



**LOCAL HEALTH INTEGRATION NETWORKS (LHINs)  
and THE FUTURE OF RURAL HEALTH**

**TORC ISSUES PAPER  
From the Rural Health Forum Held September 25, 2006 in Sudbury**

**April 2007**

## Summary of Recommendations

- 1) **A comprehensive rural and northern health strategy needs to be developed which formally links the Ministry of Health and Long-Term Care's health system transformation agenda with the provincial government's Rural Plan;**
- 2) **LHINs should pay special attention to the heterogeneous health needs of rural populations and this should be reflected in their action plans and strategies.**
- 3) **There needs to be sustained and meaningful community engagement/involvement with rural & northern communities throughout the LHIN implementation process if positive system change is to occur;**
- 4) **LHINs should broaden their consultation efforts to include other important sectors such as social services, corrections and community economic development given the impact of these 'determinants of health' on the overall health status of rural and northern communities;**
- 5) **LHINs need to share information continuously with rural communities and be very clear about their mandate and what they propose to do with respect to the delivery of health services at the local level;**
- 6) **LHINs should pay more attention to managing public and provider expectations during their transition to full authority by articulating realistic goals and timeframes;**
- 7) **The Ministry of Health and Long-Term Care and the LHINs need to explain to rural & northern communities how funding will flow to the LHINs, the accountability of the LHINs for managing this 'funding envelope' and what methodologies or formulas the LHINs will use to disburse funds to local health care providers;**
- 8) **One of the top priorities for LHINs should be improving access to health care for rural and northern communities and developing creative, flexible approaches to bring the services to the people who need them;**
- 9) **All LHINs that serve rural and northern residents need to make e-Health a priority in their planning;**
- 10) **Provincial and federal governments should continue to invest resources in e-Health initiatives which enhance information sharing; better coordinate health service delivery; and improve access to health services for rural and northern residents;**

- 11) It is recommended that funding for the development of integrated and comprehensive primary care models (e.g. Family Health Teams, Community Health Centres) continue to be made available to all rural and northern communities;**
- 12) The LHINs need to give special attention to high-need rural populations (e.g. rural elderly, rural women, rural youth, First Nation communities, francophones etc.) in their integrated health service planning; and they need to clearly articulate what specific strategies they intend to use to ameliorate the well-documented health challenges for these groups;**
- 13) A standardized evaluation template should be adopted by all LHINs to objectively assess the on-going performance and impact of implementation of this 'made-in-Ontario' regional model. To this end, the principles outlined within the regionalization policy paper by the Society of Rural Physicians of Canada would be a very useful starting point for an evaluation framework.**

## INTRODUCTION

The Province of Ontario has embarked on a significant restructuring of the health care system described by the Ministry of Health and Long-Term Care as its “Transformation Agenda”. A key component of this system transformation has been the establishment of 14 Local Health Integration Networks or LHINs ([www.lhins.on.ca](http://www.lhins.on.ca)).

According to the Ministry of Health and Long-Term Care website, *“LHINs are 14 local entities designed to plan, integrate and fund local health services, including hospitals, community care access centres, home care, long-term care and mental health within specific geographic areas...While LHINs will not directly provide services, the government is giving them the mandate for planning, integrating and funding health care services. LHINs will oversee nearly two thirds of the health care budget in Ontario - \$21 billion. They have been specifically mandated to engage people and providers in their communities about their needs and priorities”*. On March 1, 2006, the government passed the Local Health System Integration Act which provides the legislative framework for LHINs to carry out their new mandate.

Over this past year, TORC’s Rural Health Working Group has been hearing from TORC members and rural health care providers about their concerns regarding these new organizations and requests for clarification about how the LHINs will affect the organization, funding and delivery of rural health services. In keeping with its mandate, TORC in collaboration with the Centre for Rural and Northern Health Research, organized a September 25th forum in Sudbury on *“LHINs and the Future of Rural Health”*. Proceedings of this forum have already been published ([www.torc.on.ca](http://www.torc.on.ca)). The purpose of this issues paper is to provide additional context and clarity to the key issues raised by forum participants and to offer specific recommendations for LHINs as well as Ministry of Health and Long-Term Care officials overseeing the implementation of LHINs in Ontario.

