

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

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## 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.

# **An OPHA Policy Discussion Paper on Public Health Local Health Integration Networks and Regional Health Authorities**

## **INTRODUCTION**

In April 2006, the Ministry of Health and Long-Term Care (MOHLTC) established fourteen Local Health Integrated Networks (LHIN). The LHINs are responsible for integrating services in each of their specific geographic areas, although they are not responsible for directly providing services. In creating the LHINs, the MOHLTC included many institutions/programs: hospitals, CCACs, CHCs, LTC facilities and mental health/addictions' centres. However, several services were not initially included in the LHINs: ambulances, laboratories, independent health facilities, and *public health*. The bulk of primary care services also remain outside the LHINs.

The lack of inclusion of public health within LHINs is not necessarily a permanent situation and regionalization processes in many other parts of the country phased in the addition of individual health system components. 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.

## **APPROACH**

The development of this paper has, to a large degree, relied on previous key informant interviews, literature reviews and system analysis conducted by the project consultant in assessing the structure and functioning of public health systems in Canada including:<sup>i</sup>

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<sup>i</sup> References have been provided for those reports that are available in the public domain.

- Assessing the impact of regionalization on public health in Canada (2004)
- Incorporating a population health approach in provincial health systems (2006)<sup>1</sup>
- The design of public health systems in other countries (2003)<sup>2</sup>
- Detailed reviews of three other provincial/territorial public health systems (2006-2007).<sup>3</sup>

A supplementary Medline search was conducted to identify any new publications since 2004 on regionalization of health services. Information on LHINs was primarily retrieved from the MOHLTC's website.

This material formed the basis for key informant interviews with selected Ontario Medical Officers of Health, a LHIN CEO and Board member, and policy analysts from three professional organizations (AOHC, OMA, alPHa). A list of key informants is provided in Appendix I.

## CONTEXT

### *The Renewal of Public Health in Ontario*

The SARS outbreak exposed several gaps in the province's public health system that were extensively described in subsequent reports.<sup>4-6</sup> In response, the MOHLTC released *Operation Health Protection*, which outlined the government's planned approach to strengthening the public health system in Ontario.<sup>7</sup> Focussing on the governance, structure and capacity of the province's public health units, the Capacity Review Committee (CRC) made several recommendations that have direct and indirect relevance to LHINs.<sup>8</sup>

- Directly relevant LHIN-related recommendations:
  - The Chief Medical Officer of Health or designate should meet regularly with the LHINs chief executive officers to identify opportunities for partnership with public health

- Every medical officer of health or designate should regularly meet with the chief executive officers of the LHIN(s) to which the health unit relates to identify mechanisms for collaboration in planning and service delivery
- Public health at both the provincial and local level should participate in the new LHIN Local Data Management Partnerships.
- Indirectly relevant LHIN-related recommendations:
  - Public health units should be governed by autonomous, locally-based boards of health. These boards should focus primarily on the delivery of public health programs and services
  - Boards of health should consist of eight to fourteen members with equal balance between municipal appointees and local citizen representatives appointed by the board under authority delegated from the province.
  - For programs that are currently cost-shared, the funding formula should be 75% provincial and 25% municipal.
  - Amalgamation of 8 groupings of existing public health units.

The CRC's final report is still in the hands of the MOHLTC and no decision has been made regarding the significant changes to public health unit governance and the recommended amalgamations.

Another relevant *Operation Health Protection* commitment was the establishment of regional infection control and communicable disease networks (RICN). The RICNs are designed to coordinate infection prevention and control activities and promote standardization in healthcare facilities across Ontario. Their boundaries correspond to the LHINs and the last four RICNs are being implemented in 2007.

### ***Establishment of Local Health Integration Networks***

The LHINs are to be responsible for integrating health services within their specific geographic areas. They will not provide services directly and the governance structures of individual organizations are not

being altered. As of April 2007, the LHINs were to take on their full role of planning and funding health services. The intent is for the LHINs to manage almost two-thirds of the Ministry's budget (\$37.9 billion). Each LHIN is governed by a merit-based nine member board of directors that have been appointed by the province. The board of directors is responsible for the management and control of the affairs of the LHIN and a Memorandum of Understanding (MOU) governs the relationship between the LHIN and MOHLTC. LHINs accordingly will be establishing a series of funding and accountability agreements with individual health organizations in their regions.

