

SUBMISSION

Patients First Consultation Submission to the Ministry of Health & Long-Term Care

February 25, 2016



Introduction

The Wellesley Institute works to improve health and health equity in the Greater Toronto Area through research and policy based on the the social determinants of health.

We welcome the Ministry of Health and Long-Term Care's strides towards improving health in our province. Wellesley Institute supports the aims of *Patients First*. We are especially supportive of the plans to promote population based planning and the focus on health equity.

In this submission we propose some safeguards that we believe will help ensure that *Patients First* delivers on its promise. We also address the need to integrate equity into planning and policy through the LHINs, and to ensure that the LHINs have access to the most up to date education and evidence to help inform their strategy development.

Patients First is an Opportunity to Enhance Health for All Ontarians

In order to bend the cost curve in health we must decrease the need for more expensive service. Action on the social determinants of health and the delivery of early intervention once an illness is developed can decrease the rates of illness and the need for more costly interventions. *Patients First* offers the possibility of the realignment of existing resources based on community need which could include a better balance of treatment, prevention and health promotion.

Bending the cost curve may also be achieved through greater efficiency in service provision. The increased system integration proposed in *Patients First* and local planning could ensure that the right services and resources are offered in the right amount to the communities where they are needed.

The most efficient health care systems assess needs and balance them against service provision. In the highest quality systems those with similar needs get the same access to care but those with different needs get different access. The most efficient health care systems are based on these fundamental principles of health equity.

The Excellent Care for All Act recognizes equity as one of the nine key attributes of a high quality health care system. As a result, equity is now an agreed upon indicator of quality.

Patients First is an important opportunity to consolidate the progress that we've made in addressing health equity in Ontario and ensuring that equity is front and centre in all health care planning and services in this province.

Population based planning and health equity can go hand in hand to help rebalance system priorities. We believe that the *Patients First* approach could deliver on this promise but that some safeguards should be considered to ensure that this happens.

Identifying Core Services

An issue with local planning in times of fiscal prudence is that tough choices sometimes need to be made on which services are funded and which are not. The breadth and depth of services and treatments offered in an area can be determined by the needs of the population, socio-demographic factors and the resources available outside health. Poorer areas, with higher levels of morbidity will have to make more

tough choices than richer areas with lower levels of morbidity. This can produce a zip code lottery where different treatments and levels of support are available in different areas.

Though local planning can be an efficient means to align resources where they are needed, we believe this approach would be improved by the Ministry of Health and Long-Term Care determining what services every Ontarian should be able to access. Local flexibility should be for services over and above a core basket of services that should be offered by each LHIN or sub-LHIN area. Unless there is an agreed upon basket of services set by the Ministry there remains a risk that the services people are able to access are dependent on where they live in the province. Inequitable access to services can lead to inequitable health outcomes between LHINs. However it can also lead to disparities through internal health tourism which will favour those who have more information, more resources and are more mobile.

Identifying a basket of core services is the approach taken in the U.K., which is now considered one of the most efficient and effective health care systems in the world. In their reorganization they first decided on the services that should be available to everyone as part of the health care system basket. The U.K. built local autonomy into service delivery but this was limited to ensure that everyone had access to the fundamental services that were guaranteed at a national level, which included primary and tertiary care.

To get *Patients First* off to a strong start the Ministry must first articulate the basket of services that every LHIN must deliver. Being clear about the services that are required sets the basis for a clear accountability process between the Ministry of Health and Long-Term Care and LHINs for the delivery of these services.

Connected to this, it is important for the Ministry to consider which services it will fund directly and at what level for each LHIN.

We believe it is beyond the scope of each LHIN to try to develop or organize tertiary level care. For example, there needs to be agreement, led by the Ministry, about how Ontario's four speciality children's hospitals and four mental health hospitals fit into health planning. These hospitals have a role and a mandate that is different to what the LHINs are designed to administer. Similarly, it should be clear what public health work for the new units will be defined at the LHIN level and what should be defined by stronger and clearer Ontario Public Health Standards. Some public health functions like immunization have to be consistent across the province; it is therefore important for provincial public health standards to ensure that these functions do not vary by LHIN.

The Role of Public Health

We believe that the inclusion of public health units in LHINs is an important opportunity to support population health planning and to build a health protection and promotion approach into the health care system. We are mindful, however, of the experience in other jurisdictions that shows that public health generally loses funding when it is brought into mainstream health system control. We believe that public health funding should be ring-fenced to ensure that their population health approach and links to municipalities remain viable.

