



STAFF REPORT FOR ACTION

Healthy People First: Opportunities and Risks in Health System Transformation in Ontario

Date:	January 11, 2016
To:	Board of Health
From:	Medical Officer of Health
Wards:	All
Reference Number:	

SUMMARY

The Ontario Ministry of Health and Long-Term Care (MOHLTC) released *Patients First: A proposal to strengthen patient-centred health care in Ontario* in December 2015 with the goal of addressing structural issues in the health care system that create inequities (Attachment 1). The *Patients First* discussion paper proposes expanding the role of the Local Health Integration Networks (LHINs) to include funding and accountability for public health.

The experience of other Canadian provinces with formal integration of public health and the larger health system suggests that opportunities for system improvement have often not been realized, and unintended risks to public health have arisen. This report reviews the implications of the MOHLTC proposals and recommends a response from the Board of Health (BOH) with particular attention to proposals with implications for local public health.

Public health plays a key role in population health and the sustainability of the health system by keeping people healthy. To minimize the risk of proposed changes compromising these contributions, the Medical Officer of Health (MOH) recommends that the BOH endorse maintaining independent governance of public health by local boards of health, protected and transparent funding for public health, and strengthened Ontario Public Health Standards.

Patients First also calls for local public health to play a formal role in planning of health care services to improve population health and health equity. Because health inequities are grounded in social determinants of health outside the health care system, the system must partner with non-health sectors beyond public health to realize this goal. The MOH

recommends that the MOHLTC mandate formal local relationships between LHINs and the municipal, education, social service and voluntary sectors as well as public health. Realignment of LHIN boundaries with the other sectors is necessary to enable intersectoral collaboration.

RECOMMENDATIONS

The Medical Officer of Health recommends that:

1. The Board of Health request the Minister of Health and Long-Term Care to ensure a continued strong role for public health in keeping people healthy by:
 - a. Maintaining independent governance of the local public health sector by boards of health;
 - b. Strengthening comprehensive provincial standards for public health through the current review of the Ontario Public Health Standards, especially for healthy public policy and other programs that keep people healthy;
 - c. Ensuring that any provincial funding directed to local boards of health by Local Health Integration Networks cannot be reallocated to other health services and that there is a transparent budget process;
2. The Board of Health request the Minister of Health and Long-Term Care to mandate a formal relationship between LHINs and senior representatives of the healthcare, municipal, education, social service and voluntary sectors as well as the Medical Officer of Health to support population health planning and service coordination in order to improve health equity and address social determinants of health;
3. The Board of Health request the Minister of Health and Long Term Care to provide the necessary resources to LHINs and Boards of Health to support collaboration on population health planning of health services;
4. The Board of Health request the Minister of Health and Long Term Care to adjust LHIN boundaries to create geographic alignment with the boundaries of municipalities, school boards, and public health units, including creating one LHIN for the City of Toronto;
5. The Board of Health request the Minister of Health and Long Term Care to create transparent accountability indicators and targets for LHINs which include population health and health equity;
6. The Board of Health forward these recommendations to City Council for adoption; and

7. The Board of Health forward this report to the Association of Local Public Health Agencies, the Council of Ontario Medical Officers of Health, the Ontario Public Health Association, the Association of Municipalities of Ontario, the Toronto City Manager, all 14 LHINs, the 36 Ontario boards of health, the Toronto School Boards, and Dalla Lana Faculty of Public Health, University of Toronto.

Financial Impact

There are no financial implications arising from this report.

ISSUE BACKGROUND

On December 17, 2015 the Ontario Ministry of Health and Long-Term Care (MOHLTC) released *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* (Attachment 1).¹ The *Patients First* discussion paper identifies four proposed changes to strengthen patient-centred care including:

- i) More effective integration of services and greater equity;
- ii) More timely access to primary care and seamless links between primary care and other services;
- iii) More consistent and accessible home and community care;
- iv) Stronger links between population and public health and other health services.

This report reviews the implications of the MOHLTC proposals and recommends a response from the Board of Health (BOH) with particular attention to Proposal Four, which most directly impacts local public health work. Proposal Four suggests:

- Create a formal relationship between Medical Officers of Health (MOHs) and each Local Health Integration Network (LHIN) to empower the MOH to work with LHIN leadership to plan population health services;
- Transfer dedicated provincial funding for public health units to the LHINs for allocation to public health units;
- LHINs would assume responsibility for the accountability agreements with public health units;
- Local boards of health would continue to set budgets and would continue to be managed at the municipal level.

