



# Health Reform and HIV/AIDS

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# Key Messages

- the health care system will continue to change rapidly, and health reform is one of the most important areas of public policy debate
- better to be proactive – to try to influence direction of reforms so that PHAs’ (people living with HIV/AIDS) interests and perspectives are enhanced
  - this means thinking about who, how and where to intervene in health care planning and reform deliberations
- need to also try to reframe terms of debate:
  - shift progressive take on health reform beyond defending Medicare or fighting off privatizers, as vital as that is
  - to creating and popularizing a progressive vision and plan for what equitable, diverse and consumer-centred health could be
  - HIV community has long been leaders in this kind of thinking
- Ontario govt and new LHINs are looking for innovation:
  - ASOs (AIDS Service Organizations), other HIV community groups and health care providers have had a long history of community-based innovation
  - can make a major contribution to overall reform

- broad view that health care system is under great strain
- considerable media and public interest on accessibility – waiting lists, new procedures/technology, supply of docs – and on quality of care
- system is changing constantly and quickly:
  - routine changes in medical care and technology
  - constant need to invest to keep up with increasing demand
- huge numbers of front-line innovations that significantly improve quality and effectiveness – and point the way to the kinds of changes needed to improve the overall system
- need to think beyond health care -- solid research showing that main determinants of health and health disparities are broad and inter-related factors such as housing, early child development, social exclusion and income inequality
- be aware of broader policy environment:
  - governments see little ‘wiggle room’ to raise overall expenditures or taxes → new health spending comes from other spheres
  - ‘elephants in the room’ – crucial to health reform, but seldom explicitly acknowledged -- power of doctors and other institutions, adverse impact of current provider incentives and payments
  - well organized pressure from the right to promote privatization, but also as part of wider campaigns to discredit and limit social spending and interventions – anti-welfare state

# Health Reform Is High on Political Agendas

- unavoidable pressure for health care system reform → serious attention from all governments to health reform
- major changes underway in Ontario:
  - new provincial strategy is being developed-- it will not come out until after the Oct election, but it will be very important
  - comprehensive overall transformation agenda -- primary care, e health records, new forms of delivery, LHINs (Local Health Integration Networks)
- all of this can't be ignored – massive change is coming
- challenge for progressives in general and sector advocates like HIV:
  - how to intervene/influence debate and reform along community-based and progressive lines
  - how to ensure that community and consumer needs are driving forces in reform, not just system efficiency and cost benefit considerations

# Health Reform Landscape: Big Issues

- **sustainability:**
  - pervasive view that current spending trends cannot be sustained
  - but strong counter arguments -- % of GDP, comparative, etc.
  - critical issue that cannot be ignored
  - context for pro-privatization arguments
- **access:**
  - to acute care – pervasive and at times hysterical focus on waiting lists
  - to full continuum of care – who defines? what does this include?
  - long-term care
  - drugs – debate on national Pharmacare
- **how and where care is delivered:**
  - primary care
  - alternative and multi-disciplinary practice models
- **quality of care:**
  - consumer-centred
  - culturally competent care
- **system organization and restructuring:**
  - LHINs and integration of system
  - e health
  - expansion of CHCs in Ontario
- **demography – esp. aging and increasing diversity**

# Reframing Health Reform Debate

- importance of values and framing:
  - if system is seen to be in crisis
  - if issue can be defined as unreasonable waiting lists or bureaucratic ineptitude
  - opens the way for simplistic privatization arguments
- danger for progressives of being seen as defensive – people know there are big problems in access and delivery:
  - Medicare can't be defended simply as an icon or value
  - the existing system has great strengths that need to be defended – esp universal access – and inequitable impact of privatization does need to be highlighted
  - but have to recognize that there are problems and bottlenecks that must be addressed
  - start from where people are at – big worries about waiting lists, finding family doctors, etc.

# Positive Vision of Health Reform

- as well as building on the best of existing system, need a forward looking vision of what good health and health care system could be
  - that appeals to widely held values – such as support for universal access, fairness and Medicare as one of defining features of Canadian society
  - that can set out a realistic and achievable vision of how equitable community and individual-centred care would work – and how to get there
- possible key components of such a vision are sketched out next
- AIDS movement needs to be part of defining such a progressive vision
  - can make a major contribution – given history of visionary thinking, on-the-ground innovation and community mobilization

# Progressive and Community-Driven Health Reform

- focus on equity to address:
  - pervasive health disparities in access and outcomes
  - diversity of populations and needs
  - broader determinants of health disparities
- focus on quality:
  - client-centred care
  - we know what works and how to deliver high quality care, and the major institutional and organizational barriers to quality
  - huge amount of community-based and other front-line innovations underway
  - challenge is building on such innovation and what is working already throughout the public system
- a seamless continuum of care defined by communities and individual needs/preferences:
  - wide scope -- long-term care, supportive housing, alternative treatments
  - easy movement between settings and types of care for patients
- community involvement in planning and priority setting is vital
- increased emphasis on up-stream health promotion and prevention
  - always within an equity and diversity lens



