Association of Ontario Health Centres
Community-governed primary health care

Association des centres de santé de l'Ontario
Soins de santé primaires gérés par la communauté

Submission to the Standing Committee of the Legislative Assembly regarding Bill 41- *Patients First Act, 2016*

From the Association of Ontario Health Centres

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Part I: Summary of Recommendations

Local Health System Integration Act (LHSIA)

1. **AOHC recommends the following four changes be made to Bill 41 to further strengthen the objects of the LHINs in Section 5 of LHSIA:**

   a) Amend the new object of a LHIN to add the second sentence as follows: To promote health equity, reduce health disparities and inequities, and respect the diversity of communities and the requirements of the French Language Services Act in the planning, design, delivery and evaluation of services. For the purpose of clarity, the LHINs should combat all forms of systemic racism and discrimination, including anti-Indigenous racism, anti-black racism, Islamophobia, homophobia, transphobia and ableism.

   b) Add a new object of a LHIN to reflect the Aboriginal Health Policy vision: To implement the Ontario Aboriginal Health Policy (AHP) 1994 and its successor policies, in order to promote health, healing and reconciliation with the diverse Indigenous populations across Ontario.

   c) Add a new object of a LHIN on oral health planning: To plan, fund and monitor publicly funded oral health services.

   d) Add a new object of a LHIN on health promotion: To advance a range of interventions that address health promotion and prevention, through planning and funding health promotion services that address the social determinants of health and support community development.

2. **Add definitions of key health terms in LHSIA:**

   Health: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization definition).

   Health equity: "reducing systemic barriers in access to high quality health care for all by addressing the specific health needs of people along the social gradient, including the most health disadvantaged populations" (MOHLTC definition from Health Equity Impact Assessment).

   Health promotion: "The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions" (World Health Organization).

3. **Strengthen planning and community engagement:**

    a) Section 6. (1) of Bill 41 should include wording that requires each LHIN board of directors to dedicate at least one seat for an Indigenous person, at least one seat for a Francophone representation and recommend equitable representation based on the diversity of the LHIN.

    b) Amend LHSIA to ensure the MOHLTC activate the Aboriginal and First Nations health council referred to in section 14 (2) 1. Rename the council to "Indigenous Advisory health council"

    c) Amend Section 14. (1) of Bill 41 with wording to ensure that each LHIN patient and family advisory committee reflect the diversity of the community, including Francophone representation.

4. **Ensure third party community support organizations are held accountable**

    a) Add wording for Section (4) of Bill 41, which amends Section 2 of LHSIA, to clarify that the French Language Services Act is applicable to services purchased by the CCACs, LHINs or inherited by the latter, including Ontario Regulation 284/11 (Provision of French Language Services on behalf of Government Agencies).

    b) Add wording to ensure that third party contractors, particularly those contracted within home and community care services, are directly accountable to the LHINs to provide high quality, culturally appropriate care when providing services to Indigenous communities.

5. **Clarify increased LHIN powers**

    a) Section 21.2 of Bill 41 needs to define more specifically through guidelines or regulations, the conditions under which it would be in "the public interest" for a LHIN to appoint a supervisor of a health service provider.

    b) Section 21.2 should include the requirement of Ministerial and Cabinet approval before the LHIN can appoint a supervisor.

    c) Section 21.2 should include a mechanism for the health service provider to request a review or to appeal the appointment of a supervisor.

    d) Section 21.2 needs to define more specifically through guidelines or regulations from the Ministry of Health and long Term Care the conditions under which a supervisor could govern a health service provider which has multiple funding sources. Specifically we are requesting a legal analysis on whether a LHIN can legally remove a board and appoint a supervisor when LHIN funding accounts for less than fifty per cent of the health service provider's funding, especially but not solely for Indigenous governed organizations.

6. **Amend Bill 41 to ensure care coordination is a function of primary care**

    a) Direct service delivery by the LHINs should be limited to care coordination only.

    b) Care coordination should be moved to health service providers in primary care as part of a three year transition plan.

Health Protection and Promotion Act

1. Amend the Health Protection and Promotion Act to ensure Public Health Units must respect the diversity of communities and the requirements of the *French Language Services Act* in the planning, design, delivery and evaluation of services.

