RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Speaking out for nursing. Speaking out for health.

Registered Nurses' Association of Ontario

Submissions to the Standing Committee on Social Policy – Review of the Local Health System Integration Act and Regulations.

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Introduction:

In 2006, the Ontario Government established the *Local Health System Integration Act (LHSIA).* The purpose of this act is to:

> … provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks.[1]

The background underpinning the legislation includes:

> The people of Ontario and their government,
>
> (a) confirm their enduring commitment to the principles of public administration, comprehensiveness, universality, portability, accessibility and accountability as provided in the *Canada Health Act* (Canada) and the *Commitment to the Future of Medicare Act, 2004*;
> (b) are committed to the promotion of the delivery of public health services by not-for-profit organizations;
> (c) acknowledge that a community's health needs and priorities are best developed by the community, health care providers and the people they serve;
> (d) are establishing local health integration networks to achieve an integrated health system and enable local communities to make decisions about their local health systems;
> (e) recognize the need for communities, health service providers, local health integration networks and the government to work together to reduce duplication and better co-ordinate health service delivery to make it easier for people to access health care;
> (f) believe that the health system should be guided by a commitment to equity and respect for diversity in communities in serving the people of Ontario and respect the requirements of the *French Language Services Act* in serving Ontario's French-speaking community;
> (g) recognize the role of First Nations and Aboriginal peoples in the planning and delivery of health services in their communities;
> (h) believe in public accountability and transparency to demonstrate that the health system is governed and managed in a way that reflects the public interest and that promotes continuous quality improvement and efficient delivery of high quality health services to all Ontarians;
> (i) confirm that access to health services will not be limited to the geographic area of the local health integration network in which an Ontarian lives; and
> (j) envision an integrated health system that delivers the health services that people need, now and in the future.[2]

LHSIA led to the creation of 14 not-for-profit corporations called Local Health Integration Networks (LHINs) who work with local health providers and community members to determine regional health service priorities.[3] LHINs currently plan, integrate and fund local health services, including:

- Hospitals
- Community Care Access Centres
- Community Support Services
- Long-term Care
- Mental Health and Addictions Services
- Community Health Centres.[4]

Community consultation and collaboration are key underpinnings of LHINs. Each LHIN is governed by a nine-person Board of Directors selected by the province using a rigorous skill and merit-based selection process.[5]

An independent effectiveness review commissioned by the Ministry of Health and Long-Term Care in 2008 found that the transition and devolution of authority to the LHINs has been effective and an overall success.[6] On November 7th 2013 the Legislative Assembly of Ontario referred a review of *LHSIA* and its regulations to the Standing Committee on Social Policy.

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing Registered Nurses (RNs) practising in all roles and practice settings. We are the strong, credible voice leading the nursing profession to influence and promote healthy public policy. Our mission is to foster knowledge-based nursing practice, promote quality work environments, deliver excellence in professional development, and advance healthy public policy to improve health. We promote the full participation of present and future RNs in improving health, and shaping and delivering health-care services.

RNAO is pleased to provide this submission to the Standing Committee on Social Policy on behalf of Ontario's RNs.

Areas of Strength:

RNAO identifies the following key areas of strength of *LHISA*:

- Section 1.0 defines the purpose of *LHISA* as: improving access to care for patients; co-ordinating and integrating service; and effective and efficient management of the local health system. RNAO supports each of these goals and feel that they should continue to form health system planning priorities moving forward.

- Section 3(1) establishes the LHIN corporations. Regionalization of health system planning has a number of advantages and if implemented effectively can achieve the aims specified in Section 1.0.

- Section 7(1) establishes a Board of Directors appointed by the Lieutenant Governor in Council as the governance structure for the LHINs. This is a strength provided that an objective process is used to select directors who are representative of the communities in which they serve.