### ***Regionalization of Health Services Elsewhere in Canada***

The regionalized health systems in other provinces include public health and their experience is highly relevant to the analysis for Ontario. There is however an important caveat. Ontario's LHINs are unlike any of the models that exist elsewhere in the country (Table 1). A key difference is that regional health authorities (RHA) have a single governance and executive management team for the broad range of services for which they are responsible. In other words, in the establishment of RHAs, all of the existing boards and executive positions (especially hospital CEOs and VPs) are eliminated. While noting this important distinction, the experiences of other provinces provide important information regarding the risks and benefits of participating in a regionalized health system. In addition, from a scenario analysis perspective, the current LHIN model may be only an interim step towards a RHA-type model seen elsewhere. There is fairly widespread scepticism among health system observers regarding the ability of LHIN boards and CEOs to manage and hold accountable the hospital sector considering the current LHIN model. If that proves to be the case, then there are two basic options for the government. Either proceed to a full RHA-type model with all of the consequent upheaval or let the LHINs migrate to a District Health Council like entity.

**Table 1: Comparison of RHAs and LHINs**

<b>Characteristic</b>	<b>Typical RHAs</b>	<b>LHINs</b>
Governance structure	Single governance board for all health services	Additional layer of governance – LHIN has board as do individual organizations
Executive management	Single executive team to lead organization	Executive team retained in each health organization
Range of services	Relatively comprehensive. Generally all health services except physician services	Less comprehensive. Several service entities not included including public health
Funding	Global from province.	Taking over majority of MOHLTC funding this year. Note that public health shared 75/25 with municipalities.
Maturity – track record	Existed for 10+ years although with periodic changes over time.	Currently first real year of operation.

### Assessing Regionalization

Every province, but Ontario, has had regional health authorities (RHA) of some kind for at least a decade. In looking at Canada's experience with health system regionalization, Lewis and Kouri observe in a 2004 essay:

“There is no common definition of a health region, no uniform understanding of what services should be regionalized and no consensus on governance. The universal theme in Canadian regionalization may well be instability: governments have constantly revisited their regional schemes, making changes ranging from marginal to dramatic.”<sup>9</sup>

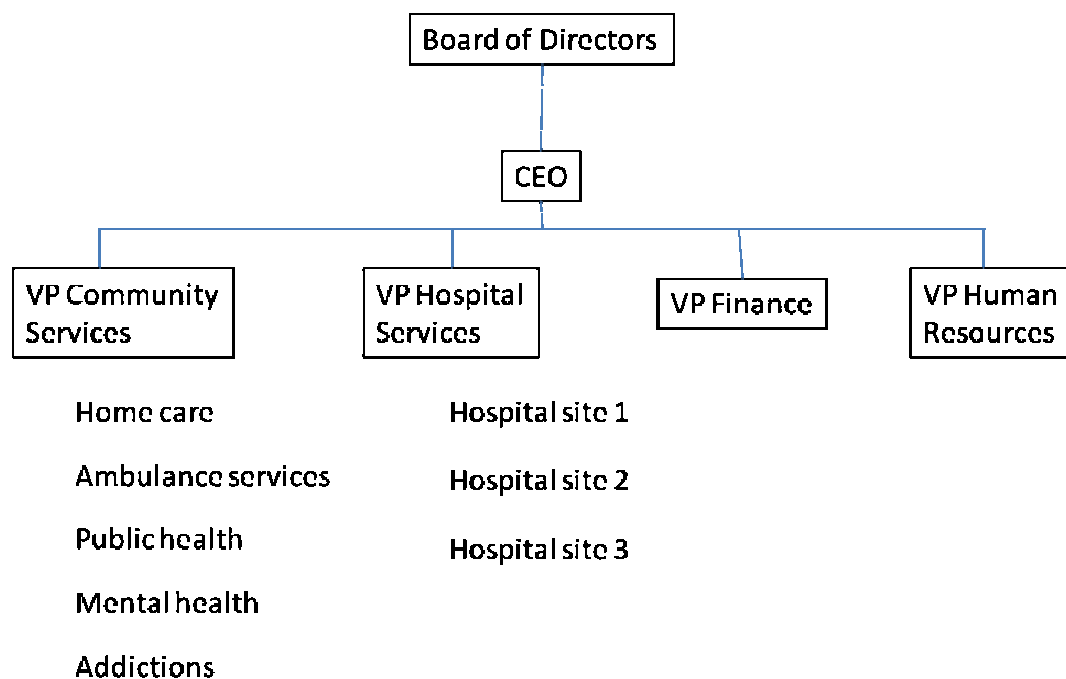
Furthermore, due to this constant change and the lack of concerted action at analyzing regionalization efforts, they state that “it is impossible to tally up the scorecard – balanced or otherwise – for regionalization. It is too diverse and too short of evaluative data.”<sup>9</sup> The changes that have occurred over time “are not resulting in a

convergence of any particular model of or evidence for what a “successful” regionalization looks like...RHAs across Canada continue to differ in size, structure, scope of responsibility and number per province.”<sup>10</sup> However, even with this perspective, there appears to be a general theme towards reducing the number of health authorities in many provinces in recent years.