The *Patients First* discussion paper anticipates that these proposed changes would lead to the following performance improvements:

- Health service delivery better reflects population needs;
- Public health and health service delivery will be better integrated to address the health needs of populations and individuals;
- The social determinants of health and healthy equity will be incorporated into health care planning;
- Stronger linkages between disease prevention, health promotion and care would be created.

In order to support the proposed changes, the *Patients First* discussion paper indicates the government would appoint an Expert Panel to advise on opportunities to deepen the partnerships between LHINs and public health units, and to advise on how to further improve public health capacity and delivery.¹

In a separate but related process, the province is reviewing the Ontario Public Health Standards (OPHS) which are the guidelines for providing mandatory health programs and services by boards of health under the authority of the Health Protection and Promotion Act (HPPA).² The Ontario Public Health Organizational Standards (OPHOS), the management and governance requirements for boards of health are also undergoing review.¹

COMMENTS

The *Patients First* discussion paper identifies that "[m]any aspects of the health care system are not able to properly benefit from public health expertise, including issues related to health equity, population health and the social determinants of health." These concepts are defined by the public health community as follows:

- **Health equity** ". . . means that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance."³
- A **population health approach** works to improve "the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health."⁴
- **Social determinants of health** include a range of factors mostly outside health services that influence our health including income, employment conditions, physical environment, education, housing and access to healthy foods, among others.⁵

Public Health in Ontario

Public health services are defined in the OPHS under the authority of the HPPA and delivered through boards of health in each of 36 geographic health units. The OPHS mandate some clinical services such as immunization, communicable disease case and contact management, and breastfeeding support, as well as a significant number of programs and services to keep people healthy, such as food safety, chronic disease and injury prevention, promoting healthy public policy, and emergency preparedness.

The OPHOS establish management, operational and governance requirements for all boards of health in Ontario including the assessment, planning, delivery, management and evaluation of public health programs and services that address local health needs.² Boards of health are held accountable for the implementation of the OPHS and the OPHOS through multi-year accountability agreements with the MOHLTC that set performance expectations and targets.

Boards of health consist of members appointed by the province and/or local municipalities, and are responsible for setting the budget for public health programs and services. The cost of public health services are shared between municipal and provincial governments, with some programs 100% provincially funded.⁶

While the details of board of health governance vary across Ontario depending on the structure of local government, all health units are geographically aligned with municipalities and school boards which greatly facilitates local partnerships necessary for delivery of public health services.

The OPHS incorporates a broad range of population-based activities designed to promote the health of the population. The importance of working with community partners to reduce health inequities is also explicitly stated in the OPHS.² Although it refers to population health, the main focus of the *Patients First* discussion paper is on services to patients - people already connected to the health care system for treatment. Keeping people healthy through health promotion and disease prevention is the primary focus of public health.

Public Health and the Health System

Patients First describes public health as disconnected from the larger health system due to the lack of a structural relationship at the local level. However, in practice local public health has a rich web of partnerships with the health system, often at the service delivery agency level, though not necessarily through the LHINs. Some examples of these partnerships, including service integration in Toronto include:

- Public health staff assigned to hospitals to support maternal child services and infection control;
- Dental clinics operated collaboratively with community health centers;
- Breastfeeding clinics operated jointly with hospitals;
- Daily connections between public health and primary care for communicable disease control; and
- Collaborating with Anishnawbe Health CHC and the Toronto Central LHIN to support development of an indigenous health strategy for Toronto.

Collaboration between local public health and LHINs is hampered by misalignment of boundaries. The City of Toronto Health Unit contains all or part of five different LHINs.

Public Health Planning

The OPHS require boards of health to conduct ongoing assessments of health unit residents and to use this information for population health planning. TPH uses data on mortality, hospitalization, reproductive outcomes, dental and oral health, behavioural risk factors, environmental health risks, demographic, socioeconomic and other social determinants measures, to fulfil these standards. The data comes from other agencies and from data collection carried out by TPH.