About AOHC

As Ontario's voice for community-governed primary health care, the Association of Ontario Health Centres (AOHC) is pleased to present our response to Bill 41, *The Patients First Act.* AOHC has a strong commitment to health equity and our response is framed through this lens.

AOHC represents 108 community-governed primary health care organizations throughout the province: 74 Community Health Centres (CHCs), 10 Aboriginal Health Access Centres (AHACs), 10 Community Family Health Teams (CFHTs) and 13 Nurse Practitioner-Led Clinics (NPLCs). Our response to Bill 41 is shaped by the vision that unites our membership: the best possible health and wellbeing for everyone living in Ontario.

To advance this vision, our mission is to champion transformative change for people and communities facing barriers to health. To do so our members have adopted a comprehensive community centred Model of Health and Wellbeing. Our Indigenous members, the AHACs, have adopted the Model of Wholistic Health and Wellbeing, a culturally-specific model. The models are based on the premise that the people and communities who face barriers to health need access to integrated primary health care services that respond to the many different factors in their daily lives that are impacting their health status.

These models are based on a growing body of evidence which demonstrates the need for a health care system that is community driven and proactively addresses the determinants of health and applies culturally safe practices and approaches. Bill 41 represents an important opportunity to make legislative changes that will help move Ontario's health care system in this direction, but we recommend first a number of amendments to strengthen the bill.

Part II: Comments on Bill 41

We remain concerned that the overall framing of this Bill and the title "Patients First" focuses on treating people when they are sick. A more appropriate title would be "People and Communities First." People only become "patients" when they are diagnosed with a health condition. The goal of our health care system should be to prevent people from getting sick. People's health status is largely determined by their socio-economic status and where they live. We need to shift the conversation from patients to people and communities to build a better balanced health system in Ontario that can respond to the determinants of health while delivering high quality medical care.

AOHC's comments will focus primarily on the proposed changes to the *Local Health System Integration Act* (LHSIA). We are supportive of the overall intent of the amendments proposed in Bill 41 which should result in stronger provincial stewardship and a bigger role for the LHINs in planning primary care. We are pleased that FHTs, NPLCs and AHACs are being added to the list of health service providers that can be funded by the LHINs. We are very pleased that the objects of the LHINs have been expanded to include promoting health equity, reducing health disparities and inequities, and respecting the diversity of communities, including the requirements of the *French Language Services Act.*

A few changes were made to Bill 41 from the previous Bill 210 which AOHC supports: additional steps in the process and notification of the Minister of Health and Long-term Care regarding service accountability agreements, directives and investigators for health service providers. We like the proposed rewording of section 37 of LHSIA which supports collaboration between health service providers to support planning of primary care services.

We now urge you to make a few more significant changes before Bill 41 is approved.

Recommendations

Local Health System Integration Act

1. Strengthen the LHIN objects

AOHC recommends the following four changes be made to Bill 41 to further strengthen the objects of the LHINs in Section 5 of LHSIA:

a) Amend the new object of a LHIN to add a second sentence to read as follows: To promote health equity, reduce health disparities and inequities, and respect the diversity of communities and the requirements of the *French Language Services Act* in the planning, design, delivery and evaluation of services. **For the purpose of clarity, the LHINs should combat all forms of systemic racism and discrimination, including anti-Indigenous racism, anti-black racism, Islamophobia, homophobia, transphobia and ableism.**

- We do not have an equitable health system when 3.5 million people in Ontario face barriers accessing health services. Among other barriers, there is growing recognition of the impact of racism on health and wellbeing, as reflected in the establishment of the Anti –Racism Directorate. Compared to non-racialized Ontarians, racialized communities face higher risk for particular health issues, including diabetes, heart disease, HIV/AIDs and certain cancers. Racialized communities face multiple barriers accessing health services including cost, racism, socio-cultural and linguistic barriers, and lack of cultural competency among providers.