### Structure of a Typical RHA

With the preceding discussion of the variation in regionalization in mind, Figure 1 provides a simplified organizational structure of a “typical” RHA.

**Figure 1: Simplified Structure of "Typical" RHA**



A key feature is that there is a single board of directors and a single executive management team for the entire health authority. The implication is that the boards of individual health organizations such as hospitals and public health no longer exist. Similarly, there are not separate CEOs of organizations, although there is typically a director for each of the community services – at least in larger RHAs. Also, in some provinces, there is an expectation for some type of community advisory

committee to exist. While Figure 1 illustrates a typical structure, the reality is that each RHA is generally allowed to define its own structure so that an RHA may differ from others in a province and over time.

Regionalization and the Intended Emphasis on Prevention and Promotion

During regionalization processes in many provinces, governments commonly declared that it would support an increased emphasis on prevention and promotion. In general, the rhetoric has been considerably stronger than the reality. As indicated by Lewis and Kouri (see Table 2), the factors affecting the impact of regionalization have the potential to go in both directions.

**Table 2: Factors Influencing the Impact of Regionalization on Disease Prevention and Health Promotion**

Factors Increasing Potential Impact	Factors Decreasing Potential Impact
<ul style="list-style-type: none"> <li>● Provincial and RHA commitment to these activities</li> <li>● Explicit and high-profile mandate to pursue these activities</li> <li>● Strong RHA leadership and buy-in from significant constituencies</li> <li>● Accountability for performance in these areas</li> <li>● Mechanisms to ensure voices of the dispossessed are heard</li> </ul>	<ul style="list-style-type: none"> <li>● Public preoccupation with acute and medical care</li> <li>● Weak provincial commitment</li> <li>● Weak RHA commitment</li> <li>● Lack of provider interest</li> <li>● Impatience with long-term time frame for achievement of goals</li> <li>● Lack of public and media interest</li> </ul>

Source: Lewis and Kouri, 2004.

According to the key informant interviews conducted on behalf of the F/P/T Advisory Committee on Population Health, there was a wide perception that reductions in province-wide programming had occurred as a result of the transfer of funding and responsibility to regional structures.<sup>11</sup> At the same time, there was a decrease in resources available at the provincial level to support regions. The difficulty is knowing whether these observations were actually due to regionalization versus the fiscal environment of the 1990s. For example, although Ontario did not regionalize, its public health system did not thrive in the early to mid 1990s. Nevertheless, a fundamental challenge exists for RHAs in that even if one has a board that is genuinely interested in addressing prevention and promotion, the demands

associated with the acute care sector are so large that they tend to occupy most of the attention.

### Common Experiences of Public Health in Regionalized Health Systems in Canada

While each provincial experience has been different, there are several common themes in the manner in which regionalization has tended to impact the structure and functioning of local public health.

#### **Creating RHAs with Too Small a Population Base**

Typically for political reasons, provinces have often created too many small RHAs. The consequent lack of critical mass of public health expertise and capacity has severely limited public health's impact. Attempts to compensate through the use of shared service areas and other mechanisms have generally been unsuccessful. Most of the positive reports of regionalization have typically occurred in the larger, predominantly urban based regions. As noted earlier, the trend over time has been for provinces to consolidate regions, which should help this issue. Nevertheless, the existence of many small regions is still the norm in many provinces.

#### **The Positive Impact of Integration**

The removal of organizational boundaries has assisted joint planning and inter-relationships with other service providers for selected types of services. There are several examples of this for infectious diseases and emergency preparedness planning, particularly between public health, acute care, and long-term care.<sup>12</sup> For example in Saskatoon, influenza surveillance data has been used to predict when the peak stress on the emergency department is likely to occur allowing the health authority to comprehensively anticipate and manage the surge by ensuring adequate numbers of staff are available, as well as efforts to free acute care beds through coordinated action by acute care, home care and long term care.<sup>13</sup> Nevertheless, even within the broad category of communicable diseases, synergies are less obvious for more behaviour-based diseases such as sexually transmitted diseases.

A current emerging theme in many RHAs is for comprehensive assessment and planning for chronic disease prevention and management. In some regions, public health is providing a leadership role in providing a comprehensive approach to assessment and planning in addition to supplying primary prevention expertise.

