# Partners for a Healthy Ontario

## A Check-up on the Municipal Role for Health

January 18, 2019

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# Executive Summary

Ontario's municipal governments are deeply invested in the public health and health care systems. This level of involvement has been evolving over time and is not generally understood by the public, Province, or stakeholders. Municipal involvement includes direct, legislated funding and service delivery, as well as indirect and sometimes voluntary efforts to address local gaps in health services. It also includes the myriad municipal services that contribute to health outcomes.

This paper reviews the current municipal role in health and provides recommendations aimed at modernizing the provincial-municipal working relationship. The provincial government is pursuing more patient-centred health services that can efficiently deliver high-quality care. With local knowledge and expertise, municipal governments can provide valuable input into the system. Given their level of financial investment, they should also have greater say over decisions that impact municipal costs and services.

Providing municipal governments with a greater voice in planning and delivery of health matters would cost the provincial government nothing, while improving public policy and better serving the people of Ontario. These changes would lead to better health outcomes in local communities in a way that is fair to property taxpayers and residents.

*Municipal Role in Health*
Municipal governments' role in health is multi-faceted, including:

- Co-funding and delivering provincial health programs like public health, long-term care, and paramedic services.
- Contributing significant capital funding for hospitals.
- Investing in accessible communities to serve persons with disabilities.
- Delivering social services, housing and recreation programs that promote healthy living, health equity, and address socio-economic factors that influence health outcomes.
- Recruiting physicians to communities that lack good access to primary care through locally funded incentives.
- Representing local health interests to health institutions and the provincial government.

Municipal governments contributed $2.1 billion for health costs in 2017, an increase of 38% over eight years. This does not include support services, like social services, housing, and recreation.

*Conclusion/Recommendations*
The current model offers municipal governments little protection against rising costs and little to no say in health planning and program delivery. Co-funded services, like long-term care, public health and paramedic services, are facing tremendous cost pressures. Costs for indirect support to health are also rising.

There is also the question of whether it is appropriate for property taxes to pay for health services when municipal governments have little say on how dollars are spent. The fact is that the health system would benefit from municipal input, which would help ensure that services are delivered to best meet local needs.

Health services planning and decision-making done through a community lens is essential. Ontario's new government has an opportunity to work with municipal governments through AMO to

improve health outcomes. This work should start with a meaningful 'government to government' dialogue about how to structure the working relationship in the most effective way possible.

This policy paper, and the more in-depth companion document, Municipal Health Issues Compendium, highlight four key recommendations to improve municipal-provincial relationships related to health:

**Recommendation #1:** That the provincial government and AMO jointly have a 'government-to-government' political forum, at least quarterly, focused on the shared interest in provincial-municipal cost-shared health programs such as paramedic services, public health, long-term care, hospital capital funding, and physician recruitment incentives. Relevant provincial ministries should also establish regular meetings with the municipal sector, through AMO, to enable information sharing and to better leverage municipal expertise in local health.

**Recommendation #2:** That the provincial government and AMO jointly have an annual policy forum to discuss broader health transformation initiatives and community health issues. The recommended form of consultation is the Deputy Minister with AMO's Health Task Force.

**Recommendation #3:** AMO calls upon the Province to mandate a municipal voice in legislation into health care service planning and decision-making by the Local Health Integration Networks (LHINs). Despite delivering health services, municipal governments do not have ways to provide input on program design. Relationships between Local Health Integration Networks (LHINs), municipal governments, and District Social Service Administration Boards (DSSABs) are inconsistent across the province. Improving and standardizing this relationship would help ensure that municipal government knowledge is integrated into local system planning and management of the health care system.

**Recommendation #4:** AMO calls upon the Province to adopt a 'health in all policies' approach and work with municipal governments, public health units, and their associations to inform such an approach. This approach encourages policy makers to systematically consider the health implications of any policy decision. By considering health when developing policy across various ministries and agencies, people will be better served. By addressing the social determinants of health, like income, gender race and sexual orientation, the "health lens" can improve overall population health and reduce health inequities.

# Introduction

The municipal order of government in Ontario plays a significant role in the public health and health care systems, both directly and indirectly. Besides funding and delivering provincial health programs like public health, long-term care and paramedic services, municipal governments contribute considerable amounts of capital funding for hospitals. They provide incentives to recruit physicians to practice in their communities. More broadly, they create accessible communities for persons with disabilities and healthy built environments. Residents also increasingly look to their municipal councils to represent their local health interests to health institutions and the provincial government.