- Section 16(1) requires LHINs to continuously engage diverse communities and health system stakeholders when planning and setting priorities. RNAO asserts that communities and the persons within these communities must be at the forefront of health system planning discussions, as a necessary condition to enable person-centred care. Furthermore, LHINs must target specific engagement of vulnerable communities. Section 16(4) does include specific provisions for the consultation of Aboriginal and Francophone persons, which is positive. However, RNAO urges that this provision be expanded to include other marginalized groups such as (not limited to): low-income persons, visible minorities, new immigrants, LGBQT persons, and older persons.

Areas for Improvement:

RNAO identifies the following key areas of improvement for *LHISA:*

- Purpose, objects and structure of *LHISA* are largely focused on illness-based planning and funding. There is tremendous opportunity to refine *LHISA* to place a greater emphasis on health equity, health promotion and addressing the social determinants of health. This will be pivotal in sustaining a publicly-funded and not-for-profit health system, which is the system that most Ontarians – including Ontario's RNs – support.

- A fundamental disconnect exists between Section 1.0 which defines the purpose of LHINs as enabling health system co-ordination and integration, and Section 2(2) which defines the health service providers within the LHIN's planning and funding jurisdiction.

LHISA currently prevents LHINs from engaging in whole system regional planning. The following health service providers are missing from the LHIN's jurisdiction:

- Home Health Care and Support Service Organizations (despite reference under Section 2(2)(8);
- Primary Care Organizations (aside from Community Health Centres which are referenced under Section 2(2)(9)); and
- Public Health Units.

In 2012, RNAO released its' *Enhancing Community Care for Ontarians (ECCO) model* that proposes to transform the current health system into a person-centred structure that is fully integrated and co-ordinated. The ECCO model positions LHINs as the overall health system planner at the regional level. We detail next each of the aforementioned sectors currently missing in *LHISA* as discussed in RNAO's ECCO model.

a) Home Health Care and Support Service Organizations – It is clear that the government is shifting attention and resources towards advancing community care. Recent investments in home health-care and funding reform are clear indicators that this is occurring. However, LHINs are limited in planning and funding home health care and support service organizations given the mandate afforded to Community Care Access Centres (CCACs) through the *Community Care Access Corporations Act.* While LHINs fund CCACs, they have little planning and funding control over home health care and support service organizations. A significant proportion of the funding allocated to CCACs (approximately 9 per cent) is used for administration of the CCAC corporation.[7] As a means of improving planning capacity, eliminating duplication and improving access to care, RNAO recommends that the functions of CCACs be transitioned into existing structures, with the LHIN performing whole system regional planning and funding. Rather than reporting to CCACs, home health-care and support service organizations need to report to LHINs directly as their funder. LHINs will not be able to respond to the planning demands of a changing health system until they are able to plan for the entire health system, not just fragments. Many of the shortcomings attributed to the LHINs are associated with the 'chopped' approach to health system planning whereby LHINs are accountable for certain sectors while expected to achieve whole system integration at the regional level.

b) Primary Care Organizations – Currently LHINs are accountable for funding and planning a small (although important) part of primary care: 73 Community Health Centres. The ECCO model calls for primary care to be the anchor of the health

system and that the government improve access to interprofessional primary care for Ontarians. This cannot happen unless the *LHISA* provides the LHINs with planning accountability for all primary care organizations, including: Family Health Teams, Nurse Practitioner-led Clinics, Aboriginal Health Access Centres, Patient Enrollment Models and Solo Primary Care Providers. Presently the Ministry of Health and Long-Term Care is tasked with leading provincial primary care planning which is not sufficient to meet local community needs. How is the Ministry able to plan for impeding retirements or relocations of primary care providers in the rural reaches of the province? The Ministry does not have this type of planning capacity. Moreover, the Ministry should not be engaged in this type of planning given its stewardship functions. This is clearly the role of the LHINs and is consistent with the aims of *LHISA* which are to work with communities to set regional health system planning priorities.

