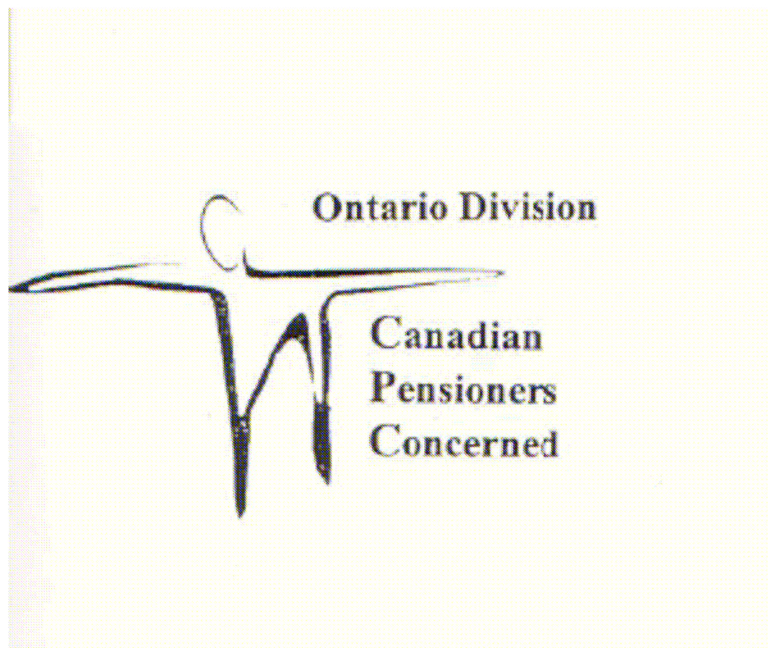


# Submission to the Standing Committee on Social Policy
# On
# Bill 36
# The Local Health System Integration Act

**Submitted By:**

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**Summary of Recommendations**

**1. Amend Bill 36 Preamble to include the following statements:**
**The foundation of the integrated system is based on the following principles:**
**a) The five principles of the Canada Health Act**
**b) Community based Boards, responsible and accountable to the community and the government**
**c) The local community has the legislated right to meaningful consultation/participation and determination of the services it needs in its local LHIN**
**d) The primacy of non-profit provision of services over for-profit.**

**2. Amend Bill 36 to include the following under the section on Definitions:**
**a) The term "entities" must be defined.**
**b) Under section 2.3 the order to "integrate" applies to for-profit entities as well as non-profit.**
**c) Non-profit service providers must not be required to "integrate" with for-profit entities unless there is no other option available.**
**d) All providers of health services provided and funded by the LHINs and Ministry of Health and Long Term Care (The Ministry) must be covered by the legislation. The Minister must have identical powers to make orders with respect to not-for-profit and for-profit providers.**

**4. Amend Bill 36 to ensure the following:**
**a) Evidence based criteria founded on evidence based performance standards must be used to evaluate the performance of each LHIN. The evaluation results must be public.**
**b) Each LHIN must be held publicly accountable to the community it serves as well as to the Minister.**
**c) LHINs funding is based on the actual needs of the population and include a number of variables such as socio-economic status of the population, health status, age distribution, number of recent immigrants ethno/cultural diversity etc.**
**d) Each community must be consulted and participate in planning and setting the priorities of its LHIN. The procedures for consultation must be part of the Regulations. The Ministry's strategic plan should be informed by the local LHINs plans.**
**e) Clarification is needed on the relationship between the Public Health Departments and the relevant LHINs.**
**f) Health Promotion should be one of the critical priorities for each LHIN.**

**5. Amend Bill 36 to ensure that:**
**a) The Board of Directors must number not less than 21 not more than 25, and should reflect the nature and complexity of the community being served.**
**b) A Seniors Advisory Committee will be one of the committees required under the Regulations for each LHINs.**
**c) The Aboriginal Community has representation on those LHINs serving a significant proportion of their population.**
**d) The Board of Directors must be required to meet for a minimum of 10 meetings a year and these meetings must be open to the public.**
**e) The Auditor General should be required to perform a comprehensive / value for money audit on all of the LHINs on a periodic basis or upon request from the Legislature.**