This data helps to increase understanding of the determinants of health, supports evidence informed decision-making and enables TPH to develop policies and services to keep people healthy and reduce health inequities.⁷ This work has been shared with the health system, other sectors and the public through online data and widely-disseminated public reports that identify and characterize priority health issues in Toronto including, for example: [*The Unequal City 2015: Income and Health Inequities in Toronto*](#); [*Healthy Futures: 2014 Toronto Student Survey*](#); [*Racialization and Health Inequities in Toronto*](#) (2013); and [*The Global City: Newcomer Health in Toronto*](#) (2011).

The capacity of local public health agencies to collect and use population health data varies between health units, and is generally greater in larger agencies.

Public Health and Non-Health Sectors

Recognizing that the health of a population is determined to a significant extent by social, economic and environmental factors, the public health system has adopted and embedded a social determinants of health approach to public health program and service design and delivery. Social determinants of health are largely responsible for the health inequities which are referred to in the *Patients First* document. To address social determinants of health, public health works in partnership with the municipal, education, social services and voluntary sectors. These key partnerships are critical to ensure public health decisions are responsive to community needs, shape legislation, policies and programs that impact health, and address health inequities.

Some examples of local partnerships between public health and non-health sectors in Toronto include:

- Collaborating with Toronto school boards to conduct a school-based survey of youth health and develop a collaborative response to the issues identified;
- Working with City Planning and Transportation Services to create local programs and policies supportive of chronic disease and injury prevention;
- Delivering the Investing In Families program for high risk families jointly with Toronto Employment and Social Services, Toronto Parks Forestry and Recreation, Toronto Children's Services and the Toronto Public Library;
- Developing plans to respond to the health impacts of climate change with a number of municipal services;
- Working with the United Way of Toronto and community-based NGOs to implement programs to improve access to healthy food for low income neighbourhoods.

These partnerships are facilitated by the geographic alignment between public health and the municipal, education, social service and voluntary sectors.

Local Health Integration Networks

Local Health Integration Networks (LHINs) are governed by the Local Health Systems Integration Act, 2006, and were established a decade ago in Ontario with the purpose of

planning and managing health system performance in the acute care, long-term care, community services and mental health and addictions sectors. There are 14 LHINs in Ontario serving geographic populations based on hospital catchment areas, which do not align with municipal, education or public health jurisdictions.

The *Patients First* discussion paper identifies LHINs as the focus for improved service quality and accountability, and further integration of planning and funding of health services, including public health, with the caveat that in order to be successful in a new model they would require some adjustments and additional tools.¹

Regional Integration of Public Health and Healthcare - the Experience of Other Jurisdictions

In contrast to Ontario's strong municipal involvement in public health governance and funding, in every other province public health has been integrated over the past 25 years into Regional Health Authorities (RHAs). These RHAs are 100% provincially funded and are responsible for planning and delivering a comprehensive range of healthcare and public health services for a defined geographic area. While there is variation in the design of RHAs within and among provinces, these entities differ from Ontario's LHINs in that in their formation, the executives and boards of individual health organizations were eliminated. Each RHA has a single health system-wide executive team and governance board. Despite this difference, public health's experience of being integrated into these regionalized models is highly relevant for considering the proposed provincial direction outlined in *Patients First*. A summary of the experience of other jurisdictions is provided in the attached report *The Impacts on the Public Health Function with Integration with Regionalized Healthcare Systems* by Dr. Brent Moloughney [Attachment 2].⁸ The following sections discuss potential opportunities and risks associated with the changes to public health proposed for Ontario in *Patients First*, drawing on the experiences of other provinces which have made similar changes, and makes recommendations to maximize the potential opportunities and minimize the risks that have been experienced elsewhere.

Opportunities

Patients First echoes two main arguments which have been made in other jurisdictions for strengthening the connections between public health and the healthcare system. First, public health's greater involvement with the healthcare system could bring a population health perspective to the understanding of health issues and the planning of healthcare services. In doing so, social determinants of health and healthy equity would be better incorporated into health system planning. Second, public health provides some clinically focused services which could be strengthened by improving service coordination (i.e., integration) with other health service providers.⁸

a) Health System Planning

Public health's expertise in understanding and applying population health assessment, including social determinants of health, to service planning could be advantageous for the

broader health system. The OPHS require that boards of health analyse surveillance data, including monitoring trends over time, emerging trends and priority populations.² The Population Health and Surveillance Protocol, 2008, specifies that the determinants of health have to be considered when identifying priority populations and using population health data to contribute to the maintenance and improvement of the health and well-being of the population, including a reduction of health inequities.⁹ Public health has experience in using a broad range of data to assess the effectiveness of health interventions in the local population.