Other typical areas where examples of better integration of services have occurred include various maternal-child and outreach programs between different service providers. Examples include post-partum early follow-up, breastfeeding support, high-risk family follow-up, etc. A common organizational structure has also allowed a re-thinking and easier movement of programs that were placed within public health organizations for pragmatic reasons, but may fit better with other parts of the health system. Examples can include early childhood psychology, speech language pathology, and podiatry. Regionalization provides an opportunity to rethink some of these program-organizational pairings and facilitate at a minimum better links with other providers or the actual transferring of responsibility for the program.

### **The Less Positive Impact of Integration**

There is a dual edge to the concept of “integration”. Regionalization has frequently resulted in the loss of support staff (e.g. business managers, IT support, clerical staff), computer equipment, and physical space. In one instance, a province eliminated all of the public health directors and managers just prior to the transfer of public health services to the regions. While regionalization has been an opportunity at times to shift some programs, public health has also been on the receiving end of programs that do not fit their core mandate (e.g. hearing aid program). There is also a potential risk that being embedded within a much larger organization focussed on clinical treatment issues can result in the re-orientation of public health over time to a much greater clinical focus for its own activities.

### **Fragmentation of the Public Health System**

Regionalization processes in most provinces left it to the discretion of individual RHAs to establish their own organizational structure. The result is that public health within each RHA needed to argue to maintain its

organizational integrity, as well as its level of reporting within the organization. Generally speaking, larger public health entities have been more successful in addressing these issues. Across a province though, it is often highly variable whether the MOH (or some other public health lead) reports to the CEO or even attends executive management meetings. Depending on the board and/or CEO, public health's position and relationship can change literally overnight.

A balanced perspective also requires acknowledgement that public health leaders have not always had the necessary skills to meaningfully contribute at the executive management table, which requires one to possess additional skills beyond heading a public health organization.

Regionalization processes have also at times coincided with the stripping of certain programs, particularly environmental health programs, and their transfer to other government departments. This seems to reflect an underlying ideology that it would be beneficial to put all of the regulatory staff into one department. The resulting fragmentation has proved problematic in the provinces that have gone down this road including some combination of difficulties maintaining public health focussed human resources, as well as coordination and communication with the rest of the public health system. In one large province, many of the PHNs were transferred at times to other government departments or to work for directors of outpatient hospital departments. Similar to the public health inspector experience, there tends to be a shift in focus of public health practitioners' work towards the core mandate of the new host organization which has at times resulted in PHNs having greater involvement in child protection services or a reduced focus on core public health services such as immunizations.

An indirect consequence of regionalization is that with all of the emphasis on the RHAs, there is often a perspective that there is little requirement for provincial level capacity. The result is a hollowing out of capacity and authority. To further complicate things, many provinces do not have well described definitions of their public health functions and programs. Therefore the public health teams within each RHA need to describe and advocate for their function and role. Accountability mechanisms are accordingly weak as well.

## **Funding**

With the implementation of global budgets for RHAs, it is very difficult to track how much money is actually in the public health system. Not surprisingly, acute care needs generate perpetual pressures on the rest of health budgets. However, instead of a single strategic decision being made provincially to say “we are going to invest \$x on public health based prevention”, this decision must be made/fought within each and every RHA in very close proximity to the acute care demands. Some provinces have instituted one-way valves to allow only funds to move from acute care to the community. However, there are a variety of ways these can be, and are, circumvented.

The experience elsewhere has indicated little evidence that reallocation has worked to public health's benefit. In one case where a RHA board planned to shift significant funds to public health from acute care, the province stepped in to prevent this because of the intended loss of some treatment services. Similarly in BC, despite the widely held view of their success in handling SARS, public health's budget was reduced the subsequent year. A more recent trend is that post-SARS, some provinces have initiated public health renewal efforts with an increase in *provincial* investment in public health resulting in additional resources for RHAs.

## **Population-Based Planning**

One of the main arguments for including public health within a RHA is to bring a population health perspective to the analysis and planning of health services. This has occurred in some settings and appears dependent on a critical mass of public health expertise and public health's participation in the executive management team. These criteria are by no means universal in most jurisdictions. The best example where it has been applied appears to be Quebec in which a population approach has been explicitly articulated for their system.<sup>14</sup> Quebec is also the only province where many of the potential risks of regionalization have been specifically addressed.