**6. Amend Bill 36 to ensure that:**

**a) The Government is required to provide to the relevant Standing Committee of the Legislature, detailed comparisons between the current level of funding for health services in each region of the province and the funding apportioned out to the LHINs.**
**b) Funding and Accountability Agreements be set for a minimum of three years.**
**c)) Ageism is prohibited in all forms of planning and service delivery.**
**d) Each LHIN should have an independent Ombudsperson's office that reports to the Legislature.**

**7. Amend Bill 36 to ensure that:**

**a) Effective and responsive service delivery is the primary focus of the LHINs.**
**b) The public has the right to appeal an arbitrary delisting of services. If a decision on delisting services is made, it must come after extensive public consultation.**
**c) The public and non-profit service providers have the right to appeal a decision to transfer services to another provider.**
**d) The use of competitive bidding to select appropriate service providers for each LHIN is not used for the funding of service providers. The selection criteria must include a proven record of the quality and continuity of care provided to care recipients.**

# Brief on Bill 36

Canadian Pensioners Concerned Inc. (CPC), founded in 1969, is a national, voluntary, membership-based, non-partisan organization of mature Canadians committed to preserving and enhancing a humanitarian vision of life for all citizens of all ages.

CPC began with a special concern about whether retirement income would allow for a good quality of life for seniors. We have expanded our interests over the years to include all age groups and especially those who by virtue of illness, physical or psychological impairments, age and/or economic need are especially vulnerable in a society driven by the market place and economically determined values, often to the exclusion of other social values that sustain and enhance a fair, just and inclusive social order.

## Introduction

We are supportive in principle of the development of a regionalized health planning and service delivery system in Ontario, the Local Health Integrated Networks (LHINs). We hope that the LHINs will be able to achieve the decentralization of planning and focused service delivery that is desired by the Minister but we are concerned that the model being used for much of the thinking is the British National Health Service (NHS) which has been plagued with many instances of planning errors, funding problems and poor responsiveness. Best practices must be used not only in service delivery but also in the funding, planning and establishment of service regions. We must use more successful models in Canada and in countries other than the United Kingdom.

An integrated continuum of care that is not inhibited by compartmentalized care providers and different funding envelopes is what Ontarians need. This is an opportunity to create a cost-effective system that provides access to all citizens with the service they need, at the level they need and at the time they need it. If the LHINs achieve this we will have taken a significant step in responding to the needs of our aging population

We have a number of concerns regarding Bill 36 which we will raise in the order in which the matters occur in the body of the proposed legislation. Each relevant section will be identified by its title in the legislation. Our concerns focus not only on what is written into the legislation but also on what is missing from the document as it now stands.

## 1. Preamble

The preamble is excellent in its intent. However, we find some essential elements missing and make the following Recommendation:

**Recommendation 1**

**Amend Bill 36 Preamble to include the following statements:**

**1. The foundation of the integrated system is based on the following principles:**

- **a) The five principles of the Canada Health Act**
- **b) Community based Boards, responsible and accountable to the community and the government**
- **c) The local community has the legislated right to meaningful consultation/participation and determination of the services it needs in its local LHIN**
- **d) The primacy of non-profit provision of services over for-profit.**

We particularly appreciate the recognition that LHINs' boundaries will not be exclusionary, though we wonder how exactly that can be assured. It will be difficult to ensure that LHINs do not become de facto exclusionary planning bodies. (How do you plan for a population beyond your sphere of control?)

**2. Definitions**

We have some concerns about the section dealing with definitions. The terms used to define "integrate" make sense but we see some difficulties. If "integration" of some "entities" is required, it must only happen after full, meaningful consultation with members of the affected community and organizations have taken place. We want to see protection for non-profit entities that will not permit them to be required to "integrate" with for-profit entities.

Furthermore, the term "entities" is used throughout the document yet those "entities" are never defined. It is our view that it is a code word meaning "for-profit" businesses.

We are also concerned about the potential for harm in the sweeping powers of integration. We will address this issue later in our discussion on Part V of the Bill.

**Recommendation 2**

**Amend Bill 36 to include the following under the section on Definitions:**
**a) The term "entities" must be defined.**
**b) Under section 2.3 the order to "integrate" applies to for-profit entities as well as non-profit.**
**c) Non-profit service providers must not be required to "integrate" with for-profit "entities" unless there is no other option available.**

We understand the potential need for some special powers in the legislation but we would like to see clear protection for the organizations, services and communities covered by this legislation.