- We want wording added to the objects of the LHIN Act to make them responsible for combatting systemic racism and discrimination as it impacts health outcomes. The proposed wording is taken from the Premier's mandate letter to the Minister Responsible for the Anti-Racism Directorate, with the addition of wording to address homophobia, transphobia and ableism.

b) Add a new object of a LHIN to reflect the Aboriginal Health Policy vision**: To implement the Ontario Aboriginal Health Policy (AHP) 1994 and its successor policies, in order to promote health, healing and reconciliation with the diverse Indigenous populations across Ontario.**

- We propose that the LHIN objects should include specific reference to the existing Ontario Aboriginal Health Policy which set out a wholistic framework which includes Indigenous knowledge of the life cycle, Indigenous concept of wholistic heath and the continuity of care from health promotion and prevention to rehabilitation. The Ontario Aboriginal Health Policy remains relevant today as a widely supported framework and roadmap for Ontario and should be updated and complied with. The framework maintains the integrity of Indigenous rights to determination in health and strengthening Indigenous informed health models of care. Most importantly, we continue to show evidence that it is a successful framework to address the intergenerational impacts of colonization, the legacy of the residential schools, sixties scoop, millennium scoop and the community stress within Indigenous communities.

c) Under Section 5 of LHSIA add a new object of a LHIN "**to plan, fund and monitor publicly funded oral health services."**

- Oral health is an important component of overall health and wellbeing, yet access to oral health care is a significant issue for 2-3 million Ontarians who cannot afford it. Research shows a link between poor oral health and diabetes, heart disease and respiratory disease. AOHC members see firsthand the impact on health as many of the people we serve cannot afford dental care. When unable to access oral health services too many people in Ontario turn to hospital emergency rooms and physicians costing the healthcare system at least $38 million/year, but they cannot

get treatment in these settings [source: https://www.aohc.org/Information-Hospital-Emergency-Room-Visits-Dental-Problems-Ontario].

- Health system reform must incorporate oral health services to ensure population health needs are met. Ontario has public dental programs for children in very low income families (Healthy Smiles Ontario) and a patchwork of programs for people receiving social assistance. But there are no programs for low income adults and no overall planning of public oral health programs to ensure access for vulnerable populations. We want the planning, funding and monitoring of publicly funded oral health services to be mandated in the expanded role of LHINs.

d) Add a new object of a LHIN: " **to advance a range of interventions that address health promotion and prevention, through planning and funding health promotion services that address the social determinants of health and support community development.**"

- In Ontario we know that 5% of the population require 70% of health care funding. Many of these people live in poverty and are socially isolated. To be effective we need to create a culture of health and wellbeing that embraces health promotion as a core element of primary health care. This has been demonstrated to have major impacts in reducing hospital utilization rates and costs in AOHC's work with Health Links.

- As noted in the Ottawa Charter for Health Promotion, 1986, the responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs.

- AOHC supports this approach. Health promotion should not be regarded as the exclusive domain of public health, but should be a shared responsibility involving multiple stakeholders both within and outside the health care system. The LHINs should be responsible to develop and implement health promotion strategies designed to augment primary health care services in collaboration with health service providers, public health units and other key stakeholders.

2. Add definitions of key health terms

Bill 41 needs to include amendments to LHSIA that provide definitions of key health terms which are referred to in the Act. Without definitions and common understanding of key concepts such as health, health equity and health promotion, the LHINs will not interpret

their mandate in the same way across the province. We recommend that the following definitions be included in the Act:

Health: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization definition)

Health equity: "reducing systemic barriers in access to high quality health care for all by addressing the specific health needs of people along the social gradient, including the most health disadvantaged populations" (MOHLTC definition from Health Equity Impact Assessment

Health promotion: "The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions" (World Health Organization)

3. Strengthen Planning and Community Engagement

Section 6. (1) of Bill 41 replaces subsection 7 (1) of LHSIA and stipulates that the number of members on a LHIN board of directors will be twelve, but can be increased to fourteen if prescribed by Cabinet.

Part III, Section 14 of LHSIA directs the Minister of Health and Long-term Care to establish an Aboriginal and First Nations health council and a French language health services advisory council to advise the Minister about health and service delivery issues. Section 16 of LHSIA requires the LHINs to engage the community in health system planning, including engaging the local Aboriginal and First Nations health planning entity, and the local French language health planning entity.