## **Loss of Linkages with Municipalities**

A common observation from other jurisdictions is that while relationships with the rest of the health system are strengthened through

regionalization, relationships with municipalities are often weakened. In fact, the Network of Urban MOHs has a current initiative to look at how to strengthen these relationships in regionalized systems. This issue is not limited to Canada and has also been observed in England where their Chief Medical Officer called for “joined up working” to better link health authorities with municipalities.<sup>15</sup>

### **Time Requirements of Being Part of an RHA**

While the ability to inform population health based analysis and planning for the region is one of the reasons for having public health as part of the RHA, this has significant demands on the time of the senior leadership of the public health unit. In addition, the expected collaboration among services also extends to managers and staff of program teams. Typically, no new resources are provided to accommodate these new expectations. The consequence is often a reduced ability, particularly in the early years of regionalization, to engage non-health sector partners (e.g. school boards, NGOs, local community groups, etc.). Such partnerships are at further risk if RHA boundaries are not co-terminus with those of key community partners.

### **Summary**

There are potential benefits for public health’s inclusion in regionalized health systems. These include supporting a population health perspective to the assessment of needs and to the planning and implementation of health services, as well as the integration of services. The ability to achieve these benefits though is dependent on how the system has been designed and implemented. Critically important is the management of the risks associated with public health’s involvement. Many of the less than successful experiences with regionalization across the country are due to the lack of attention to these design and implementation issues. The subsequent section will address this issue in more detail.

### **Critical Success Factors for Optimizing Public Health in a Regionalized Health System**

Based on the experience of public health across Canada, the following is recommended as a critical success factors checklist to maximize

opportunities and manage potential threats for public health's involvement in a RHA structure:

- € Ensure a configuration of health authorities that supports a critical mass of public health expertise and capacity while maintaining a local perspective to service delivery.
- € Ensure co-terminus boundaries between RHAs and key partners (e.g. education, municipalities, social services, etc.) to support inter-sectoral collaboration, analysis and action.
- € Clearly articulate public health's expected roles within a RHA: deliver public health core programs; and support RHA to apply a population health approach to analysis and planning
- € Ensure public health is maintained as a separate division within RHAs
- € Ensure public health is adequately positioned within the RHA to fulfil its expected roles:
  - Public health division head reports to CEO and is a member of regional executive committee
  - MOH must have free access to the board given statutory authority
- € Provincially designate and track the funding for public health. Need to be able to follow the money and protect it from diversion to other services.
- € Provide clear provincial expectations for evidence-based public health service delivery (e.g. public health program standards) including public health system performance measures.
- € Ensure that in addition to the focus on horizontal service integration at the RHA level, that there is also vertical integration within the public health system to maintain and enhance system quality and coordination of action.

- € Provide training and support for public health staff so that they can fulfil their strategic role to re-orient the health system to a population health perspective.
- € Provide training and orientation to board members and managers on applying a population health perspective, as well as public health functions and required competencies.

If one were to assess Canadian jurisdictions on these criteria, Quebec would be the clear winner having explicitly addressed most of these items through legislation and the comprehensive *Quebec Public Health Program: 2003-2012*.<sup>16</sup>

## **ADVANTAGES AND DISADVANTAGES TO INCLUDING PUBLIC HEALTH WITHIN LHINS**

Regardless of whether public health is formally included within LHINs, there is an implicit assumption that there needs to be a close working relationship between public health and the LHINs. In assessing the relative strengths of being in or out of LHINs, there are three primary criteria that have been considered:

- Consistency with MOHLTC policy direction
- Functioning of the public health system
- Transitional costs and barriers.

### ***Consistency with MOHLTC Policy Direction***

The clear direction of MOHLTC has been to include as many service providers within LHINs as possible. Those, like public health, who remain outside the LHINs are the exceptions. There is, at first glance, a simple attractiveness for public health to be included because that is where other health services are situated. Two factors that may have prevented public health's inclusion within LHINs were: i) ongoing system

renewal efforts at the time of the LHINs announcement; and ii) extent of public health entanglement with municipalities.

### Integration

One of the primary reasons for the establishment of the LHINs is to improve the integration of services among health organizations. The opportunity for integration is relatively limited from both the perspective of most public health programs as well as from the personal health services system. Unlike other health organizations, individual health service provision is not the primary focus of public health. The provision of clinical, individual-focussed services is only one of several programmatic approaches applied by public health organizations to fulfil their mandate. Key others include assessing and monitoring the health of the public, public education, healthy public policy, regulation and enforcement, and the development of partnerships to improve health. For the latter, the majority of these key partnerships are with non-health organizations such as municipalities, schools, social services, and non-governmental organizations.

As previously described, there are a number of areas where there needs to be a close working relationship between public health and the personal health services system such as infectious disease control, emergency planning, and maternal-child programming. While regionalized systems are a mechanism to foster integration, it is not the only way. The establishment of the RICNs reflect an alternative approach for achieving integration. In addition, primary care is an important partner for public health and the bulk of these services remain outside the LHINs.