This often-overlooked municipal role in the health system comes with a sizeable financial contribution from municipal property taxpayers. Municipal governments have had to invest more and more in the public health and health care systems to meet rising costs. As well, municipal governments commonly step up to fill in gaps in provincial services at the community level. This is especially true when it comes to providing services for the most vulnerable and providing better access to high-quality care.

Municipal governments paid $2.1 billion for health costs in 2017. This is an increase of 38% since 2009 when municipal spending in health totaled $1.5 billion.[1] This figure does not include municipal funding for a range of services that promote health equity, address the social determinants of health, and contribute to healthy living and outcomes. These services include affordable housing, social services, and recreation programs.

The Association of Municipalities of Ontario (AMO) has examined how the municipal role for health should evolve to meet the needs of residents in an effective, efficient and fiscally sustainable manner. The future role of municipal government must be redefined to reflect its growing role. This will involve rethinking provincial and municipal government roles, responsibilities, and engagement practices for our public health and primary health care systems. Going forward, municipal governments need to participate fully in health policy and planning processes as equal partners, not as mere stakeholders. They also need to safeguard against rising costs and advocate for enough funding to ensure high quality service.

Frankly, municipal governments question why they should invest so heavily in provincial health care and public health systems, when they have so little say in health care policy and programs. Withdrawing support isn't a viable option – municipal governments are too committed to the well-being of their communities. The obvious and practical approach is to include municipal governments in program design and delivery so that local property tax funding is used effectively. However, it will involve changes to how the Ministry of Health and Long-Term Care, and its agencies, make decisions.

As the order of government that is closest to the people, and one that is making a significant financial investment in health-related services, municipal governments need to have a meaningful say. AMO shares the provincial government's interest in patient-centred health services that are effective, efficient, and provide the highest quality of care. Our aim is to work in partnership with

[1] AMO calculations from Schedules 12, 40 and 51, Provincial Summaries by Schedule, Financial Information Returns, Ministry of Municipal Affairs and Housing, 2009-2017. Note- this includes services that contribute to the health of seniors.

the provincial government to build and sustain healthy communities for the people of Ontario. This paper explores how we can work together to achieve this goal.

# Objectives

**Define the Municipal Role in Public Health and Primary Health Care Systems:** The first objective is to start an overdue conversation with the provincial government about the appropriate municipal role in the public health and primary health care systems. This includes discussing opportunities for collaboration and engagement to improve health outcomes within an overall province-wide vision for health. The goal is to secure the appropriate and fair level of "local say for pay" in health matters that property taxpayers deserve.

**Promote Awareness of the Municipal Role in Health Care:** There needs to be greater awareness among AMO's membership and the public about the evolving and growing role of municipal government in health care. In particular, municipal governments need to learn how they can advocate to promote their interests, improve services in their communities, and protect against rising costs.

**Encourage a "health in all policies" approach to provincial policy-making:** This would require the Province to apply a "health lens" to all policy making across ministries and agencies, using a 'whole of government' approach. This would allow the government to maximize opportunities to promote healthy and prosperous communities.

This is not a comprehensive review of all the health issues confronting Ontario. Rather, it is focused on ways to modernize the provincial-municipal working relationship when it comes to health. Providing municipal governments with a greater voice in planning and delivery of health matters would cost the provincial government nothing, while improving the public policy and better serving the people of Ontario. These changes will lead to better health outcomes in local communities in a way that is fair to property taxpayers and residents.

To accompany this discussion paper, AMO has developed "A Health Compendium of Municipal Health Activities and Recommendations". This companion document provides an overview of municipal activities and interests in health. It also includes recommendations aimed at improving patient outcomes and system performance in areas of municipal involvement. Notably, the compendium includes detailed recommendations about governance, planning, and funding. These recommendations will serve as a starting basis for conversation with the provincial government once enhanced consultative processes are in place.

This discussion paper and the compendium are both products of AMO's Health Task Force.[2] They represent the position of the AMO board.

[2] AMO's Health Task Force is a representative group comprised of municipal elected officials and senior staff across the province. The list of the current membership who informed the development of this paper is found In Appendix A.