**3. Health Service Provider (2)**

All for-profit providers of health services must be covered by this Legislation including private clinics, private diagnostic services etc. We believe that the LHINs must cover all providers equally – not leaving some outside its service planning and control. When a health service is provided, the ACT must cover it and thus we are concerned about the exclusion of health services provided by physicians, optometrist, dentists etc.

**Recommendation 3**

**All providers of health services provided and funded by the LHINs and Ministry of Health and Long Term Care (The Ministry) must be covered by the legislation.**

**4. PART II LOCAL HEALTH INTEGRATION NETWORKS**

There must be publicly agreed upon criteria used to measure the LHINs performance. These criteria must include the quality of service delivery, the use of best practices, and population satisfaction. There must be **evidence based performance standards** that are under constant review. **Evidence based criteria** must be used to make these judgments. We have excellent models developed across Canada and elsewhere that can be used to improve the effectiveness and sustainability of the system.

We recognize that there must be accountability to the Minister **but** we also believe that each LHIN must be held accountable to the community it serves. We would like to see a formal line of appeal for the community to the Minister of Health and/or the appropriate Standing Committee of the Legislature over the actions taken by a LHINS in service planning and delivery. Public accountability in the broader sense is important.

We believe that the provincial government must ensure that LHINS funding is based on a number of variables including socio-economic status of the population, health status, age distribution, number of recent immigrants ethno/cultural diversity etc and of course, the actual needs of the population. We believe that the government must report to the Standing Committee of the Legislature on the actual cost of services before the creation of each LHIN and subsequent to its creation.

Provincial priorities, established by broad consultation and legislative discussion, must allow for the inclusion of local priorities. The community must be consulted and participate in planning and setting the **priorities** of each LHIN.

We believe that the **planning** must come from the community through the LHINs to inform the Minister's development of the government's strategic plan. LHINs should be required to follow a strategic planning process similar to that required of Municipal Governments in the development and periodic review of their Official Plans.

We are concerned that **Public Health Departments** must be linked to the LHINs. **Health Promotion** must be one of the core services provided by LHINS and this will require them to work with Boards of Health, School Boards and a number of Municipal departments and programs. However, this collaboration must not lead to increased costs for the local government organizations that are involved.

A critical issue will be the appropriate funding of the LHINS based upon evidence of need and costs. The Ministry of Health and Long Term Care cannot use the LHINs to deflect responsibility for funding shortfalls.

**Recommendation 4**

**Amend Bill 36 to ensure the following:**
**a) Evidence based criteria founded on evidence based performance standards must be used to evaluate the performance of each LHIN. The evaluation results must be public.**
**b) Each LHIN must be held publicly accountable to the community it serves as well as to the Minister.**
**c) LHINs funding is based on the actual needs of the population and must include a number of variables such as socio-economic status of the population, health status, age distribution, number of recent immigrants ethno/cultural diversity etc.**
**d) Each community must be consulted and participate in planning and setting the priorities of its LHIN. The procedures for consultation must be part of the Regulations. The Ministry's strategic plan should be informed by the local LHINs plans.**
**e) Clarification is needed on the relationship between the Public Health Departments and the relevant LHINs.**
**f) Health Promotion should be one of the central priorities for each LHIN.**

**5. Board of Directors**
Given the size both in geography and/or population, we find it incomprehensible to think that a Board of Nine (9) Directors could possible understand and plan for the diverse population and diverse needs of a LHIN. We see this approach as setting a higher priority on efficiency of decision-making rather than on community representation and understanding. The size of the Board provides critical proof that the government is not interested in strong community based organizations for the LHINs.

**Committees**
A Seniors Advisory Committee should be one of the committees required under the Regulations for each LHIN. There should also be a Seniors Advisory Committee established to give advice to the Minister on priority setting for services across the province.

We are concerned about the impact of the LHINs on the health care services for the aboriginal communities. We believe that where the numbers warrant, they must be represented on the Board of the LHINs.

**Conflict of interest**
The conflict of Interest policy for the members and employees of the network should be common to all LHINs and must be in the public domain.