Increased connection to the healthcare system could increase access to shared data systems or electronic medical records that would further increase public health's contribution to health system planning and could be a key benefit of integration.

While achieving a greater population health perspective to health system planning and a greater emphasis on prevention and health promotion have been common themes of health system integration elsewhere, their achievement has been uneven. The expectation for public health to provide a population health perspective to broader health system planning has generally not been explicit nor have the structural mechanisms to achieve it been mandated. For example, it has been left to the discretion of individual RHAs to decide on public health's structure and the extent of its involvement in health system decisions. As a result, Medical Officers of Health and public health staff in many RHAs have limited opportunity for involvement in overall system planning. RHAs' public health capacity to analyze population health information is also variable and is a requirement in order to contribute to system planning. The RHAs that have achieved active involvement of public health with system planning have had strong and interested RHA leadership combined with strong public health leadership and epidemiologic capacity.

b) Health Service Integration

Health service integration is a key component of the MOHLTC's proposed plans outlined in *Patients First*. The potential opportunity is to focus on streamlining services and creating stronger linkages between various health care services. Public health has a primary focus on prevention and health promotion work. However, some public health programs and services also provide clinical service to communities and individuals that are responsive to local needs and fill service gaps, particularly for vulnerable populations. For example, at TPH the tuberculosis (TB) program works with health professionals and the community to reduce the incidence and impact of TB in Toronto, while also providing support for individuals with TB and their families. The sexual health program provides consultation, support, resources, programming and clinical services to clients who are not well served by other health service providers.

RHAs in other provinces have placed particular emphasis on the integration of clinical health services. Commonly identified examples of improvements from better integration of public health services with the healthcare system include maternal-child programming such as post-partum follow-up, high-risk family follow-up, and breastfeeding support, as well as communication and coordination for follow-up of communicable diseases. The

opportunities for integration tend to be greater in provinces where public health has historically had a greater role in clinical service delivery than in Ontario. However, while integration has made sense for clinical services, in pursuing the goal of integration, a common adverse effect has been the re-orienting of public health's vital prevention and promotion work to a more clinical treatment focus.

Service integration plans also need to consider the broader social determinants of health which are often outside the immediate scope of healthcare services. In order to begin to address health inequities and social determinants of health, a more formal relationship between LHINs and public health is not enough. LHINs should also develop formal relationships with the municipal, social services, education, and voluntary sectors to support regional planning. This type of work has been taking place through the Toronto Central LHIN and should be considered a best practice for supporting service integration.

Risks

There are significant potential opportunities for improvements to the health system by integrating public health. However, the experience of other jurisdictions indicated there are also risks to public health of moving into an integrated model. Two types of adverse effects of public health integration into regional health structures have been seen in other jurisdictions which have hampered public health's role in keeping people healthy.

a) Reductions in Public Health Capacity

Concerns about reductions in public health capacity associated with regionalization processes emerged in the late 1990s. This included direct diversion of public health funding to other parts of the health system; fragmentation of public health capacity by breaking up public health departments and distributing them to multiple, often non-public health managers; and re-orienting public health services to illness care. Achieving a critical mass of public health capacity with a population health focus has also been undermined by provinces creating too many RHAs with small populations in order to focus on individual level care. In addition, as noted earlier, public health leadership has not consistently been included in health system decision making.

Regionalization plans have often emphasized prevention and health promotion. However the financial pressures of illness care (the "tyranny of the acute") have led to organizational structures and leadership that are typically driven and rewarded for the timely delivery of illness care, rather than for improvements in the population's health. It has been reported that approximately 97% of the RHAs budget is focused on individual-level care.⁸ The Canadian public health experience in a RHA model is echoed in England where it has been recognized that public health's involvement in regional health structures has resulted in fragmentation of public health, reduced community prevention activities and a reduced focus on the social determinants of health.

b) Barriers to Partnership with Non-health Sectors

Upstream prevention requires inter-sectoral collaboration with municipalities, education, social services and other partners, as discussed earlier. Public health staff in many RHAs have experienced a series of barriers to engaging potential partners as a result of re-

orientation of efforts to focus on illness-related issues, diversion of attention to planning healthcare services, and active discouragement of partnering with external agencies. Despite the original intent for public health to bring a population health perspective to the healthcare system, often the much larger mandate for illness care influences public health to a more clinical orientation. Misalignment of RHA service boundaries with municipal, education and social services agencies is an added barrier to collaboration across sectors on social determinants of health and health inequities.

