15 indicators. All but one of these indicators pertains to hospital services. Of these: six pertain to reducing ER length-of-stay, and reducing ER visits and hospital readmissions; one pertains to reducing Alternate Level of Care days; and the rest pertain to reducing wait times for hospital procedures, surgeries and diagnostics. The only non-hospital performance measure sets a target wait time for access to home care services of approximately one month. In any case, these targets are not upheld. Further, currently, the LHINs have dual systems of planning – an Integrated Health Service Plan and an Accountability Agreement – each of which sets out a different set of goals, none of which are upheld."

At the very least, the LHINs require significant reform and the proposal to expand LHINs' powers may offer an opportunity to win some positive change.

Changes to the LHINs must include the following:

- The requirement to measure and plan to meet population need for care in their regions must be made a priority.
- The LHINs' extraordinary restructuring powers must be repealed.
- The overuse of consultants and PR firms must be stopped.
- All new capacity in the health care system must be created under public non-profit ownership only. The LHINs should be prohibited from moving services from non-profit entities to for-profit entities.
- The public must have clear rights to access documents, data, and reports. There must be accountability for LHINs that refuse to release information that should be in the public domain.
- Public consultation is not the same as "community engagement". LHINs are required only to practice "community engagement" and their processes are not democratic. The public should be involved in decisions pertaining to their health and the health care systems in their communities. Meaningful public consultation and redress for serious complaints must be understood as cornerstone to sound planning. Similarly, the Minister's strategic plan that is supposed to guide the health care system should be subject to proper public debate, public input and democratic process. (Currently there are no democratic processes for these so-called strategic plans.)
- LHIN Boards should be democratic, accountable to their communities and representative of the diversity of their communities.