AOHC members include 10 Aboriginal Health Access Centres and a number of Community Health Centres who serve Francophones. Based on the experience of our members we make the following recommendations:

a) Representation on LHIN board of directors

Section 6. (1) of Bill 41 should include wording that requires each LHIN board of directors to dedicate at least one seat for an Indigenous person, at least one seat for a Francophone representation and recommend equitable representation based on the diversity of the LHIN.

- There are many highly skilled and diverse people who are qualified to meet the needs of the Board. This is not an either/or proposition. By putting this requirement in legislation, it will require the LHINs and the MOHLTC to seek out people who bring skills and diversity to the Board and it ensures that the voice of the community informs the important governance of the LHINs.

- Specifically, this requirement ensures that the Indigenous member could provide local Indigenous health expertise to the LHIN board in service of the Indigenous population within the LHIN. It would improve the Indigenous community's access to LHIN decision making, directly impacting AHACs and Aboriginal CHCs. Indigenous LHIN Board members should be required to demonstrate senior level Indigenous health expertise and experience working with status and non-status First Nations, Métis and Inuit communities, on and off-reserve and in urban settings. We believe that this approach will positively impact on Indigenous health outcomes while meaningfully contributing to Ontario's health system transformation by reflecting the *Patients First* goal to promote health equity.

b) Activate and rename Indigenous Advisory health council

Amend LHSIA to ensure the MOHLTC activate the Aboriginal and First Nations health council referred to in section 14 (2) 1. Rename the council to "Indigenous Advisory health council"

- Communities have been waiting for over a decade for the formation of a provincial Indigenous advisory health council under LHSIA. The ad hoc nature of Indigenous health planning by LHINs has created an environment where we are losing ground on a number of health issues, such as reducing rates of chronic disease and suicide. Indigenous people require a provincial primary health care action plan and a provincial Indigenous Advisory health council to advise the Minister directly, share information and set priorities for strategy development and planning. This council should include people with lived experience and subject matter expertise, as well as representation from Indigenous health and wellness service delivery agencies involved in the LHIN Indigenous Health Committees.

c) Ensure Francophone and other diverse representation on Patient and Family Advisory Committee

Amend Section 14. (1) of Bill 41 with wording to ensure that each LHIN patient and family advisory committee reflect the diversity of the community, including Francophone representation.

4. Ensure third party community support organizations are held accountable

a) LHSIA needs to be amended to ensure that third party contractors who are not deemed health service providers must be held accountable for providing high quality, culturally appropriate services and that they comply with the *French Language Services Act.*

AOHC recommends additional wording for Section (4) of Bill 41, which amends Section 2 of LHSIA, to clarify that the *French Language Services Act* is applicable to services purchased by the CCACs, LHINs or inherited by the latter, including Ontario Regulation 284/11 (Provision of French Language Services on behalf of Government Agencies).

- This addition would ensure that when LHINs inherit home care service contracts currently in place with CCACs or purchase community support services there is an obligation for these third party contractors to comply with the French Language Services Act, including Ontario Regulation 284/11 , and provide services in French when serving the Francophone community.

b) **Section (4) of Bill 41 also needs to be amended to ensure that third party contractors, particularly those currently contracted within home and community care services, are directly accountable to the LHINs to provide high quality, culturally appropriate care when providing services to Indigenous communities.**

- Home and Community Care continues to be an area of Ontario's health system where Indigenous people are at great risk and experience serious harm on a regular basis. There continues to be significant confusion amongst service providers and jurisdictional discord. High levels of systemic racism and inequities are causing undue stress for people, families and communities. They are also contributing to premature death. Bill 41 needs to ensure that LHINs have the authority and direct accountability to continue to support real solutions for Indigenous people in the management of home and community care coordination and services, including palliative and end of life care.

5. Clarify increased LHIN powers

Bill 41 makes a number of amendments to Section 21 of LHSIA. These include allowing a LHIN to appoint a supervisor to replace the board of directors of a LHIN-funded health service provider (except for hospitals and long term care homes) when they consider it in the public interest to do so.