How Ontario Can Maximize Opportunities and Minimize Risks

As the provincial government considers how to move forward on the proposals in *Patients First*, there are steps it should take to maximize hoped-for opportunities for health system improvement and mitigate potential risks experienced in other provinces of undermining public health's primary mandate to keep people healthy.

1. Maintain independent public health governance

As outlined in *Patients First*, boards of health should continue to be accountable for implementing OPHS and OPHOS and determining public health budgets to support them. This would enable an independent voice for local healthy public policy and would be consistent with the current structure of independent governance for other health service provider organizations.

2. Protect provincial funding for public health services

Keeping people healthy should be a mainstay of health system sustainability, but the experience of other jurisdictions indicates that short term pressing needs and the “tyranny of the acute” may make funding for longer term health improvement programs vulnerable. As indicated in *Patients First*, any public health funding directed through the LHINs should be transparent and should not be available for reallocation to other health services.

3. Strengthen the Ontario Public Health Standards

The review of OPHS and OPHOS should strengthen standards for effective and accountable local public health services especially for upstream disease prevention, health promotion and healthy public policy programs. Standards should mandate critical partnerships with non-health sectors.

4. Formalize local relationships between LHINs, public health and the municipal, education, social service and voluntary sectors.

If LHINs are to play a meaningful role in addressing health equity and social determinants of health, strengthening their relationship with Medical Officers of Health is not enough. A formal relationship between LHINs, public health, and non-health sectors

which play a key role in social determinants of health would enable coordination of cross sector efforts to address health equity. Local multi-sectoral engagement could be implemented through a formal structure, such as a Local Health Council with a clear provincial mandate, supported by the LHIN with senior membership from the health care sector (acute care, long term care, primary care and community care) public health, and non-health sectors (municipal, social services, education and voluntary). A model of this type is currently in place in the Toronto Central LHIN.

5. Ensure capacity for population health planning

Both LHINs and local public health agencies have fully committed their resources to their current mandates. To enable an enhanced focus on population health planning of health services in an integrated model, both LHINs and local public health must have the capacity to collaborate. To ensure success, the MOHLTC should provide the resources necessary to support these new roles. Capacity needs may be greater for smaller LHINs and public health units.

6. Align LHIN boundaries with public health, municipal and education jurisdictions

The misalignment of LHIN and health unit boundaries is a barrier to greater integration. The current alignment of health units with municipal and education service boundaries is critical for the essential partnerships with those sectors which enable public health to deliver on its mandate. If LHINs are to achieve closer integration with public health and play a meaningful role in addressing health equity through social determinants of health, alignment of healthcare planning with the geography of other non-health sectors is essential. Boundary alignment may mean that there will continue to be LHINs which contain more than one municipality (though in their entirety). In some parts of the province amalgamation of small health units may be helpful in achieving geographic alignment and sufficient capacity for integration as well as compliance with strengthened public health standards. However, the situation in Toronto where one health unit and municipality has five LHINs should be resolved by creating a single LHIN for the City of Toronto.

7. Implement accountability measures for population health and health equity.

As the health system enhances its efforts to improve population health and health equity, system accountability measures should follow suit. LHINs should have indicators and targets for the health of the population they serve rather than just the patients they serve. Population indicators should measure and track the equity of distribution of health within the population, rather than just access to health services.

CONCLUSION

If the provincial government proceeds in the direction outlined in *Patients First* for public health, experience from other jurisdictions indicates that care must be taken in order to realize the potential opportunities for improved population health planning and

service integration. Furthermore, steps must be taken to avoid the risk of compromising the key public health contribution to health system sustainability by keeping people healthy. If the Ontario health system is truly to play a greater role in creating health equity by addressing social determinants of health, it must create formal partnerships with sectors beyond health and be held accountable for this aspect of its performance.

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ATTACHMENTS

Attachment 1: Ministry of Health and Long-Term Care. (2015). *Patients first: A proposal to strengthen patient-centred health care in Ontario*. Discussion Paper December, 2015.

Attachment 2: *The Impacts on the Public Health Function with Integration with Regionalized Healthcare Systems*. Moloughney, B. (2016)

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