# The Evolving Municipal Role in Health

Municipal governments need to consider their evolving role in health and the appropriate level of municipal participation in health policy, planning, and delivery. This is especially timely as health services strive to become more patient-centred and community driven. There needs to be a clear municipal role within a broader province-wide vision for health care.

The *Constitution Act, 1867,* gives the provincial government full powers to provide health care services. The provincial government also has jurisdiction over municipal governments and can therefore mandate a municipal role in provincial health activities. In Ontario, municipal governments fund and deliver more health services than in other provinces and territories. In some cases, this municipal role is formally required under specific provincial legislation and regulations. They co-fund and deliver health services such as paramedic services, long-term care, and public health. Municipal governments have a clear interest in how the provincial government directs these programs.

Municipal governments also get involved with health care informally, to better meet the needs of local residents. Funding for hospitals and for physician recruitment incentives continues even though it is not required by legislation. Municipal governments fill in gaps in provincial funding to respond to service needs in the local community. Lastly, section 130 of the *Municipal Act*, enables municipal governments to "regulate matters […] for purposes related to the health, safety, and well-being of the inhabitants of the municipality".[3]

There is much more at play than the delivery of services that treat patients, promote health, and prevent harm. Municipal governments act and advocate on health matters because their residents increasingly expect their councils to do so. This may be because people have few ways to voice their views directly, and because there is a general lack of coordination across all health service providers.

Many municipal governments help people to navigate the many different services available in the community, including health services. An example of this is municipal funding for 2-1-1 operations in many areas, which provide local residents with information and referral to community services. A more integrated system of care between municipal and provincial services would improve health outcomes and create efficiencies that should also improve access.

A discussion on health is not complete without examining the role of municipal social services in improving overall population health. As key social service providers and community builders, municipal governments and their partners, including public health units and District Social Service Administration Boards (DSSABs), have significant influence over the social determinants of health affecting a community. It is well understood that a person's place in society has a direct impact on their health. A range of economic and social conditions – such as housing, income, education, and employment – influence individual and group differences in health status.

[3] For a fuller explanation of the current government roles and responsibilities, see background information in Appendix B of this paper.

Discrimination or historical trauma are also important social determinants of health for certain groups such as Indigenous People.[4] Together municipal governments, DSSABs and Public Health Units have a role to play in addressing health inequities by addressing the social determinants of health.

Municipal social services and health promotion activities can lead to better and more equitable health outcomes. For example, municipal social and recreation programs for seniors promote physical activity and address senior isolation. These municipal services keep seniors happy, healthy and independent for longer, improving overall health outcomes and quality of life.

Affordable and social housing for seniors addresses another one of the social determinants of health for this population, especially in rural and northern areas. In fact, investing in affordable housing broadly can prevent illnesses and lead to improved health outcomes, reducing the burden on health services.

Municipal approaches to the built environment also help create healthier communities. Promoting active lifestyles by installing bicycle lanes and planning walkable communities encourages people to be social and active. This prevents and postpones chronic health conditions that are costly to the provincial health care system.

Researchers and public health experts maintain that investing in health promotion and social services now will result in future cost savings to the health care system as populations age. In the U.S., researchers have estimated that every dollar spent on prevention and health promotion results in a $3.48 financial return in reduced costs to the medical system.[5]

A recent Canadian study demonstrates that spending one more cent on social services for every dollar spent on health care would increase the life expectancy for Canadians by five years, while reducing avoidable mortality by three percent.[6] This evidence further demonstrates municipal governments and DSSABs are essential players in promoting positive health outcomes for Ontarians.

Despite the evolving municipal role in health, there has been little corresponding change to municipal input into health policy, planning, and funding decisions. In addition, there is little protection against rising costs. Municipal governments often raise the issue of whether it is appropriate for them to pay for health services from the property tax base, especially since they have little say on how these dollars are spent. Already stretched, the property tax base barely covers core-mandated responsibilities within the current fiscal environment, let alone the provincial responsibility for health services. Municipal governments do their best to meet resident needs using only nine cents of every household tax dollar. Funding more health costs is not an option.