The valuable information and feedback generated at the forum reveals that rural and northern stakeholders (consumers and providers) have concerns about the well-documented health status challenges of rural and northern communities coupled with the ongoing challenges in accessing health services, given travel distances and health human resource shortages. Because it is early on in the mandate of LHINs, it is not clear whether the introduction of LHINs will ameliorate or exacerbate these problems. Therefore, a number of key observations and issues have been identified in this paper which requires further discussion and action to ensure that LHINs can meet the unique health challenges faced by rural and northern communities.

## **KEY ISSUES & RECOMMENDATIONS FOR ACTION**

### **Issue #1: Rural Health Disparities**

The first speaker at the forum was Dr. Pitblado who gave a presentation on a recently-released national report which examines rural health and its determinants. The report is the result of a multi-year research project, conjointly undertaken by the Canadian Institute for Health Information, the Centre for Rural and Northern Health Research and the Public Health Agency of Canada. The report *How Healthy are Rural Canadians? An Assessment of their Health Status and Health Determinants* examines the concept of 'place' as a determinant of health, and looks at variations in mortality rates and the overall health status of rural Canadians.

#### **Key findings from this national report:**

- Generally, rural residents of Canada are less healthy than their urban counterparts;
- In general, rural residents exhibited less-healthy behaviours than urban residents (higher rates of smoking and exposure to second-hand smoke, eating less fruits and vegetables, and less physically active);
- Overall life expectancy rates are much poorer for young boys and girls in rural communities;
- General mortality rates are higher in rural communities due to chronic disease conditions, number of accidents, injuries and poisonings, incidence of suicide, rates of obesity, lack of physical activity and poorer nutrition;
- Rural communities generally showed a health disadvantage for many health-related measures examined in this study, whereas some health measures did not show any pronounced rural-urban differences;
- A higher prevalence of arthritis/rheumatism was found among rural Canadians and was higher among rural women than rural men. Few significant rural-urban differences were observed for asthma, diabetes and high blood pressure;
- Some adverse health measures, such as higher stress levels and higher incidence rates for most cancers (excluding lung cancer) were found to be more prevalent in urban areas;
- Place of residence (degree of rurality) is a contributor to health status differentials above and beyond socio-economic factors; and living in areas with low population densities is associated with special health risks.

According to Dr. Pitblado, the overall conclusion from this report is as follows:

“As this report has shown, rural residents in Canada are more likely to be in poorer socioeconomic conditions, to have lower educational attainment, to be involved in economic activities with higher health risks (for example, farming, fishing, mining and logging) and to exhibit less desirable health behaviours. These factors may be compounded by less access to prevention, early detection, treatment or support services to make good health status even more difficult to achieve in rural or remote areas”.

-CIHI, How Healthy are Rural Canadians?, (Sept. 2006)

This national report is the most recent to be released which documents the significant health challenges faced by rural and northern communities. Appendix 3 contains a listing of some of the provincial, national and international reports that have been previously released and describe some of these same rural health issues.

#### **Recommended Actions:**

- **A comprehensive rural and northern health strategy needs to be developed which formally links the Ministry of Health and Long-Term Care’s health system transformation agenda with the provincial government’s Rural Plan (<http://www.omafra.gov.on.ca/english/rural/ruralplan07/rp07-intro.htm>);**
- **LHINs should pay special attention to the heterogeneous health needs of rural populations and this should be reflected in their action plans and strategies.**

*My conventional notion of ‘rural’ was challenged by visits to different rural communities. The South East LHIN will have to take the differing and unique needs of rural communities into account as the LHIN continues its planning work.*

-Paul Huras, CEO, South East LHIN  
(Sudbury Forum, Sept. 25, 2006)

## **Issue #2: Community Engagement & Communication Strategies**

As part of their legislative mandate (Bill 36), LHINs are required to engage their communities. Forum participants heard about the recent community engagement efforts of three LHINs and while these initial engagement/consultation efforts are a good first start, the lessons learned from regional authorities in other provinces is that successful partnerships with rural communities requires sustained and ongoing community engagement processes. Also, one of the successes of the regional authority model has

been the ability to create linkages with other key sectors that have a direct bearing on the determinants of health (e.g. housing, employment, income etc.).

The LHINs are also using their initial community consultations to raise the profile of their new organizations and explain to stakeholders their role and mandate in creating more integrated local health care systems. The feedback from forum participants is that the role of LHINs still requires further clarification. As one participant noted,

*“Efforts should be made to reduce complexity and confusion over which services are to be funded and how they will be delivered versus which services are beyond the LHIN’s responsibility”.*

Finally, public and provider expectations will be much higher than the capacity of LHINs to deliver during this initial transition phase to a new regional system of care. The experience of other provinces is that the benefits of regionalization may take years to be fully achieved and all stakeholders must be committed to long-term goals.