Considering the burden of chronic disease morbidity and mortality, there is increasing interest in chronic disease prevention and management. Certainly public health needs to partner with the personal health services system to ensure a comprehensive approach to prevention, but action in this area is not limited to the formal health system. There must also be active involvement of community partners such as schools, municipalities, NGOs, etc. None of these will ever be part of the LHINs so that regardless of whether public health is included in LHINs, there will always be a need to engage external partners.

With respect to chronic disease management, public health has an interest that effective clinical preventive services are implemented. While public health can assist with goal setting and monitoring of achievements, it is not critical that public health is actively involved in improving clinical settings to achieve such goals if other parts of the health system provide leadership in this area.

Another aspect of integration is developing an integrated health services plan. Public health involvement would strengthen this responsibility by bringing its experience with applying a population health perspective, as well as providing LHINs with a more comprehensive range of programming.

### Funding

Starting this year, LHINs will have funding authority transferred to them from MOHLTC. In theory there will be an ability for a LHIN to “facilitate” a change in service provision among institutions. It is unclear how this might be enacted, particularly with larger institutions. Considering that hospitals have retained their own well-connected boards and CEOs, how they will respond to a LHIN attempting to hold them accountable remains to be seen.

Inclusion in LHINs would presumably result in health unit funding flowing through the LHIN. There does not appear to be any advantage to this. The experience in many other provinces has been the difficulty of public health to protect its budget from the pressures of treatment services and little in the way of reallocation of resources from other parts of the health system. If public health was included in LHINs, then it would be advisable to safeguard those funds from diversion. This risks setting a ceiling for public health funding. In addition, it will undermine the role of the provincial Public Health Division. This contrasts with the clear message from the post-SARS reports of the need to strengthen the role of the Division.

An additional complexity is that MOHLTC is not the sole funder of public health units. The Ministry of Health Promotion and the Ministry of Children and Youth Services also provide significant funding for core public health programs. These Ministries may not wish to have their funds routed through LHINs leaving public health with a mix of funding

routes and accountabilities that would impair the potential integration benefits of being within a LHIN.

### ***LHINs' Impact on Public Health System Functioning***

#### **Public Health System Renewal**

Recent reports have identified numerous concerns regarding the structure and functioning of public health in Ontario. While renewal steps have been initiated, these efforts are very much a work in progress. Key strategic initiatives to be pursued include 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. The experience across most of Canada has been that the health system's preoccupation with horizontal integration regionally has distracted the need for vertical integration within the public health system. The reality is that there needs to be an appropriate balance between these horizontal and vertical dimensions of integration.

An important component of public health system renewal is the creation of the Ontario Health Protection and Promotion Agency. The Agency is expected to provide scientific and technical advice and support to those working across sectors to protect and improve the health of Ontarians. Accordingly, public health units will be a key client group of the new Agency. Fulfilment of the Agency's mandate is not likely to be affected by whether or not public health units are formally included within LHINs.

#### **Population Health Assessment and Surveillance**

As LHINs increasingly consider community health needs and conduct analysis for complex health issues such as chronic diseases, it is likely

that the interaction between LHINs and public health will need to increase. The desire for health services to be planned and implemented from a population health perspective argues for a close working relationship between public health and LHINs.

### Healthy Public Policy

On some issues of healthy public policy, a LHIN would offer a much bigger and stronger voice than public health alone. While to some degree this is a function of size and impacted by governance model, a mobilized LHIN encompassing multiple health care organizations is a considerable asset for health advocacy. However, considering the breadth of responsibilities of LHINs, the frequency with which a LHIN became involved with public policy issues would likely be limited.

### Emergency Preparedness and Response

Inclusion in a LHIN might be expected to assist emergency planning across different health system components. However, a close working relationship is also required with other community partners such as municipalities. For some types of emergencies (e.g. meningococcal outbreak) that require generic health care skills such as immunization, regional approaches have assisted with staff mobilization from other health institutions. Nevertheless, this is only one type of emergency, and in many other scenarios, surge capacity from the rest of the health system will not be available either because it is also overwhelmed and/or the required skill sets (e.g. disease investigation and control) are not widely held in acute or long-term care settings.

### Community Partnerships

Inclusion in LHINs places a structural emphasis on the partnership between public health and institutional health service providers. This partnership is important. However, it is only one partner group for public health. Public health's primary work is to create an environment where people live, work and play that supports health. While public health has an interest in what occurs in the health provider's office (e.g. clinical preventive services), public health's primary interest is in what the conditions are to support health before and after the person makes contact with the personal health services system. This requires strong community partnerships, which may be weakened if the finite available

time of public health leaders and staff are markedly diverted to LHIN-focussed planning and integration efforts.

