Local Health Integration Networks
Report on Information to Date – May 4, 2005

Background: In the summer of 2004, the Ontario government proposed the development of Local Health Integration Networks (LHINs). Fourteen LHINs will cover the province with a mandate to plan, coordinate, integrate, and fund a variety of health and social services including hospital, nursing home, home for aged, home care, addiction, child treatment, community support, and mental health services.

The government says that LHINs may eventually fund the following health service providers (subject to approval by the Legislative Assembly):

- Hospitals (including divested psychiatric hospitals)
- Community Care Access Centres
- Community Support Service Agencies (e.g. alzheimer societies, associations for people with physical disabilities, meals on wheels, hearing societies, family counselling centres, VONs, CNIBs, hospices, child treatment centres, etc.)
- Mental Health and Addictions Agencies
- Community Health Centres
- Long-Term Care Homes

The government says that LHINs would not fund the following:

- Physicians
- Ambulance Services (emergency and non-emergency)
- Laboratories
- Provincial drug programs
- Individualized care

Further policy analysis will be done with respect to the relationship between LHINs and independent health facilities, **public health programs**, and provincial networks.

Each LHIN will be funded by the provincial government, governed by a board of directors appointed by the provincial government, and bound by a performance agreement with the Ministry of Health and Long Term Care (MOHLTC). The government had planned to appoint LHIN CEOs and initial LHIN boards by April 1, 2005, but failed to meet this deadline. They promise to do so soon, stating:

> The LHIN boards are intended to be skills-based and not representational of a specific group or area. In addition to other qualifications, the directors of LHINs would have a background in one or more of health care, public administration, management, accounting, finance, law, human resources, labour relations, communications or information management.
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> The Government has selected 3 Board candidates for each of the 14 founding LHIN boards of directors, consisting of a board Chair and two directors.
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> If the Standing Committee on Government Agencies concurs with the selection of these candidates, they would apply for incorporation of each LHIN under the Corporations Act and, upon incorporation, they would become the founding members of the board of each LHIN.
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> LHIN boards are expected to reach their full complement of up to 9 members by the end of 2005. The ministry is currently developing a community process that will be led by each LHIN Board, to help identify and recommend potential board candidates to the Minister, to complete the Board membership…. Board members will be remunerated in accordance with the Government Appointees Directives, which includes per diem rates.[1]

The government plans that each LHIN would be responsible by 2007/08 for:

> (a) Local health system planning in accordance with MOHLTC strategic directions
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> (b) Local health system integration and service coordination (including integration with other LHINs)
>
> (c) Accountability and performance management (including accountability agreements with health service providers funded by LHINs)
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> (d) Local community engagement
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> (e) Evaluation and reporting
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> (f) Funding
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> - Providing funds to health service providers within the scope of LHINs and within the available LHIN funding envelope
> - Providing advice on capital needs to the MOHLTC.[2]

[1] MOHLTC LHIN Bulletin # 11, May 2
[2] MOHLTC LHIN Bulletin # 11, May 2

The ministry wants "standardized" LHIN design. It is currently selecting office sites and standardized office designs and anticipates that these will be finalized in the next few weeks. Also, work is underway to identify models for a **shared "back office"** of certain operations (e.g. purchasing, procurement, payroll, etc.) for all LHINs.

This proposed LHIN reform raises **many serious problems** for public health care and health care workers. Key issues are identified below.

Cutting Community Jobs and Services

The government has tried to play on the ambiguity of the term "integration". While some forms of integration may be beneficial to the patient (e.g. creating a seamless system where patients can move from provider to provider with ease and comfort), other forms threaten services in local communities.

Unfortunately, the government has focused on cost cutting, and, in particular, centralizing and shrinking services. LHINs will be able to implement such changes through their power to fund health care providers and to require them to sign accountability agreements.

Support Services Threatened: Right from the start of transformation, government focused on shrinking and centralizing support and administrative services. Already, government and hospitals have moved to centralize health care support services through moving to establish organizations like "Hospital Business Services". The plan is for these new organizations to take over and centralize support services formerly provided by hospitals, homes and other not-for profit organizations. The plan is for many of the services taken over to then be **contracted-out** to for-profit corporations.

Notably, other jurisdictions have attacked health care support services and the results have been negative, raising serious questions about infection control and the adequate provision of services in hospitals and homes. Highlighting these developments is becoming an important part of CUPE's response.

Clinical Services Threatened: Early in its mandate, when the Liberal government first stepped up its campaign to restrain health care funding, it focused exclusively on restraining support and administrative costs, at least in public. The hospitals however claimed that the level of savings desired was not attainable through support and administrative services alone.

By April 2005, the Ministry of Health and Long Term Care admitted as much and began to move on the centralization of clinical services, with Health Minister Smitherman publicly calling for the centralization of hospital surgical procedures and the removal of less serious surgeries from hospitals. This is pretty clear direction to the LHINs about how the government wants them to solve the funding problems they will inherit.

While the *Toronto Star* has reported that the first surgical clinic to be established will be "not-for-profit", the removal of surgeries from hospitals squarely raises the possibility of **the establishment of for-profit surgical clinics.** Indeed, when Smitherman announced his interest in establishing surgical clinics, the chosen sponsor of his speech proposed private sector clinics providing two tier care as soon as Smitherman sat down.

Small Communities Threatened: While all communities will be affected by centralization, smaller communities are especially threatened, with community members forced to travel even further to get the care they need. Local communities will also be hit by job loss, jobs that may not be easily replaced.

Notably, major recent experiences with the centralization of provincial services suggest that this form of integration can increase costs: specifically, the merger of hospitals under the Health Services Restructuring Commission and the centralization of jail services in the mid to late 1990s.