*We need to continually seek to understand the rural context and have leaders who understand, live in, come from and are assigned to rural areas.*

-Dan Florizone, CEO, Five Hills Health Region, Saskatchewan

#### **Recommended Actions:**

- **There needs to be sustained and meaningful community engagement/involvement with rural & northern communities throughout the LHIN implementation process if positive system change is to occur;**
- **The LHINs should broaden their consultation efforts to include other important sectors such as social services, corrections and community economic development given the impact of these ‘determinants of health’ on the overall health status of rural and northern communities;**
- **The LHINs need to share information continuously with rural communities and be very clear about their mandate and what they propose to do with respect to the delivery of health services at the local level;**
- **LHINs should pay more attention to managing public and provider expectations during their transition to full authority by articulating realistic goals and timeframes.**

### Issue #3: Devolution of Authority

The implementation of LHINs in Ontario is about the devolution of funding authority to regional entities to plan, manage and integrate local systems of care. While the structure and mandate of LHINs does differ from regional authorities in other provinces, the 'made-in-Ontario' solution still represents a fundamental departure from past practice in terms of the planning and allocation of funds for health services. While the LHINs did a good job at the forum of explaining the key priorities of their first Integrated Health Services Plans (IHSPs), there was no explanation of their critical role in funding health services, nor any information provided on the process and timelines for the devolution of funding control to these bodies.

*LHINs are somewhat similar to Regional Health Authorities in all other Canadian Provinces, but also very different. Local provider boards will continue to exist. LHINs will be responsible for managing the system, not operating services.*

-Paul Huras, CEO, South East LHIN  
(Sudbury Forum, Sept. 26, 2006)

Also, there was very little mentioned at the forum about governance models, LHIN decision-making processes and the composition of LHIN boards. These boards will be making very significant decisions about the future allocation of local health resources but it is not clear if they are structured appropriately or have the capacity to make these decisions.

#### Recommended Action:

- **The Ministry of Health and Long-Term Care and the LHINs need to explain to rural & northern communities how funding will flow to the LHINs, the accountability of the LHINs for managing this 'funding envelope' and what methodologies or formulas the LHINs will use to disburse funds to local health care providers.**

### Issue #4: Access to Services

Geographic access to health services has been a continuing problem for rural and northern residents because of long travel distances, poor winter driving conditions and ongoing shortages of health care professionals. During small group discussions, lack of access to health services was a recurring theme.

*One of the key mandates of my organization is to ensure there is equitable access to health services throughout the region.*

-Andrew Will, CEO, Aspen Regional Health  
(Sudbury Forum, Sept. 26, 2006)

### **Recommended Action:**

- **One of the top priorities for LHINs should be improving access to health care for rural and northern communities and developing creative, flexible approaches to bring the services to the people who need them (e.g. mobile care)**

### **Issue #5: e-Health Strategies**

One of the few success stories in recent years for rural health care has been the introduction of e-Health strategies which have allowed certain patients to receive diagnosis, treatment and support without having to travel great distances to see a specialist (e.g. telemedicine through Ontario Telemedicine Network) or have improved the clinical coordination of care through a shared electronic health record.

*The introduction of e-health has the capacity to drastically improve health care in Northeastern Ontario, and is beginning to bridge the distance gap for many consumers.*

-David Murray, CEO, North East LHIN  
(Sudbury Forum, Sept. 26, 2006)

In the small group discussions, forum participants noted that if LHINs are serious about system integration, *“a common IT platform is an essential component to successful integration”*.

### **Recommended Actions:**

- **All LHINs that serve rural and northern residents need to make e-Health a priority in their planning;**
- **Provincial and federal governments should continue to invest resources in e-Health initiatives which enhance information sharing; better coordinate health service delivery; and improve access to health services for rural and northern residents.**

### **Issue #6: Innovative Service Delivery Models**

Dr. Mary Robertson Lacroix, Project Manager for the Innovative Rural Communities Project, reported that innovation is “alive and well in rural and northern communities” and their research is confirming that “rurality is a driver not a barrier to innovation”.