c) Public Health Units – Including Public Health Units under *LHISA* will be critical to advancing the LHIN's role in addressing health equity, health promotion and disease prevention. Public Health Units hold the social determinants of health as a core of their work and have significant expertise in mobilizing and engaging communities with an emphasis on vulnerable populations. When the LHINs were first developed in 2006, RNAO joined the voice of others to support excluding Public Health Units from the LHIN mandate. This advocacy was grounded in concern that the core of public health would be eroded within an 'illness-based system' and overshadowed by the hospital system. Those concerns had a time and a place; however, our health system is evolving at an unprecedented pace and demands an emphasis on health promotion that can only be achieved through an accountability relationship between public health units and LHINs. Moving forward, we recommend transitioning the reporting relationship of Public Health Units from the Ministry of Health and Long-Term Care to LHINs keeping in mind the following imperatives:

    i. Public Health Unit funding not be reduced;

    ii. Public health specific programming not be eliminated;

    iii. The identity and mandate of public health as 'health promotion and disease prevention' be fully retained to enable a more weel defined balance with an 'illness-based care system';

    iv. The local governance model (i.e. Board of Health) must remain and the dual reporting relationship be preserved (Public Health Units would report to the LHIN and the local municipality).

- Sections 16(1) and 16(2)(b) under *LHISA* requires LHINs to engage health service providers when planning and setting priorities. Section 16(6) also requires that a Health Professionals Advisory Committee be struck within each LHIN. It is critical that all health care professionals, representative of the interprofessional care team, be engaged equally by the LHIN. To date, the engagement of health care professionals has focused on physicians and this is evident by the many 'physician-lead' programs that exist. The challenge with this approach is that it provides only one planning perspective and it is not reflective of the interprofessional nature of care delivery. There is opportunity to ensure that *LHISA* is reflective of the leadership of nursing, medicine and other professions.

Recommendations:

RNAO recommends that the Standing Committee on Social Policy consider the following enhancements to *LHISA:*

1) Place a greater emphasis on health equity, health promotion and addressing the social determinants of health.

2) Specifically mandate that LHINs engage and consult with a variety of vulnerable groups, including (but not limited to): First Nations, Francophones, low-income groups, visible minorities, new immigrants, LGBQT persons, and older persons.

3) Amend the definition of Health Service Provider to include:

    a. Home health care and support service organizations (funded and accountable to the LHIN);

    b. All of primary care (Family Health Teams, Nurse Practitioner-led Clinics, Aboriginal Health Access Centres, Patient Enrollment Models and Solo Primary Care Providers); and

    c. Public Health Units.

4) Further amend *LHISA* and the *Community Care Access Corporations Act* to transition the planning and funding functions of CCACs to LHINs.

5) Mandate that LHINs possess a shared interprofessional leadership model that includes one physician, one RN and one other health-care professional (who is neither a physician nor RN).

Conclusion:

In conclusion, the *LHISA* review is occurring at a pivotal time in health system transformation. RNAO supports an enhanced legislated role for LHINs - which at eight years of maturity -- must be enabled and made fully accountable for whole system regional planning and funding. The current model of 'chopped planning/funding' will continue to hamper the LHINs from fostering system co-ordination and integration. Not moving in this direction will result in ongoing duplication such as it exists now between the LHINs and the CCACs, lack of integrated services, delays in access to health services for Ontarians, and higher than necessary health system administrative costs. RNAO is pleased to offer recommendations, consistent with its ECCO model, to dramatically improve the planning and funding capacity of the LHINs.

References

[1] Local Health System Integration Act – Section 1.0
[2] Local Health System Integration Act – Preamble
[3] Ontario's Local Health Integration Networks: http://lhins.on.ca/aboutlhin.aspx?ekmensel=e2f22c9a_72_184_btnlink
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[6] LHIN Effectiveness Review: http://www.lhins.on.ca/uploadedFiles/Public_Community/Ministry_LHIN_Communications/FINAL_MOHLTC%20LHIN%20Effectiveness%20Report%20October.pdf
[7] Auditor General of Ontario: http://www.auditor.on.ca/en/reports_en/en10/304en10.pdf