### ***Transition Costs/Barriers***

The preceding discussion has attempted to elucidate the relative benefits of including public health units within LHINs. However these preceding factors are weighed, there are a number of substantial transition related issues that must be considered if public health were to be included in LHINs.

### **Addressing Municipal Government Involvement**

The type and extent of current municipal involvement in public health is a barrier to public health's inclusion in LHINs. This is particularly the case in those parts of the province in which regional council is the Board of Health. Inclusion in LHINs would mean having regional council being held accountable to a LHIN board, which is not likely to be acceptable to these municipalities. Nevertheless, this barrier is not insurmountable. The CRC recommended a change in governance to autonomous, locally-based boards of health. The current cost-sharing of public health services is probably less of a barrier and might even be eliminated through the current review of cost shared services. A more remote possibility is the elimination of municipal involvement entirely, which was done in regionalization processes elsewhere, and would involve altering health unit governance, uploading of cost sharing, and addressing the many support services such as human resources, finance, legal, physical plant, communications, and others that municipalities provide. These steps are not a small undertaking and would take substantial effort to implement. The CRC report acknowledges that some links with municipalities is a system strength and the experience elsewhere has been the need for a targeted effort to re-institute this important strategic partnership with municipalities that have been strained by regionalized systems. A change in health unit boundaries is an additional complexity that could influence municipalities and is discussed further below.

### **Boundaries**

The government made a conscious decision to take a hospital-centric perspective in the establishment of LHIN boundaries. The result is a less

than perfect alignment of public health units with LHINs. This is not simply a case where there are multiple health units contained within some LHINs, but rather cases where 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. For example, Leeds, Grenville and Lanark District Health Unit is split between two LHINs. While the CRC recommended a number of amalgamations of smaller health units and these were constructed to be consistent with LHIN boundaries, the most problematic areas remain. The following discussion focuses on Toronto recognizing that the implications extend to the rest of the GTA and to other parts of the province facing similar circumstances.

Recognizing the importance of inter-sectoral collaboration to 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. 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 essentially 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. For example, if Toronto Public Health were to be aligned with its local LHINs there would be multiple impacts. First, it would no longer be appropriate for the health department to be based within municipal government since it would only address a portion of the city. This obviously has implications for governance, funding and support services. For the myriad of school-based programs, the Toronto District School Board would need to interact with five different LHIN-based public health units. Simply organizing immunization programs would become extremely complicated not to mention other areas such as policy advice, outbreak control, etc. Advocacy and

implementation of public health related by-laws such as tobacco control would need to be coordinated among five different health units, their boards and MOHs. Toronto restaurants would be similarly inspected by inspectors from five health units.

The transition costs to such a move would be enormous. It has taken many years for the amalgamation of the former six city units to form Toronto Public Health. That amalgamation was conceptually simpler because health units were just being added together. For LHINs, one would need to transfer responsibility for multiple chunks of territory with a need to address surveillance systems, transfer of staff and associated labour issues and resources. This would be on top of likely needing to extricate public health from all of the municipal governments in the GTA. 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. For a variety of reasons, the GTA is the most likely centre for any future public health emergencies. It would be extremely unfortunate if during this prolonged period of confusion and disarray that another major public health emergency occurred in the GTA. 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 over the medium term and to public health's relationships with its non-health partners permanently.

Alternatives to resetting public health's boundaries and still placing public health in LHINs are limited. One might ignore the boundary differences and identify a lead LHIN to fund specific health units that are mostly contiguous. As previously described, LHIN-based funding for public health offers no obvious advantages and the desired synergies hoped for in planning and service integration that would drive inclusion in LHINs will be tempered because the coverage areas for service groups are misaligned. Essentially, this approach offers little advantage over the status quo of encouraging partnership activities where appropriate. Attempting to partially implement LHIN alignment in some parts of the province while ignoring the GTA and other problem areas will not be helpful considering the size and complexity of the GTA and

the need for more not less consistency in system design across the province.

One consideration is the ultimate number of health units. CRC recommended 22 and there are 14 LHINs. It is beyond the scope of this paper to assess the further amalgamations that would be required. Just as there are multiple hospitals and other organizations within any one LHIN, then there presumably could be multiple health units. This would change if the LHIN model migrated to a formal RHA model which would likely require further health unit amalgamations.