Some forum participants commented that the traditional medical model is not serving rural and northern communities well. The development of interdisciplinary primary health care teams is a viable solution to addressing physician shortages while also providing a broader continuum of care to rural and northern residents. To-date, these primary care models (e.g. Family Health Teams, Community Health Centres etc.) have been made

available to only selected rural and northern communities using labour-intensive application processes.

In the small group discussions, one participant notes that it is “*vital to think outside the box for innovative solutions to service challenges*”.

**Recommended Action:**

- **It is recommended that funding for the development of integrated and comprehensive primary care models (e.g. Family Health Teams, Community Health Centres) continue to be made available to all rural and northern communities.**

## **Issue #7: Special Populations**

The forum identified that, within a population health perspective for rural & northern communities, the poorest health status is consistently found among First Nation communities. To-date, the LHINs have not done a good job of engaging these special communities in the establishment of LHIN priorities. Forum participants also learned that Francophone communities in the north are also at a disadvantage because of their lower scores on a variety of health status measures.

France Gelinias, Executive Director of the Centre de Sante Communautaire de Sudbury, provided the following list of structural ingredients for meeting the health needs rural francophones:

### **Success Factors for Meeting the Needs of Ontario’s Rural Francophone Population:**

- 1. Interdisciplinary Team**  
Providing a single point of access, responding to multiple needs and utilizing shared resources.
- 2. Critical Mass**  
Putting collective resources expertise and personnel under one roof to become recognized and viable within the community.
- 3. Networked in their Communities**  
Important to be staffed by individuals who live in and understand the needs of the community.
- 4. Community Administration**  
Important for health organizations to be administered by local representatives who oversee a local budget and that there is flexibility in decision-making regarding these resources.
- 5. Community Governance**  
For local organizations to be effective they must be governed by local directors who are selected and accountable to the

population they serve.

**Recommended Action:**

- **The LHINs need to give special attention to high-need rural groups (rural elderly, rural women, rural youth, First Nation communities, francophones etc.) in their integrated health service planning; and they need to clearly articulate what specific strategies they intend to use to ameliorate the well-documented health challenges for these groups.**

**Issue #8: Evaluation of Regionalization**

One of the final speakers of the day was Dr. Hutten-Czapski from the Society of Rural Physicians of Canada. He explained that the SPRC has recently developed a policy paper regarding health regionalization in Canada and offered the following principles and questions that could be used to guide and evaluate regionalization efforts in Ontario:

✓ ***Stated measurable goals***

A clear definition of the problem(s) to be solved and the method by which this will be evaluated is essential. Do the LHINs have a clear definition of what they are to do and how their performance will be evaluated?

✓ ***Evidence-based decision-making***

Changes, and the implementation of new structures, must be based on available evidence. Do the LHINs have adequate access to the resources needed to make informed decisions?

✓ ***Rigorous cost analysis***

Cost-benefit analyses must include the hidden costs to patients in the form of missed work due to travel to distant services, the cost of travel to regionalized services and associated costs for family members who accompany them etc. Rural citizens carry a significantly higher financial burden than their urban counterparts when services are regionalized. Will the LHINs seek to reduce this burden?

✓ ***Definition of a viable region***

Regions must be based on sound operational principles and all levels of care from primary through tertiary care must be available to all citizens of a region. Is the region looking after its own in its sphere of services?

✓ ***Equity of access***

Rural citizens already have decreased access to health resources, services and personnel. Regionalization should reduce these inequities and not exacerbate them. Is utilization being driven by medical need or by a patient's address (postal code)?

✓ **Core services**

Care should be organized with defined local, regional and provincial services and these should be provided as close to home as practical. Regional centres should not be given money to fulfill roles for the region without requiring them to take patients from the smaller communities of a region. Does the referral hospital take patients from its catchment on the same basis as their “own” patients?

✓ **Meaningful input**

Health care professionals are in a unique position to provide useful observations/input on the organization of regions and policies respecting service delivery. Management theory supports the development of policy as close to the service provision as possible. Are LHIN boards urban dominated? Is rural input actively encouraged and, if so, how is it received?

✓ **Education & research**

Those implementing or changing regional systems must be cognizant of the need for continuing education of health professionals and the conducting of health research within the system. Will the LHINs be doing education and research?

**Recommended Action:**

- **A standardized evaluation template should be adopted by all LHINs to objectively assess the on-going performance and impact of implementation of this ‘made-in-Ontario’ regional model. To this end, the principles outlined within the regionalization policy paper by the Society of Rural Physicians of Canada would be a very useful starting point for an evaluation framework.**