**Meetings**
The role and responsibilities of the LHINS are far too important to the community and providers to allow them to choose to meet quarterly. We believe that the minimum should be 10 meetings per calendar year. Furthermore, the meetings must be open to the public. In camera meetings should be restricted and only permitted on the limited grounds found in the Municipal Act.

**Audit**
The Auditor General should be required to perform a comprehensive / value for money audit on all of the LHINs on a periodic basis or upon request from the Legislature.

**Recommendation 5**

**Amend Bill 36 to ensure that:**
**a) The Board of Directors must number not less than 21 not more than 25, and should reflect the nature and complexity of the community being served.**
**b) A Seniors Advisory Committee be one of the committees required under the Regulations for each LHINs.**
**c) The Aboriginal Community has representation on those LHINs serving a significant proportion of their population.**
**d) The Board of Directors must be required to meet for a minimum of 10 meetings a year and these meetings must be open to the public.**
**e) The Auditor General should be required to perform a comprehensive / value for money audit on all of the LHINs on a periodic basis or upon request from the Legislature.**

## PART III PLANNING AND COMMUNITY ENGAGEMENT

A local health integration network **must** engage the community in its strategic planning and program and service delivery planning. That engagement must be required and full disclosure made of all submissions received by each LHIN. **(Recommendation 4d)**

A Seniors' Health Framework should be the basis for all priority and planning activities across the system of LHINs. Seniors are in an excellent position to help improve the quality, effectiveness and level of service provision for this rapidly growing segment of the population. [We note that currently over 41% of all health dollars are spent on people over the age of 60.]

We call for each LHIN to have a Seniors Advisory Committee (SAC) that will play an active role in the planning and priority setting of each LHIN. (**Recommendation 4b)** They will ensure that the services needed by the seniors' population are delivered in the most effective way and in response to their actual needs. The SAC will be responsible for evaluating the service provision and informing the planning processes.

## 6. PART IV FUNDING AND ACCOUNTABILITY

A critical issue will be the adequacy of the provincial funding of the LHINs. We have dealt with this concern under **Recommendation 4c.** The issue of Accountability is touched on in **Recommendation 4b.** The LHINs must not be a tool for the government to squeeze the dollars going to the provision of health services in the province. **It will be important for the government to provide detailed comparisons between the current level of funding for health services in each region of the province and the funding apportioned out to the LHINs.**

Funding and Accountability Agreements must be set for a minimum of three years. The Government has the power to make changes in response to recommendations from the Auditor General and/or in response to changed population needs.

Currently the Acute Care system and hospitals in particular, are not individually or collectively accountable for their treatment of elderly patients. Hospitals are forcing elderly patients to take the first available space in the Long Term Care or Nursing Home system wherever it is located. The Ministry of Health and Long Term Care is shutting its eyes to this violation of the regulations. LHINs must not be allowed to carryout this practice. Furthermore, it is common for Elderly patients to not be given priority status in respect of complex medical treatment even when it is medically appropriate. Age discrimination is alive and well in Ontario. LHINS must not be allowed to practice ageist policies. [This fact is one of the many reasons justifying a Seniors Advisory Committee for every LHIN]

Each LHIN should have an independent Ombudsman's office. They should be able to access all relevant information needed to deal with complaints and they should be required to provide an annual report to the appropriate Standing Committee of the Legislature.

**Recommendation 6**

> **a) The Government must be required to provide to the relevant Standing Committee of the Legislature, detailed comparisons between the current level of funding for health services in each region of the province and the funding apportioned out to the LHINs.**
> **b) Funding and Accountability Agreements must be set for a minimum of three years. This is essential to provide a reasonable planning timetable.**
> **c) Ageism is prohibited in all forms of planning and service delivery.**
> **d) Each LHIN should have an independent Ombudsperson's office**

## 7. PART V INTEGRATION AND DEVOLUTION

The requirement that services be integrated appears to be suggesting that there are inefficiencies in the system that the LHINs must overcome. A commendable goal provided it is not the primary function of the LHINs. **Effective and responsive service delivery must be the primary focus.**

**Integration by networks (Section 25) Required integration (Section 26) Integration by health service providers (Section 27)**

These three sections provide a view of the powers that will be exercised by the LHINs as they deal with the delivery and funding of services.

