

Executive Summary
A Discussion Paper on
Public Health,
Local Health Integration Networks, and
Regional Health Authorities

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Prepared by:
Dr. Brent Moloughney
Public Health Consultant

Executive Summary

In April 2006, the Ministry of Health and Long-Term Care (MOHLTC) established fourteen Local Health Integrated Networks (LHIN) to integrate health services across the province. While many health institutions such as hospitals, CCACs and CHCs were initially included in the LHINs, several types of organizations, including public health units, were not included. The Ontario Public Health Association (OPHA) requested the preparation of this discussion paper to assist the OPHA Board to engage in a discussion about the relationship between public health, LHINs and the experience with regional health authorities (RHA) in other provinces to inform OPHA's position on public health renewal. The development of this paper has relied on a series of recent projects addressing the design and functioning of public health systems that have been conducted by the project consultant and were supplemented with additional key informant interviews.

The LHIN model differs from regionalized health systems in other provinces in that RHAs possess a single governance and executive management team for the broad range of services for which they are responsible. In all other provinces, public health has been included within their RHAs. While regionalization has been implemented differently among and within provinces, there are a number of consistent themes that have tended to occur.

The two main reasons for including public health within RHAs is to bring a population health perspective to assessing needs and planning all health services, as well as to foster better integration of services. The extent to which a population health perspective to RHA planning has occurred has been variable and has been associated with a critical mass of public health expertise, as well as public health's active participation at senior executive tables within the RHA. These are far from universal since it is left to individual RHAs in most provinces to decide whether public health remains intact as a single division, as well as its reporting relationship within the RHA. In addition, many provinces established multiple, small RHAs with an insufficient critical mass of public health expertise and capacity. In some jurisdictions, parts of the public health mandate and workforce (e.g. public health inspectors, some public health nursing programs) were transferred to other government departments resulting in difficulties with maintaining capacity for, and coordination of, public health actions.

There are positive examples of integration resulting from regionalization, particularly in areas of infectious disease control, emergency preparedness, and maternal/child health programs. However, these examples are not uniform and tend to be RHA specific. The increasing interest in integrated chronic disease prevention and management is offering public health, in some settings, a leadership role in providing a comprehensive approach to assessment and planning in addition to supplying primary prevention expertise. Integration has also had negative impacts in some settings with losses of support services and the potential for re-orientation of public health over time to a much greater clinical focus. With the emphasis on horizontal integration across the health system, there has tended to be a hollowing out of provincial level capacity and authority, less emphasis on vertical integration of the public health system, and a straining of external relationships with municipalities and community partners.

While regionalization processes in many provinces was associated with rhetoric towards an increased emphasis on prevention and promotion, this generally did not occur. Reallocations of funds from other health sectors to public health have not occurred and despite attempted safeguards such as one-way valves, public health budgets have been pressured by the global funding models for RHAs.

Overall, there are potential benefits for public health's inclusion in regionalized health systems. However, with the exception of Quebec, the design and implementation of how public health is to operate within RHAs has not been addressed so that a very mixed picture has emerged within and among other provinces. The main body of this paper provides a listing of critical success factors for inclusion of public health in regionalized health systems.

The experience with public health's involvement in RHAs over the past decade for most of the country is pertinent to assessing public health's inclusion in LHINs in Ontario. There needs to be a close working relationship between LHINs and public health for a number of areas including population health assessment, emergency preparedness, and opportunities for service integration. Formal inclusion within LHINs is one mechanism to support this relationship. However, unlike other components of the health system, the delivery of personal health services is not the primary purpose for public health organizations. Public health focuses on the health of groups of people (i.e. populations) and seeks ways to promote and protect the health of people by influencing the social and physical environments where they work, live and play. Therefore, the opportunities for integration with the rest of the health system are more limited for public health than it is for other health organizations. The reality is that most of public health's partners are outside the health system so that inclusion in a LHIN does not contribute to these critical partnerships and could detract from them if the participation burden in LHINs is too large. While regionalization is a mechanism to foster integration, it is not the only way as evidenced by the Regional Infection Control Networks. A major policy lever for LHINs

is their funding authority to institutions. However, it is not clear how this would be advantageous for public health since reallocation of funds to public health has not been observed elsewhere and public health funds are vulnerable to be redirected to urgent pressures. In addition, MOHLTC is not the sole funder of public health units since the Ministry of Health Promotion and the Ministry of Children and Youth Services also provide significant funding.

Ontario's public health system renewal efforts have only just begun and much work remains. This includes establishing the Health Protection and Promotion Agency, improving the capacity of the Public Health Division, ensuring a critical mass of expertise in all health units, improving coordination among health units and the provincial level, improving units' governance, leadership and planning, improving quality, and strengthening the public health workforce. Inclusion within a LHIN does not directly address any of these critical needs. While inclusion in LHINs may facilitate health unit amalgamations or result in improvements in the governance structure of some health units, these system improvements could be enacted without LHIN involvement.

While public health's inclusion in LHINs offers a mix of opportunities and challenges whose balance is dependent on design and implementation, there are a number of transition costs that must be considered. Some linkage of public health with municipalities is viewed as a system strength in this province. However, current governance models and perhaps shared funding are also barriers to public health's inclusion in LHINs particularly in those parts of the province in which regional council is the Board of Health. Nevertheless, this barrier is not insurmountable and the Capacity Review Committee's (CRC) recommendations address many of these issues.

A much more problematic issue is the boundary misalignment between many LHINs and public health units. Recognizing the importance of inter-sectoral collaboration to support a population health approach to health system planning and implementation, regionalized systems typically strive to achieve alignment of boundaries of health, education, and social services. If this is not the case, then there will be difficulties in establishing the desired partnerships and collaboration that are needed. In contrast, the establishment of the LHINs took a hospital-centric perspective such that some health units relate to multiple LHINs and vice versa. The greatest challenges are concentrated in the Greater Toronto Area (GTA) where there is an extremely poor alignment of public health boundaries with LHINs. For example, the Toronto Public Health Department maps to the entirety of one LHIN and portions of four others. Accordingly, GTA LHINs relate to more than one health unit. There are also similar although less extensive misalignments in other parts of the province.

At the moment, there are difficulties for LHINs and public health to collaborate because of differences in their boundaries. However, a change in public health unit boundaries to those of LHINs would result in enormous transition costs and be driving public health

system design for the benefit of hospitals at the expense of the critical community partnerships public health requires with school boards, municipalities and others. The result would be a likely period of several years of reorganization and relative paralysis which would be magnified across multiple LHINs/health units. It is not an exaggeration to predict that the public health system would be sent into disarray at a time when it needs to be renewing itself. One would have to be extremely convinced of the benefits that would be realized from boundary alignment to warrant this substantial blow to system stability, including emergency preparedness and response, over the medium term and to public health's relationships with its non-health partners on a long-term basis. Alternatives to resetting public health's boundaries and still placing public health in LHINs offer little advantage over the status quo.

Balanced against these substantial transition costs is the reality that LHINs are a new and unique model that many health system observers view as having an uncertain future. Considering these factors, while active partnerships between LHINs and public health should be encouraged, it would be prudent to avoid doing significant damage to Ontario's public health system in order to align with a LHIN-based model that may alter from its current form.