### The Future of LHINs

The LHINs represent a new and relatively unique health system model and it is not entirely clear how they will fair and evolve over time. A major challenge for them will be the establishment of effective accountability mechanisms with large health institutions that have retained their own boards and executives. Despite the breadth of expectations for LHINs, their capacity is limited. At the time of their announcement, an external perspective on the future of LHINs was expressed as follows: "...the next three years will tell the tale. Again, the experience of other Canadian provinces would suggest that "regionalization lite" will be replaced with the "full meal deal," including abolishing independent healthcare corporations and their boards, if significant progress is not made."<sup>17</sup> Such a move would be dramatic and has typically occurred in other provinces in the context of a significant financial crisis. Considering the newness of the LHINs and the uncertainty regarding their future, 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.

## ***Net Balance***

The following Table summarizes the main advantages and disadvantages of including public health within LHINs. Readers are invited to reach their own conclusions both on individual factors, and more importantly, on the net balance of all of the factors.

<b>Factor</b>	<b>Public Health Outside LHINs</b>	<b>Public Health Within LHINs</b>
Alignment with MOHLTC policy	Public health one of a limited number of organizations not included. Additional/special efforts required to engage public health in each LHIN-public health combination.	Provides LHINs with more complete continuum of services (prevention to palliation).
Integration of services	Recognizes that clinical services are a relatively minor component of public health responsibilities. Alternative mechanisms to achieve service integration for specific areas (e.g. RICNs).	Supports better horizontal health system integration. Supports comprehensive health system planning and analysis assuming that a population health perspective underlies this. Risk increasing pressure on public health for clinical service delivery.
LHIN funding lever	Retain funding function of Public Health Division.	Need to protect public health funds from diversion. Opportunities for real transfer of monies to public health limited. Potential loss of influence and system leadership by Public Health Division.
Priorities for public health system renewal	Opportunity to focus on them in comprehensive manner.	Little if any contribution towards strengthening public health system directly. LHIN inclusion is possible mechanism to improving critical mass and governance, but these could be achieved by other means. Potential for distraction of leadership/management away from renewal efforts due to focus on LHIN activities.

<b>Factor</b>	<b>Public Health Outside LHINs</b>	<b>Public Health Within LHINs</b>
Population Health Assessment and Surveillance	Requires public health and LHINs to be working together to avoid duplication of efforts for population health assessment and needs identification.	Public health brings its population health assessment and surveillance skills to strengthen LHIN actions and influence broader health planning.
Healthy Public Policy	Status quo. Public health has proven track record in this area. Some limits due to size of some health units, as well as some governance models. Both can be addressed without LHINs.	Properly mobilized, a LHIN could speak with a much stronger voice than just a public health unit. A LHIN has many issues to address and therefore may be selective about how often would weigh in on a public health issue.
Emergency Preparedness and Response	Requires ad hoc processes to be established.	Consistent with the mandate of a LHIN. Surge capacity potential in selected types of emergencies (e.g. mass immunization).
Community Partnerships	Long-established partnerships – non-health system partners are more numerous and critical for most program areas (i.e. school boards, municipalities, social services, NGOs, voluntary sector, other government departments (Agriculture, Environment, Child and Youth Services), etc. .	Emphasizes health system partners. Likely reduce municipal partner involvement. Risk diversion of attention from community partners.
Municipal involvement	Structurally supported. Mixed experience province-wide. Some favourable, whereas viewed as significant negative in other parts of province. Could be addressed without LHIN involvement (CRC recommendations).	Need to address governance. May need to shift to 100% provincial funding. May need alternative mechanisms to maintain strategic municipal linkages.

<b>Factor</b>	<b>Public Health Outside LHINs</b>	<b>Public Health Within LHINs</b>
Boundaries	Required amalgamations can be pursued while seeking greater alignment with LHINs	Major misalignment of boundaries, particularly but not limited to GTA. No clear option to favourably address without significant disruption of programs and partnerships with significant community partners.
Future of LHINs	Engage but avoid massive changes to public health system to align with model that will likely evolve over time.	Risk undergoing massive changes to align with model that may undergo significant changes in relative near future.

## APPENDIX I – LIST OF KEY INFORMANTS

Key informants interviewed for this project included:

Dr. Penny Sutcliffe	MOH – Sudbury and District Health Unit
Dr. David McKeown	MOH – Toronto Public Health
Dr. Graham Pollett	MOH – Middlesex-London District Health Unit
Dr. Robert Cushman	CEO and Secretary – Champlain LHIN
Dr. Robert Boudreau	Former MOH, Current Board Member – Champlain LHIN
John Wellner	Director of Policy – OMA
Paul Michael	Policy Analyst - OMA
Linda Stewart	Executive Director - alPHa
Scott Wolfe	Senior Policy Analyst - AOHC

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