Bottom line: "Integration" will likely be used as a cover for removing jobs and services from local communities as well as privatizing health care services.

Eroding Community Control

The MOHLTC emphasizes the movement of some powers from its direct control to the LHINs. However, the autonomy of the LHINs from the government will be very modest. The LHIN boards will be appointed by the provincial government through order-in-council, board members will receive (for the first time) significant remuneration from the province, and LHINs will be required to sign memorandums of understanding and annual performance agreements with the ministry.

As a result, LHIN boards will be primarily responsible to the provincial government rather than local communities.

In contrast to the LHINs, hospital and other health care providers have community-based boards that have fiercely protected their funding and their services. As the LHINs will wield considerable power, this is a significant change. Notably when community care access centre boards were taken over by the provincial government in 2001, they immediately ceased public campaigns for more funding, with the result that their funding was flat lined for several years.

Compounding this lack of community control, the proposed LHINs cover vast and very diverse areas. So, for example, Scarborough is in the same proposed LHIN as Halliburton. Obviously, the two communities have little in common and little connection. Rather than uniting Toronto under one LHIN, the LHINs will split Toronto out over five different LHINs that cover large parts of southern Ontario. All of north eastern Ontario is lumped together in one vast LHIN.

The LHIN boundaries have been formed based on hospital referral patterns, overriding political and social boundaries. The proposed LHINs are not "local", they are not based on communities, and they do not represent communities of interest. As a result, they lack any real basis for political coherence. It will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN.

Conflict within the LHINs: The large, socially diverse areas covered by the LHINs also suggest that there will be significant conflict over resource allocation within the LHINs. Already there are clear signs of this.

Since the early 1990s, all other provinces have moved to some form of regionalized health services. So it is notable that these provincial governments regularly change regional boundaries – sometimes radically.

Bottom line: The proposed LHIN structure puts up significant barriers to local community control of health care. Conflicts between communities within a single LHIN are likely. Changes to LHIN boundaries are also quite likely.

Provincial Government Accountability Diminished

Flak Catchers: While LHINs may weaken local community control, they also create another level bureaucracy, a level that is controlled by the provincial government, a level which will inevitably catch much of the "flak" for the health care decisions made for the area.

This new structure will insulate government from the consequences of its decisions to cutback or privatize services. The government will control LHINs by appointing board members, establishing accountability agreements with the LHINS, and setting funding levels. The LHINs however will have to actually implement government health care decisions in their areas. As a result, they will be the first targets for popular discontent with their decisions, even if their actual autonomy from government is more imaginary than real.

Bottom line: We will have to deal not just with the provincial government (and health care providers) but also with the 14 LHINs. Likely, the provincial government will respond to complaints by stating that "it is not us – it is a decision of the LHIN." Compounding the problem, the LHIN will largely be unaccountable to the local community.

Privatization

LHINs require a split between purchasers and providers of health care services. Such a split has already been established in home health care, where Community Care Access Centres fund home care providers through a system of competitive bidding. In effect this means compulsory contracting out of home care services. Providers regularly lose contracts and home care workers have no successor rights. As a result, wages, benefits, and collective agreements are very weak and giant for-profit corporations are squeezing not-for-profit organizations out.

We must prevent this from happening in other health care sectors.

Funding: Much remains unclear about how LHINs will be funded by the provincial government and how, in turn, LHINs will fund health care providers.

- What role, exactly, will the province have in funding?
- How will funding for each LHIN be decided – By historical levels (which vary significantly by hospital)? By population and demographic figures? By volume and complexity of services provided? By some combination of the above?
- Will capital funding eventually devolve to the LHIN?
- How will LHINs distribute money to provider organizations?
- Will certain services (e.g. cancer care services, cardiac services, acute care services) be exempted from LHINs funding and be funded directly by the province?

Notably, the hospitals have taken a very dim view of devolving funding to the LHINs.

> The OHA strongly supports the government's plan to take time and to conduct further research in making its decision on the devolution of funding responsibilities to the LHINs…. **We believe that hospital rate setting must remain at the provincial level** to maintain equity and avoid balkanization of the system. Through the JPPC, we also recommend that the OHA, hospitals and the government, **develop a common hospital funding formula for use across the province.** To ensure provincial clinical standards are met, we believe that the government should create a provincial specialized services agency to monitor, fund and evaluate provincially based programs and services, such as Cancer Care Ontario and the Cardiac Care Network**.** Finally**,** hospitals also believe that the funding **of capital and health research should remain with the Ontario government** given their obvious provincial and even national significance.[3]

Bottom line: Whatever the funding methods finally decided upon, increased privatization and competition between providers will likely be a feature of the purchaser-provider split required by the current LHIN proposal.

Bargaining Units Thrown into Question

The Ontario Hospital Association has raised the possibility of the LHINs becoming the employer:

> "When LHINs do receive funding responsibilities, "related employer" provisions in the Ontario Labour Relations Act mean that the LHIN could be considered the employer. This means a potential impact on collective bargaining, compensation, pay equity, health and safety, union certification and many other labour related matters."

If this happens, the status of **all** bargaining units in the Ontario health care sector is thrown into question. In any case, CCAC bargaining unit restructuring is likely.

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[3] Speaking Remarks, Sheila Jarvis, Chair of the Board of Directors Ontario Hospital Association, to Conference on Optimizing the Effectiveness of Local Health Integration Networks, 25 February 2005

Future changes in LHIN boundaries are quite likely, given the experience in other provinces with regionalization. So if representation rights do become associated with the LHINs, we could see **repeated rounds of representation votes between unions.** This would weaken labour solidarity, unless steps are taken.

Bottom line: The LHINs reform opens up uncertainty concerning the future of health care (and some social service) bargaining units in the province. Taking measures to preserve labour unity will become more important.

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