Similarly, we argue strongly for coterminous boundaries for LHINs and public health units; local planning will be enhanced by LHIN and public health unit boundaries that are in sync. Currently, the area for which Toronto Public Health is responsible crosses the boundaries of five LHINs; we believe that well coordinated population-based planning cannot occur with so many parties with different stakes involved

with this single public health organization. We hope that LHIN boundary changes will allow Toronto to move toward one LHIN and one public health unit.

There is also a need to consider how boundaries overlap between different systems. For example the Ministry of Children and Youth Services has 33 lead agencies across the province. There will be merit to move as much as possible towards aligning LHIN and public health unit boundaries with those used in the delivery of other provincial or municipal services.

Population-Based Funding Strategy for LHINs

Accountability as part of the reforms proposed in *Patients First* should include outcome measures as well as process measures.

We welcome that the proposal attempts to fill gaps in the health care system and improve access to care. We would like the Ministry to go further and to hold the health care system to account through measures of outcomes and quality.

The *Patients First* document discusses equity as a driver, and this is an important and welcome approach. We believe that this calls for a population-based funding strategy for LHINs. If LHINs are going to deliver an equitable basket of services so that the same access to health care services are available in every LHIN and if we should expect the same outcomes across LHINs we believe there will need to be a funding formula that takes into account the social determinants of health that change the risk of illness and the outcomes from illnesses.

We expect that within LHINs there will need to be a clear process of population-based planning and LHINs may need some support with this task. We discuss below approaches to health equity planning that we think should be developed to support the LHINs in population-based planning.

Addressing Health Inequities in Ontario

As *Patients First* notes, some Ontarians struggle to access health and social services. Individual characteristics such as gender, racialization, sexual orientation, immigrant status, and income have been shown to impact access to health services, quality of care, and health outcomes.

There are many examples of these impacts on health outcomes in Ontario. For example, Ontarians who live in lower income areas have a 4.5 years lower life expectancy than those who live in high income areas. Those who speak only French, men who self-identify as “Black,” those who are homeless and women from South Asian, West Asian and “Arab” groups are all at greater risk of poor self-reported health. Refugees from Sub-Saharan Africa are at a more than three times greater risk of having low birth weight babies, and infants from the lowest income neighbourhoods have been shown to have a 60 percent greater risk of mortality in the year after hospital discharge. Finally, diabetes mortality in Ontario decreased between 1994 and 2005; but this progress was much more pronounced in high income groups than in others.

In Ontario, the data also indicate differences in service use. Between 2001 and 2012 low-income Ontarians spent 18 more days in hospital compared to high-income Ontarians. Women have more hospital admissions

than men for asthma. Children from low-income neighbourhoods are more likely to experience potentially avoidable hospitalizations than children from high-income neighbourhoods.

There are significant disparities in health for different populations across the province. A high quality health care system needs to match these population needs to effective interventions. This is not only more equitable, it is also more efficient.

Health Quality Ontario, is developing a strategy which aims to achieve equitable health care in Ontario. Equity is now agreed upon as an important dimension of quality. At Health Quality Ontario's Health Equity Summit in November 2015, Minister Hoskins endorsed the use of the Health Equity Impact Assessment (HEIA) tool in designing and evaluating all policies. These forward-thinking changes will have measurable impacts in advancing health equity across the province.

Patients First is an opportunity to move our thinking from equitable access to services to what we need to ensure equitable health outcomes for all Ontarians.

Building Health Equity Infrastructure in Ontario

To move to the next level of health equity in Ontario we need to build skills and capacity across the health care system. Equity must be everyone's business and the enhanced role for LHINs provides an important opportunity to embed equity in all aspects of the health care system. To do so, however, it is important for every LHIN to have the infrastructure that gives them the knowledge and capacity to drive equity at all levels of their expanded role. We propose three recommendations which will help us attain this goal.