# Progressive Reform Landscape: Players

- defend Medicare from right
  - Physicians for Medicare, Council of Canadians
- Ontario Health Coalition:
  - same + strong community mobilizing against privatization, esp P3s
- Cdn Health Coalition
  - same + Pharmacare
- health union and provider groups
  - often progressive and innovative, but key role is to defend member interests
- wide and complex range of sector specific advocacy, provider and research groups
- some trying to reframe debate through such ideas as Second Stage of Medicare
  - from CHCs and allies
  - completing original vision with focus on population health, wellness, equity, increased prevention, health promotion, client-centred care, coordination
- and through broad quality and innovation agenda
  - Michael Rachlis, Canadian Centre for Policy Alternatives, etc

# Challenge: Ensuring Reform is Positive for PHAs

- PHA community and providers will be affected by wider reforms and system transformations – but what specific implications?
  - equity is far more crucial than for most populations:
    - PHAs have always been marginalized to varying degrees
    - shift in epidemic to poorer and more marginalized communities
  - quality also is more critical:
    - HIV treatment is complex and often intensive
    - like other chronic care (→ implications for allies)
  - coordination and integration – the driving forces of new LHINs – are more important to PHAs given the complexity and multi-disciplinary nature of treatment
  - HIV treatment changes very quickly -- arguably faster than most sectors
- challenge for AIDS movement is to ensure:
  - PHA interests are represented and affected positively by overall system reforms
  - HIV/AIDS is sufficiently recognized within the new ten year health strategy

## Opportunity: HIV as Major Source/Driver of Innovation

- HIV community service providers and docs and other health care providers have had a long history of:
  - providing care in the most difficult circumstances and for people with incredibly complex needs
  - pioneering collaborations within health care and beyond with community organizations
  - front-line innovation in care and support
  - fighting for and winning big advances on access – Trillium drug plan
  - identifying support needed to empower individual PHAs – e.g. ASO counselling and connecting, CATIE and others for useable information
  - importance of continuum of care, including community-based and alternative
  - sophisticated prevention – and linked into treatment and support as part of a community-based continuum
- potential to make a major contribution to health reform
  - not just to protect community interests, but to lead innovation
  - reform that is driven by individuals defining and managing their own care and by community organizations
  - so, one challenge is how to position ASOs and providers in reform processes and debates

# Examples: HIV and Hot Reform Issues

- one of the most contentious public issues – and a focus of major govt attention – has been wait times:
  - focus on particular conditions or operations → danger of neglect of other areas
  - are their areas where wait times for specialist care or tests are too long for HIV?  
→ push for pilots to apply lessons learned in other areas to HIV
  - the advantage to be promoted is that HIV physicians and other providers are already well organized and connected
- chronic care management is also seen as a critical component of overall reform and of LHIN strategies:
  - HIV providers have been leaders in integrating medical and community-based care
  - again → could position yourselves as pilot project of integrated chronic management of complex care needs
  - probably easiest – and most strategic for you – to make this case in big city LHINs with major concentrations of PHAs and HIV care
- alternative practice models:
  - can pose HIV docs and their practices as leaders of innovation that have long involved multi-disciplinary teams and connections to non-medical care
  - could consider emerging models such as Community Family Health Teams

# Local Health Integration Networks

- LHINs were seen to be a key part of the overall provincial ‘transformation agenda’ unveiled in the fall of 2004
- Ontario is the last province to develop regional health authorities
- 14 LHINs will control the envelope of funds for regions and will establish planning for more integrated organization and delivery of health care
- basic idea is that the incredibly complex health care system can best be planned and coordinated regionally rather than centrally
- goals of integrated planning and care have a lot of potential, but only if the LHINs
  - really are driven by community needs and priorities
  - develop effective and responsive governance and community engagement
  - build on the many existing coordinating and planning networks
  - foster innovation and then scale up what works across the system
  - create a system that provides equitable access to a seamless continuum of care for all

## Some Critical Limitations

- the LHINs will operate within an overall provincial strategy – yet to be developed – and broad direction from the Ministry
- some vital elements of the system are not within the LHINs mandate:
  - physicians
  - public health
  - provincial drugs programmes like ODB and Trillium
- significant concerns expressed by community providers and advocates:
  - uncertainty -- esp over future of smaller community-based service providers – would this be restructuring under another name?
  - boundaries – e.g. 5 in GTA, four are mixed urban and rural
  - would LHINs increase private provision of care as CCACs (Community Care Access Centres) had done?
  - would they really be representative and accountable to local communities?