Under section 25 and 26, public consultation and notification is not required under any of the actions/powers available to each LHINS. In fact, the public/community is not formally included in the planning, operation and decision-making processes of the LHINS. This is wrong in our view but unfortunately is consistent with the underlying centralizing focus for decision making that we see in this legislation.

The LHINs may close or cease to fund services provided by a "service provider" or transfer those services and by so doing force the public to pay for those services if they continue to need them. The so called protection from direct consumer payment is in the 'weasel' clause

> "(3) No integration decision shall permit a transfer of services that results in a requirement for an individual to pay for those services, *except as otherwise permitted by law*."(emphasis ours).

**The public has no real protection from an arbitrary delisting of services. This is unacceptable.**

Religious institutions are protected from being required to do a service contrary to their religious beliefs. (Sections 26 & 28). The Minister appears to have forgotten the campaign by some in the faith communities to take over control of hospital boards to stop the performance of abortions. We understand the necessary protection for Freedom of Religion, however, in a publicly funded system, the public must have the unfettered right to services that have been deemed medically necessary.

**Integration by regulation (Section 33)**

This gives us cause for concern. We see this as opening the door to increasing the role of for-profit institutions in the health care system. There are no protections for the organizations or for the communities affected by integration decisions. Nor is there any determination about the type of organization to which a service might be transferred, nor is there a definition of "non-clinical services". Clinical services need the support of non-clinical services and contracting out does not by its very nature guarantee a responsive and responsible system of service.

1. Why should the Government want to have the power to force a public hospital or other self-governing entities to contract out "non-clinical services"?

There is nothing to stop the government from forcing any organization to 'transfer out' services to other entities. This need for this extreme power must be justified.

Finally, the draft legislation is silent on the very controversial issue of "competitive bidding" that has been the destructive practice under the CCAC system. It has destroyed non-profit community organizations; it has created havoc among those in need of receiving care as continuity of care has disappeared, and it has driven down wages and the skill sets of those employed in the business of home care.

**Recommendation 7**

> **Amend Bill 36 to ensure that:**
> **a) Effective and responsive service delivery is the primary focus of the LHINs.**
> **b) The public has the right to appeal an arbitrary delisting of services. If a decision on delisting services is made, it must come after extensive public consultation.**
> **c) The public and non-profit service providers have the right to appeal an arbitrary decision to transfer services to another provider.**
> **d) The use of competitive bidding to select appropriate service providers for each LHIN is not used for the funding of service providers. The selection criteria must include a proven record of the quality and continuity of care provided to care recipients.**

**OUR CONCLUSIONS**

We are troubled by the total absence of references to the "for-profit" service providers throughout this Act. It would appear that this legislation is setting up a two-tiered system – one system in the "public sphere" governed by this legislation and another system left untouched by the legislation, free to do what it wants, where it wants and to serve those it chooses to serve. The government is well aware of the many research studies that have shown for-profit health care providers have far higher administrative costs than non-profits, and those financial resources should be going into the provision of services.

It is also clear that the government has not thought to engage the insights or advice from the very community that, at the present time, consumes over forty percent (40%) of our current public health care dollars – let alone

the private sector dollars. We must have Senior Advisory Committees created to advise the Minister of Health and Long Term Care and each of the LHINs.

Bill 36 leaves much to the writing of Regulations that will carry out the intent of the legislation. We must have a guarantee that the Regulations will be brought to the Legislature for a full debate.

It is not too late to make some essential changes to the legislation. We have raised concerns especially about the failure to protect the non-profit nature of our health care system and the deliberate marginalization of the concept of community governance. “Community” is a term raised throughout the draft legislation yet it is set aside in the interest of command and control from the Minister and the Ministry of Health and Long Term Care.

Far from meeting the resonant words of the preamble, this draft legislation leaves much to be desired. We do not see it as the government fulfilling **our** vision of “an integrated health system that delivers the health services that people need, now and in the future.” (Preamble) Our vision sees an integrated system focusing on wellness and health promotion while ensuring the real care needs are being met. We believe that such a vision can be achieved if we listen to those being served and develop a responsive and responsible system.