Ontario Health Coalition

LHINs

Report on the LHINs workshop in Hamilton from the Burlington Health Coalition

The Ministry of Health and Long-Term Care of the Ontario Government plans to establish 14 Local Health Integration Networks (LHINs)---what are known in other provinces as "regional health authorities". These will be purely administrative structures, not directly involved in the delivery of health care. (Smitherman insists on using the word "local" instead of "regional" to emphasize that health care is delivered to people in local hospitals and by local agencies.) It was pointed out at the Community Workshop that most European countries have adopted this kind of administrative model, and that Ontario is the last province in Canada to do so. Although there appears to have been little public discussion about the LHIN proposal, there is no doubt about the government,s determination to move ahead with it, and to do so quickly so that the implementation process will not falter. The LHINs are to be "up and running" by April 2005 and will be fully functioning by April 2006.

Natalie Mehra and others at the Ontario Health Coalition are concerned that the LHINs will be undemocratic, with no provision for input from ordinary citizens. This is certainly the way it will be. Each LHIN is to have a small board of seven to nine people who are health-care professionals and administrators. The government will appoint the CEO of each LHIN by an order-in-council. (A proposal at the Community Workshop to create" a local community advisory body to address local issues and report back to the LHIN board" did not receive enough support to make it onto the list of five top priorities. See below.)

The Hamilton LHIN Community Workshop was attended by approximately 400 people, almost all of who were health professionals and administrators. In an opening address, Gail Peach, who is heading up the LHIN implementation process, said, "We are here today to kick off the health integration transformation agenda." She emphasized the word "transformation", noting that when she trained as a nurse 35 years ago, people were talking enthusiastically about providing health-care services in teams. "But it still isn't happening," she added. The LHINs will attempt to change this. Later in her speech she made the surprising statement that primary health care will not be incorporated into the LHINs. Likewise, the setting-up of 150 new family health teams will proceed without involvement from the LHINs. One can surmise that they do not want to rely on cooperation from the doctors.

The main part of the workshop was spent identifying and discussing in small groups about thirty "integration opportunities", proposed by workshop participants. These covered the entire health-care spectrum, from managing diagnostic tests and assessment of cancer patients to the question of transparency in the way the LHINs operate. Many of the proposed topics had to do with the integration of services for the elderly, for mental health patients, for aboriginal communities, for autistic children and other groups with special needs. In the morning I joined one on "building an integrated community-based care", and in the afternoon, one on "integrating primary care and health promotion into the LHINs. "In both groups the discussion was at a high level. People spoke with passion about their concerns, and they spoke well. For example, the director of a long-term care facility, who had been reluctant to give up a whole day for the workshop, said at one point, "The question uppermost in my mind is: 'How can we keep people

in their own homes, if they want to stay there, and not have them going into long-term care facilities?'" Among the participants at the workshop were many directors of long-term care facilities and executives from CCACs. There were also many people from agencies delivering programs for the mentally ill, from providers of homecare like the V.O.N. and from service providers like Meals on Wheels. Several people observed that the trust that used to exist between different agencies has been greatly eroded by the competitive bidding process. They would welcome a return to collaborating instead of competing with each other.

Following the discussions in small groups, the leader of each group put together a brief report highlighting what people in the group thought were the most important integration opportunities. These were typed up and posted on the two long walls in the meeting room where everyone could read them. After about an hour the participants were asked to vote for the proposals they favoured the most by placing a ballot card in an envelope taped to the wall under each report. People could choose their top five priorities with regard to patient care (blue ballots) and their top five priorities for administrative changes (yellow ballots). After the ballots were counted, the following proposals emerged as the top priorities:

Top priorities for patient care

Integration of geriatric services (216 votes)

Integrating mental health with other services (94 votes)

Health promotion and prevention (!) (73 votes)

LHIN cross-sectoral palliative care/ end-of-life care (69 votes)

Inclusion of community services in LHINs (68 votes)

Top priorities for administration

Integrated information technology plans for the LHINs (179 votes)

Integration of ministry sectors to better address the population (138votes)

Network integration (115 votes)

Report cards for the LHINs (90 votes)

Continuing the LHIN conversations·and developing a report (66 votes)

It is encouraging that so many votes went to geriatric services, which, of course, would include homecare and long-term care facilities as well as services like Meals on Wheels. It is also encouraging that mental health received a high priority. More details about the results of the voting at this workshop and at the other thirteen taking places around the province can be found (after November 20) at www.prioritysetting.ca(password: LHIN or lhin)

One final observation: throughout the day I did not once hear anyone say the words "privatization", "P3 hospitals" or "job security". The words and phrases that kept coming up over and over again were "integration opportunities", "evidence-based", "best practices", "sharing of information" and "continuum of caring". (To achieve a continuum of caring from integration opportunities will require serious sharing of information and evidence-based best practices. Now we're talking!)