## AIDS Is Outside LHINs' Formal Mandates, But Connected

- HIV is among certain programmes designated as provincial
- HIV \$ for community-based groups will still flow from the Ministry's AIDS Bureau
- but this will need to be well linked to regional planning through the LHINs:
  - the AIDS Bureau and other provincial programmes will be moving into a new LHINs Liaison Office
  - at best, this highlights the need for consistent standards and provincial level strategy in key areas – and that these strategies need to be well coordinated into each LHIN
- the AIDS Bureau initiated community planning in regions across the province
  - the goal is that these planners will then work closely with the local LHINs to bring HIV/AIDS issue into LHIN planning

## Beyond Formal Mandates, LHINs Will Be Important To HIV/AIDS

- the LHINs will be responsible for many of the institutional settings within which HIV care is provided:
  - hospitals, CHCs, other community providers, mental health, etc that PHAs rely on beyond their primary and specialized HIV care
- the LHINs have key integrating and coordinating functions:
  - so providers – such as HIV docs and ASOs -- will be drawn into referral and coordinating networks with the LHINs to support their clients
- more generally, LHINs are a critical part of the rapidly changing strategic environment for health that will affect every sector:
  - it will be better to be **proactive** in defining what coordination and planning is needed from the point of view of PHAs and HIV providers
  - ASOs and other providers are well positioned to take a lead in this



# Good First Year

- all the LHINs have undertaken extensive community consultations:
  - varied a great deal LHIN to LHIN
  - but far more comprehensive and intensive than ever before
  - 6,000 + people and 200 organizations participated in Toronto Central LHIN
- LHINs undertook research to understand their local environment:
  - population health needs
  - surveying existing local networks and coordinating bodies
- produced their first Integrated Health Service Plans in the fall – 3 year strategic plans
- key next steps=
  - creating coordinating and planning structures to implement the IHSPs
  - funding is flowing through the LHINs in fiscal 07-08 and extensive discussions are underway on funding frameworks
  - actual flow of \$ will be phased
  - a critical part of implementation and funding will be setting up service accountability agreements with providers

# Example: Toronto Central LHIN

- IHSP identified major integrated care priorities – mental health, seniors, rehabilitation – and building solid foundations – human resources, e health, back office integration
- its first planning assumption was to recognize the importance of broader social determinants of health
- it highlighted other unique features of Toronto’s population:
  - incredible diversity
  - pervasive social and economic inequality
  - concentrations of specific needs – such as HIV
  - but also concentrations of research, specialized expertise, major hospitals and other institutions, community-based providers, and dense networks and collaborations to build on

# Challenges for LHINs Moving Forward

- building on a good start in community engagement
  - how to create structures and processes that will embed significant community participation in planning and priority setting from now on?
  - how to make boards and other planning bodies more representative?
  - so there is real consumer and local input to the inevitable trade-offs and complex priority setting to come
  - more specifically = how to make sure that HIV community is also part of this where necessary
- building on existing provider and community planning and coordinating networks
- ensuring community and consumer-driven standards get built into performance agreements with providers:
  - what would a continuum of care look like from consumer's point of view?
  - what does good HIV care in hospitals look like?
  - how to address the key existing problem of lack of availability of community support programmes for PHAs coming out of hospital?

# LHIN Challenges II: Equity

- how to build equity and diversity into planning and service delivery:
  - what are good standards of culturally competent care?
  - what are indicators of adequate access for diverse populations?
  - what research is needed on health disparities among different communities
  - what action plans to address the disparities?
- how to build social determinants into action:
  - planning tables and facilitating wide collaborations beyond health
  - encouraging innovations in programming that build in SDoH – like CHCs
  - acting on SDoH is increasingly impt for HIV as the shape of epidemic changes and more marginalized communities face the harshest impact

# LHIN Challenges III: Cross-Sectoral Planning

- LHINs will need to develop collaborative and planning process beyond their health care sectors if they are to really address broader social determinants of health:
  - some of this will be quite practical planning – all LHINs are going to need to include public health and other providers beyond their mandate in their planning
  - ASOs and other service providers will likely want to be included at such broader planning tables as well
  - AIDS providers can argue that they have a long history of innovative and effective cross-sectoral collaboration
  - more specifically, you will likely want to ensure that HIV docs are involved in any linking of LHINs to primary care initiatives in their regions
- there also needs to be cross-LHIN coordination:
  - particular challenge in Toronto with 5 LHINs → need cross GTA planning table
  - and in areas like HIV/AIDS -- where people come from many other LHINs to get specialized care in Toronto

# LHIN Challenges IV: Wider Provincial Strategies

- mental health is top priority for the Province and for every LHIN:
  - HIV care providers have long emphasized the integral connection between treating the virus and its impact, and supporting the whole person, including mental health
  - mental health was identified as top priority in recent HIOV community consultations in Toronto
  - have been many innovative care models in HIV and mental health
  - HIV/AIDS providers will want to get linked to mental health planning in your local LHINs
- e health is also a major driver within Ministry strategy and within each LHIN:
  - given a defined population with complex needs → could this be an area for pilot projects or ASO or HIV practices hooking in as demonstration sites for wider e records or info management projects?
  - you could think bigger and push HIV docs as a pilot in innovative knowledge management:
    - HIV community has long history and solid infrastructure for translating research into practical knowledge – CATIE and others
    - OAN, OHTN and others can be seen as distributed electronic networks to exchange info and build up 'best practices'

- funds community-based research on the relationships between health and housing, poverty and income distribution, social exclusion and other social and economic inequalities
- provides workshops, training and other capacity building support to non-profit community groups
- works to identify and advance policy alternatives and solutions to pressing issues of urban health
- works in diverse collaborations and partnerships for progressive social change
- all of this is geared to addressing the pervasive impact of the social determinants of health