For *Patients First* to be effective every LHIN needs:

1. A health equity plan built on data

To achieve equitable health outcomes for all Ontarians it is important for LHINs to understand the populations that they serve and have a deep understanding of existing disparities. This means that every LHIN needs to collect and analyze data on the patients that they serve and health disparities at a local level. The development of data collection in primary care settings and hospitals which includes demographics, social determinants of health, and equity indicators will yield a valuable source of information which can be analyzed to identify specific disparities. A health equity plan would target identified disparities with strategies which may have the greatest impact and would measure its success. Data collection for equity purposes has already been implemented in some LHINs. Toronto Central LHIN has been leading with its socio-demographic data collection tool that has been rolled out across its hospitals and CHCs. The Toronto Central LHIN tool asks patients eight standardized demographic questions with the option for institutions to three additional questions based on local need. Data is analyzed to identify and address differences in health outcomes based on demographic characteristics. Other LHINs have built on the Toronto Central LHIN's leadership on this file. Formalizing these data collection and analysis requirements will be important for the success of *Patients First*.

2. Training and support in developing equitable policies

Collecting data is an important start, but LHINs also need to know how to turn data into policies that lead to equitable health outcomes. Addressing disparities in the health system requires a systematic understanding of the specific needs of underserved populations and the key barriers to access. LHINs

need tools, templates, and supports to build equity into their policies and to build and equity strategy. Each LHIN will need to write a plan on delivering health equity and will need support to do so.

There has been progress in Ontario with the implementation of the Health Equity Impact Assessment (HEIA) tool. The HEIA tool, which was developed by MOHLTC and Bob Gardner of the Wellesley Institute, allows for the health equity impacts of policies and programs to be identified and for the development of plans to enhance the positive impacts and minimize the negative impacts of policies and programs. The HEIA tool works on the premise that many policy and program decisions that produce inequities are unintentional. Using the tool formalizes the consideration of possible inequitable impacts of new or existing policies and programs. HEIAs are increasingly being used by health care institutions across Ontario. The next step is for LHINs to use this tool in their policy development. They could also require its use by funded organizations.

LHINs will need formalized support to implement widespread use of the HEIA tool. To date, to support the Ministry of Health and Long-Term Care, CAMH has produced online training for HEIA and a runs community of interest of over 1,000 people. Public Health Ontario has undertaken an analysis of barriers to adopting HEIA and has developed a supplement of the HEIA for public health usage. The Ministry of Health and Long-Term Care has also developed a French Language version of HEIA. For *Patients First* to embed HEIA as a fundamental health care policy and program development tool there needs to be a centralized training and support resource available to LHINs and service providers to provide expertise and practical support.

In addition to HEIA there are other impact assessment tools and planning frameworks that have been used to promote equity. Training and support in these would increase the capacity of Ontario to move towards a more equitable service response.

We believe that the training and support needs of the LHINs requires the development of a centralized health equity observatory. This would be the centre for training and the development of new knowledge on equity planning. It would help to foster the development of knowledge linkages between decision makers and academia and also help to develop new expertise.

3. Access to a repository of health equity interventions that have been demonstrated to achieve equitable outcomes

Health equity strategies are important to produce the environment for change, however, in some cases there will be a need for the deployment of more appropriate service models to meet the needs of populations.

There is now a wealth of information available on evidenced based service adaptations which can promote equity is access and outcomes. LHINS may not have the capacity to identify these new models of treatment and service configuration. We would suggest that a Health Equity Observatory documents new interventions and approaches that improve equity of access and outcomes.

We can also see merits in the Observatory cataloguing Health Equity Impact Assessments conducted in Ontario as well as being able confidentially to share the impacts of LHIN health equity strategies and interventions. Through these mechanisms the Observatory could build our capacity to improve health equity in Ontario.

Conclusion

The opportunity in *Patients First* is to use the new model to align the possibilities of population-based equitable care with a balance of innovation in treatment and upstream thinking to improve effectiveness and outcomes. We are on the right road but we may need some extra safeguards to ensure that we get where we are going. Mandating a basket of core services, clearly defining the role of public health and ring-fencing public health funding and implementing a population-based funding strategy for LHINs are important safeguards that will lay the groundwork for *Patients First* to succeed.

Patients First outlines important developments which will work toward improving health outcomes for all Ontarians. The expanded role for LHINs is an important step forward and will allow equity to be built into all policies, programs and services at the local level across the province. LHINs are the right level of health care administration to do this work but there is a need for the development of equity infrastructure to support their work. Our recommendations will help the LHINs move equity goals to the forefront of service delivery, using the best available data from Ontario, Canada and around the world.



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