[4] Canada, Government of. "Social Determinants of Health and Social Inequalities" at: https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

[5] Ron Z. Goetzel et al.,"Can health promotion programs save Medicare money?" *Clinical Interventions in Aging* 2 (1): 2007.

[6] Daniel J. Dutton et al., "Effect of provincial spending on social services and health care on health outcomes in Canada: an observational longitudinal study," *Canadian Medical Association Journal* 190 (3): 2018.

# Principles for the Municipal Role in Health

When considering the appropriate municipal role in health, first principles guide the way. The recommendations in this paper and its accompanying compendium flow from these principles detailed below.


**Program Delivery Subsidiarity –** Services are most responsive to residents when delivered at the most local scale that is feasible.

**Funding –** As health care is a provincial area of responsibility under the Canadian Constitution, costs should not be borne by the property tax base. There is one exception: public health (population health) should be a shared provincial-municipal responsibility since it historically originated in municipal government.

**Local Pay/Local Say –** As municipal governments co-fund many health services, there should be a corresponding 'local say for local pay.' In other words, municipal input on provincial policy decision-making and planning is essential as a matter of fairness. It will also inform good public policy and planning decisions.

**Governance/Engagement –** As municipal councils are closest to the people, they should have a well-considered voice and clear ways to represent local interests to the provincial government and health institutions to inform planning and funding decisions.

# Municipal Involvement in Provincial Health Policy, Planning and Funding Decisions

Given that municipal government and DSSABs are on the front lines, it is necessary, fair and appropriate that they are involved in health policy, planning, and funding decisions.[7] Despite delivering health services for people, municipal governments do not have ways to provide input on program design. It is appropriate that the provincial government talk frequently with municipal governments through AMO given the impact on municipal finances and the quality of services.

**Recommendation:** That the provincial government and AMO jointly have 'government-to-government' political forums, at least quarterly, focused on the shared interest in provincial-municipal, cost-shared health programs such as Emergency Medical Services, Public Health, Long-Term Care, hospital capital funding, and physician recruitment incentives. Relevant provincial ministries should also establish regular meetings with ***the municipal sector through AMO,*** use of municipal working groups to share information and better leverage municipal frontline expertise in local health.

**Recommendation**: That the provincial government and AMO jointly have an annual policy forum to discuss broader health transformation initiatives and community health issues. The recommended form of consultation is with the Deputy Minister with AMO's Health Task Force.

Improving interactions between Local Health Integration Networks (LHINs), municipal governments, and DSSABs is important. LHINs are responsible for local system planning and management of the health care system. Relationships between the LHINs and municipal governments vary across Ontario. Some have productive working arrangements, while others report that the relationship could improve. Municipal governments have "on the ground" knowledge of communities that can help inform planning and funding decisions for local health services.[8] This opportunity should not be lost.

There are several ways to improve local relationships. LHINs could be required to consult with municipal governments throughout the year, such as at a Council meeting. Municipal governments could also be included more as representatives on LHIN advisory bodies. AMO is not recommending that municipal governments have representation on the Board of LHINs at this time. Ultimately, we need to explore different ways to make the relationship work better.

LHINs also need to think beyond health provision and make connections with municipal governments and DSSABs by consulting with them on matters of provincial policy. There is great unrealized potential to work together more closely. For example, on initiatives aimed at ending homelessness, addressing the opioid crisis and better serving people with mental health conditions

[7] For a complete list of key AMO recommendations, see Appendix D.

[8] For an explanation of the current LHIN structure and relationships to government and health providers, see Appendix C of this paper.

and addictions. Further consultation on potential partnership opportunities, like shared service hubs, would also be valuable.

There is a precedent to mandate an appropriate relationship in legislation. For example, other acts governing school boards require consultation and/or co-operation on local planning with municipal governments and DDSABs. An example is the *Education Act* and the *Child Care and Early Years Act*, which sets out obligations between municipal governments, DSSABs and school boards.

**Recommendation:** AMO calls upon the Province to mandate, through legislation, a municipal voice in health care service planning and decision-making by the Local Health Integration Networks (LHINs).

# Health in All Policies

It is beneficial to apply an overall health lens when developing policy, regardless of the policy area. Many public health units and their associations, including the Association of Local Public Health Agencies (alPHa), have asked the provincial government to use an 'all of government' approach to health by adopting a 'health in all policies' lens.