AOHC recommends the following amendments:

a) Section 21.2 of Bill 41 needs to define more specifically through guidelines or regulations the conditions under which it would be in "the public interest" for a LHIN to appoint a supervisor of a health service provider.

b) Section 21.2 should include the requirement of Ministerial and Cabinet approval before the LHIN can appoint a supervisor

c) Section 21.2 should include a mechanism for the health service provider to request a review or to appeal the appointment of a supervisor

d) Section 21.2 needs to define more specifically through guidelines or regulations from the Ministry of Health and long Term Care the conditions under which a supervisor could govern a health service provider which has multiple funding sources. Specifically we are requesting a legal analysis on whether a LHIN can legally remove a board and

appoint a supervisor when LHIN funding accounts for less than fifty per cent of the health service provider's funding, especially but not solely for Indigenous governed organizations.

- Community governed agencies, including AOHC members are governed by community boards. The changes in Bill 41 would allow the LHINs to undertake investigations and appoint a supervisor to replace the community board of directors when they consider it in the public interest to do so. This is a significant new authority for the LHINs and would lead to a loss of local control and accountability for a CHC, AHAC, NPLC or CFHT. Yet the definition of public interest in section 35 of Bill 41 is very broad. We are calling for more specific guidelines for a LHIN to identify the conditions under which they would be permitted to appoint a supervisor of a health service provider.

- Bill 41 requires the LHINs to give advance notice to the Minister of Health and long Term Care if they are issuing a directive to a health service provider and if they are appointing an investigator. But there is no requirement to notify the Minister if the LHIN is taking the final step of appointing a supervisor of a health service provider. Under the *Public Hospitals Act,* the authority to appoint a hospital supervisor with significant powers to operate a hospital rests with the Lieutenant Governor in Council; that is, Cabinet. We are recommending the same requirement of Cabinet approval before a LHIN can appoint a supervisor to operate a community health service provider. We are also requesting the right to appeal the decision.

- Many AOHC members receive their funding from multiple sources besides the LHIN. It is not clear to us whether a LHIN has the legal authority to replace the board with a LHIN-appointed supervisor to govern a CHC or AHAC when LHIN funding represents only a portion of their funding. This is particularly an issue for Indigenous governance.

6. Ensure Care Coordination is a function of primary care

Bill 41 expands the mandate of the LHINs to provide the direct services of CCACs as they are transferred to the LHINs. AOHC would like to see an amendment to Bill 41 that addresses the following concerns:

a) **Direct service delivery by the LHINs should be limited to CCAC services only.**

b) **Care coordination should be moved to health service providers in primary care as part of a three year transition plan.**

- The LHIN's role should be planning, integrating, funding and evaluating local health systems. They should not be engaged in direct service delivery. We request that a

clause be added to Bill 41 that prohibits the LHINs from doing service delivery in areas beyond CCAC services.

- All care coordination should rest with primary care, so we recommend adding a clause that requires the LHINs to transition care coordination to Primary care within three years.

- Furthermore, CCAC Care Coordinators working with Indigenous populations should be placed within Indigenous governed primary health care agencies where they exist**.** Due to widespread systemic racism specifically targeting Indigenous people, there are sectors in the healthcare system where Indigenous people continue to come into regular harm: emergency, palliative care, home and community care, and mental health. These risks could be immediately reduced and Indigenous health gains accelerated by expanding the service scope and mandate of Indigenous community- governed primary health care agencies to include care coordination, hospital discharge, home and community care services and palliative/end-of-life care.

Health Protection and Promotion Act

Similar to the LHINs, public health units have responsibilities with regard to the health of Franco-Ontarians and should adhere to the requirements of the *French Language Services Act*. We recommend that Bill 41 include the following amendment to the Health Protection and Promotion Act:

> **Public Health Units must respect the diversity of communities and the requirements of the *French Language Services Act* in the planning, design, delivery and evaluation of services.**

Conclusion

AOHC appreciates the intent of *The Patients First A*ct to ensure stronger provincial stewardship of the health care system. We support the expanded role for the LHINs in primary care planning to promote health equity and reduce health disparities. We urge the Standing Committee on the Legislative Assembly to strengthen Bill 41 and address our concerns by recommending further changes as we have outlined for the Bill before it becomes law.