'Health in all policies' encourages policy makers to systematically considers the health implications of any policy decision. By considering health when developing policy across government in various ministries and agencies, people will be better served. By addressing the social determinants of health, like income, gender race and sexual orientation, the "health lens" can improve overall population health and reduce health inequities. A recent positive example of how this works is the recent Ontario Government announcement that mental health and addictions factors will be considered as part of social assistance reform. Policing initiatives that match mental health support workers with police officers on calls involving individuals experiencing a mental health crisis are another positive example. Similarly, the development of walkable communities, which encourage people to be more active, improves health outcomes. Further work with public health units and their associations could help implement such an approach.

**Recommendation:** AMO calls upon the provincial government to adopt a 'health in all policies' approach and work with municipal governments, public health units and their associations to inform such an approach.

# Conclusion: Looking Forward and Next Steps

In Ontario, the municipal role in health cannot be underestimated. While health is a provincial responsibility in the Constitution, Ontario's municipal governments contribute to patient and community health outcomes in many ways. Despite this involvement and funding, municipal governments do not have a voice in provincial health planning and decision-making. This is detrimental to the public policy process. The provincial government should take advantage of the 'on the ground' frontline experience that municipal governments and DSSABs have to offer.

Ultimately, it is also not fair or appropriate for local property taxpayers to foot the bill for gaps in provincial funding for health services. If municipal government are to help finance the provincial health system, they must have "local say for local pay".

Health services planning and decision-making done with a community lens is possible and essential. Ontario's new government has an opportunity to work with municipal governments through AMO to improve health outcomes. This work should start with a meaningful 'government to government' dialogue about how to structure the working relationship in the most effective way possible.

AMO and its member municipal governments are prepared to step up and provide our best advice on health planning, governance and funding decisions. This will ultimately benefit the people of Ontario. Working together, the municipal and the provincial orders of government can improve health outcomes for all in an effective, fair, and appropriate manner.

AMO is ready for this conversation. We expect that the provincial government will be, too.

## Appendix A – AMO Health Task Force Membership (as of November 2018)

Mark Taylor, Chair, Deputy Mayor/Councillor Ward 7, City of Ottawa
Graydon Smith, Vice-Chair, Mayor, Town of Bracebridge
Gary Carr, Regional Chair, Region of Halton
Katherine Chislett, Commissioner of Community & Health Services, Regional Municipality of York
Norman Gale, City Manager, City of Thunder Bay
Jesse Helmer, Councillor Ward 4, City of London
Michael Jacek, Senior Advisor, Association of Municipalities of Ontario (AMO)
Bernie MacLellan, Mayor, Municipality of Huron East
Dan McCormick, CAO, Rainy River District Social Services Administration Board
Leslie Muñoz, Policy Advisor, Association of Municipalities of Ontario (AMO)
Liana Nolan, Medical Officer of Health/Commissioner, Public Health, Region of Waterloo
Jim Pine, Chief Administrative Officer, County of Hastings
Nancy Polsinelli, Commissioner of Health Services, Region of Peel
Neal Roberts, President, Ontario Association of Paramedic Chiefs (OAPC)
Loretta Ryan, Executive Director, Association of Local Public Health Agencies (alPHa)
Donald Sanderson, CEO & Secretary Treasurer, West Parry Sound Health Centre
Alan Spacek, Mayor, Town of Kapuskasing and Chair, Federation of Northern Ontario Municipalities
Don Studholme, CAO, District of Timiskaming Social Services Administration Board
Monika Turner, Director of Policy, Association of Municipalities of Ontario (AMO)
Mabel Watt, Manager, Policy Integration (CAO's Office), Region of Halton

## Appendix B – Government Roles and Responsibilities

Our publicly funded health care system provides health services in a fair and equitable manner. It is a valued part of our Canadian identity and a vibrant component of our communities. The *Canada Health Act* sets out the principles that govern our health care system. Its core purpose is to ensure that all residents have reasonable access to medically necessary hospital and physician services. The principles that frame the *Canada Health Act* are: Public Administration; Comprehensiveness; Universality; Portability; and Accessibility.

The *Constitution Act, 1867*, gives the provinces and territories responsibility for the management, organization and delivery of health services for their residents, while the federal government has the power to tax, distribute funding and create legislation, as long as this does not infringe upon provincial powers. The provincial/territorial programs must satisfy the requirements under the *Canada Health Act* to qualify for the federal cash contribution under the Canada Health Transfer (CHT).

Provincial legislation is organized into three main areas to support the management and delivery of health care services:

1. Legislation that governs health care professionals with regards to scope of practice and regulatory colleges;
2. Legislation that governs providers with regards to operations e.g. hospitals, public health, and;
3. Legislation that governs administrative bodies e.g. Local Health Integration Networks.

In addition to the legislative framework, the provincial government is responsible for setting the funding and fiscal frameworks for the delivery of health care services.

Combined with constitutional powers over health care delivery, the provincial government also has jurisdiction over municipal governments. It can therefore mandate a municipal role in provincial health activities. In Ontario, municipal governments share in the funding and delivery of health care services in specific sectors, both formally as required by specific provincial legislation, e.g. *Ambulance Act,* and *Health Promotion and Protection Act*; and informally by providing services to meet the needs of its communities. In addition, Section 130 of the *Municipal Act*, enables municipal governments to "regulate matters not specifically provided for by this Act or any other Act for purposes related to the health, safety, and well-being of the inhabitants of the municipality".

Ontario's health care system is a complex network of different health care organizations and providers, working together to meet the health care needs of Ontarians. The Ministry of Health and Long-Term Care (MOHLTC) provides overall direction and leadership for the system. The provincial government is also generally responsible for capital funding of hospitals, for example. The 14 Local Health Integration Networks (LHINs) in Ontario, formed in 2006, were to move health care administration from the provincial level to the local level (albeit not municipal).

In addition to allocating funds to non-municipal health care providers across the region, the LHINs also work with each provider to plan, engage and make decisions at a local level, with the goal to improve the health care system. LHINs are responsible for hospitals, long-term care homes, community support services, Community Health Centres, and addictions and mental health agencies. They are also responsible for the direct delivery of home care, formerly delivered by the Community Care Access Centres. They do not have responsibility for physician negotiations and

billing; public health, paramedic services (with the exception of community paramedicine) or provincial networks (e.g. Cancer Care Ontario).

While the MOHLTC provides the strategy and oversight at the provincial level, the LHIN provides regional-level oversight and strategy. The Board of Directors of each health service provider is responsible for organization-level oversight and strategy.

Municipal governments and District Social Service Administration Boards (DSSABs) have relationships with both the LHINs and with the Ministry. They interact with the Ministry on funding and program delivery for public health and paramedic services. There is interaction with the LHINs on long-term care, community paramedicine, and support services to social housing. By law, public health units work with LHINs to share one another's planning activities.[9]

The role of Ontario's municipalities in health care is unique when compared to other provincial jurisdictions. Municipalities outside Ontario typically have little to no formal role in their respective provincial health systems. Instead, services are delivered and funded either provide-wide by a provincial health authority or regionally, by regional health authorities comparable in many ways to Ontario's LHINs.

Ontario's approach to public health is also distinct from other provinces. While public health in other Canadian jurisdictions is delivered and funded through provincial or regional health authorities, Ontario has 35 public health units cost-shared between municipal governments and the Province that operate separately from the LHINs. There are different governance structures in place for the units. Autonomous boards integrated into municipal structures govern four of these public health units; another four are governed by boards consisting of the councils of single-tier municipalities; six are councils of regional municipalities; and the remaining 22 are autonomous boards that operate separately from the administrative structure of their municipalities, but which have elected municipal representatives on the board.

Another key distinction of municipal governments for health in Ontario, when compared to other provinces, relates to the municipal role in emergency services and long-term care. Ontario is the only province where municipal governments are directed by legislation to play a role in funding and delivering these health services. Delivery of long-term care and paramedic services is provincially or regionally in other jurisdictions.

[9] Further detailed information on these relationships with LHINs and the Ministry found in Appendix C of this paper.

## Appendix C – The Role of Local Health Integration Networks in Ontario

As noted previously, 14 Local Health Integration Networks (LHINs) were created in 2006, formalized through the *Local Health System Integration Act*. LHINs were created as non-for-profit corporations to work with local health providers and community members to determine the health service priorities in each of their regions. LHINs are specifically responsible for funding (in one case delivering) the following:

- Hospitals
- Home care *direct delivery of services (formerly Community Care Access Centres)
- Long-Term Care
- Mental Health and Addiction Services
- Community Health Centres
- Community Paramedicine.

Services related to public health, ambulance services, physicians, and laboratories remain the responsibility of the provincial Ministry of Health and Long-Term Care.

The LHIN catchment service areas are determined using hospital service areas (HSAs) and patient data to note patients' home location in relation to the hospital, grouped into larger hospital specialist referral regions. Boundaries based on postal codes do not match municipal boundaries.

The *Local Health System Integration Act* outlines the governance structure for the LHINs including board powers and composition. LHINs operate as not-for-profit corporations with a board of no more than nine members appointed by the Lieutenant Governor in Council. The LHIN Board is responsible for appropriate by-laws and for conducting and managing the affairs of the LHIN. Each LHIN is also required to establish a Health Professionals Advisory Committee that is comprised of health care professionals, including doctors and nurses. Under the legislation, the LHINs must also enter into an accountability agreement with the Ministry of Health and Long-Term Care (MOHLTC) known as the Ministry-LHIN Performance Agreements (MLPA). The MLPA notes that the Ministry remains the steward of the health care system responsible for setting provincial strategic direction and priorities as well as developing legislation, regulations, standards, and policies.

The legislation further stipulates that each LHIN will develop an integrated health service plan (IHSP) with input from their community. Defined in legislation, community refers to patients and other individuals within the geographic boundary, health service providers and any other person or entity that provides services in or for the local health system, and employees involved in the local health system. As part of this engagement, Indigenous and First Nations and French-language health planning entities must be included. A key goal of the community/stakeholder engagement is to involve the community in regional health system priority setting and planning while considering local capacities, needs, geographic and socio-demographic challenges. The level of municipal involvement in the development of the IHSPs appears to be minimal and, in some cases, non-existent. It is challenging because LHIN boundaries, based on hospital service areas, may overlap many municipalities. Conversely, some municipal governments may have to interact with several LHINs to address the needs of their communities.

LHINs have funding authority under the *Local Health System Integration Act* for which they are required to enter into a service accountability agreement with the designated health service providers including municipal governments and District Boards of Management that operate long-

term care homes. These agreements have evolved into multi-sectoral service accountability agreements (M-SAA). In addition to setting out the provision of services and associated funding, the M-SAA sets out both accountabilities and performance expectations for the service providers. While the LHIN has financial authority for those health services providers under its purview, the Ministry of Health and Long-Term Care (MOHLTC) is responsible for determining the funding allocation and establishing the funding framework under which both MOHLTC and LHINs manage the health care system.

IHSPs aim to meet the health care service needs of communities. LHINs would do well to engage municipalities explicitly in the development and implementation of these strategies as well as planning for health services within the community. In addition, LHINs are tasked with implementing provincial strategies within their local context (e.g. aging at home strategy). Some strategies can be prescriptive, while others may allow for flexibility and innovation to accommodate community needs. LHINs engage their health service providers to implement various initiatives and may not seek the input/advice of municipalities from a community perspective.

Ontario should seize the opportunity to build the municipal relationship into the current process. At present, there is no formal method or requirement to engage municipalities in this process. It happens on an ad hoc basis and is inconsistent across the province. However, it is important to note that municipal engagement with LHINs locally does not necessarily influence health policy and programs at the provincial level.[10]

[10] Two reports were developed to inform how health inequities could be addressed including by LHINs following the development of an overall provincial strategy. They are published by Health Quality Ontario: "Health Equity Plan" http://www.hqontario.ca/Portals/0/documents/health-quality/Health_Equity_Plan_Report_En.pdf and Northern Ontario Health Equity Strategy https://www.hqontario.ca/Portals/0/documents/health-quality/health-equity-strategy-report-en.pdf

## Appendix D – Summary of Recommendations

**Recommendation #1:** That the provincial government and AMO jointly have a 'government-to-government' political forum, at least quarterly, focused on the shared interest in provincial-municipal cost-shared health programs such as paramedic services, public health, long-term care, hospital capital funding, and physician recruitment incentives. Relevant provincial ministries should also establish regular meetings with the municipal sector, through AMO, to enable information sharing and to better leverage municipal expertise in local health.

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