FINAL REPORT

REGIONAL GOVERNMENT'S ROLE IN HEALTH CARE

Regional government working with the community for better health

Task force on regional government's role in health care

Councillors Madeleine Meilleur and Alex Munter

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BACKGROUND

Ottawa-Carleton's health care system is undergoing dramatic changes. We are seeing huge shifts in the acute care hospital sector, hospital bed closures and hopefully reinvestment in the non-hospital health sector (long-term care, home care and community health services). Over the past year, this uncertainty has heightened rather than diminished as, bit by bit, the plan outlined by the Ontario Health Services Restructuring Commission is changed and modified and the Commission itself disbanded.

Each hospital is undertaking changes, each part of the system is firmly-focused on its piece of the health puzzle and groups of consumers are advocating for services they are most concerned about. But who is looking after the big picture in our community?

Last year, Regional Chair Bob Chiarelli appointed members of Council to prepare reports on various issues facing our community. Councillors Madeleine Meilleur and Alex Munter, both of whom have had significant involvement in community health issues, were appointed by the Chair as the Health Care Task Force to prepare a report on what role the region should take on this issue.

Regional government, representing all residents of Ottawa-Carleton, must take leadership to ensure the health care system responds to our population's changing health needs and that the coming transformation works.

The region has responsibility for the delivery of long-term care services (through public nursing homes), many health services (immunization, sexual health clinics, seniors' services, care for newborns and more), numerous health-related social services (low-income dental care, assistive medical devices, catastrophic drug costs and other services) and is taking on the task of providing land ambulance service. Since 1973, Regional Councillors have participated as members of the District Health Council and, over the past decade, the region has provided capital grants of almost $60 million to health services, mostly to hospitals.

Councillors Munter and Meilleur issued a discussion paper – Keeping Ottawa-Carleton Healthy – in June 1998. The paper looked at some of the current issues in health care, proposed some ideas and set out two questions for discussion:

- Should the region appoint a Community Health Advocate in its Health Department who would monitor the state of health care, identify gaps in service and work with the community and health agencies to improve care?

- Should a committee of elected Regional Councillors be involved in making decisions about health care budgets and priorities?

In the fall, Regional Council also asked Councillors Munter and Meilleur to review the current regional Health Care Facilities Capital Fund and make recommendations on how it could best be used to serve the community's current needs.

WHAT THE PUBLIC SAID

Nearly 200 individuals and organizations participated in the public consultation process. They submitted briefs, wrote letters and e-mails, met with one or both of the councillors or attended public consultation sessions. Minutes of the public sessions are attached. Written input is available on request.

In the consultation, participants generally agreed that:

- There is confidence in the quality of our local health care agencies and institutions and their highly-competent personnel, but there is significant concern in the community about the pace of change to Ottawa-Carleton's health care system.

- There has been a lack of reinvestment in community health services (like homecare, long-term care or community mental health) to fill the gaps created by cuts to hospitals.

- Individuals are uncertain about where to go to access services, where they can get information and who to call if they have a concern or question.

- The system is actually an unsystem, poorly co-ordinated, in which each agency tries to make the best decisions within its own silo of responsibility, not always aware of the impact those decisions will have on others.

- Regional government has an important role to play both in delivering services and in health care planning and policy-making.

- There was general support for the principle that the Health Department should be an advocate for a good health delivery system.

There was a fair amount of disagreement through the public consultation on a number of points, including:

- While there was agreement that the system is poorly co-ordinated or integrated, there was no agreement on how to fix that problem.

- There was no consensus on the proposal that Regional Council take on the role of a “regional health authority”, setting budgets for hospitals within an envelope designated by the province. Some felt this would increase accountability and local control. Others felt Council did not have the expertise to handle such questions and that they would become overly-politicized. Agencies and hospitals reacted particularly negatively to this notion.

- Many participants were concerned that transferring decision-making about health care budgets to a committee of elected Regional Councillors could lead to minority concerns being overlooked or over-politicization of issues.

- There was concern, particularly on the part of agencies, that devolving responsibility for health care funding decisions to the local level could leave to the provincial government reducing its financial commitments to health services.

SUMMARY OF RECOMMENDATIONS

1) **THAT** the Regional Chair hold an annual summit on the state of health care in Ottawa-Carleton, involving stakeholders and the general public, to give the public an opportunity to express concerns and for institutions to respond to them.

2) **THAT** the Ottawa-Carleton Health Department's terms of reference be amended to include advocating for a quality, accessible health delivery system as a determinant of health; and **FURTHER THAT** the duties of one of Ottawa-Carleton's Associate Medical Officers of Health be revised to include an advocacy role with respect to the health care delivery system.

3) **THAT** Regional Council support the creation of an independent ombudsman function, where patients, their families and residents can access the right of complaint and independent investigation; and **FURTHER THAT** such a function exist separately from the region, hospitals and other health care institutions, for example by expanding the jurisdiction of the Ombudsman of Ontario to cover health care services or by attaching this role to another independent agency.

4) **THAT** the Region work towards the goal of establishing a consolidated 24-hour health information line for Ottawa-Carleton and that funds be allocated for a study that brings community partners together to prepare the detailed proposal for such a line; and **FURTHER THAT** the region's contribution to operating such a line on a pilot-project basis come from within existing resources dedicated to similar functions, from restructured health care reserve funds (see recommendation 5) and from provincial or federal health funding.

5) **THAT** in accordance with provincial legislation banning the use of development charges for public hospitals, the remaining balance of $3.8 million in the Hospital Regional Development Charges Reserve Fund be earmarked for non-hospital health community health services with a priority to those projects that will reduce use of the acute care hospital sector; and **FURTHER THAT** this task force report be referred to regional finance staff for their review and that they report back to the Corporate Services and Economic Development Committee on June 15, 1999 regarding the possibility of including a component in the revised Regional Development Charges by-law for community health needs; and **FURTHER THAT** the Finance Department be directed to prepare a report on the feasibility of exempting hospitals, long-term care facilities and other non-profit health care institutions from paying development charges when they undertake new construction or expansion.

6) **THAT** Regional Council reaffirm the position it took in 1996 that it is prepared to take on the health planning and co-ordination function currently performed by the District Health Council in order to increase accountability and transparency in the health care system; and **FURTHER THAT** Council call on the provincial government to investigate the options for increasing the level of real decision-making in health care at the local level, examining the model of regional health authorities in existence in other places in Canada.

RECOMMENDATIONS

1. THAT the Regional Chair hold an annual summit on the state of health care in Ottawa-Carleton, involving stakeholders and the general public, to give the public an opportunity to express concerns and for institutions to respond to them.

Most participants were thankful for the opportunity to have a discussion about health care issues. They pointed out that citizens rarely have such an opportunity and said that, through the discussion, they both learned more about the system and had a chance to express themselves.

As the only elected official who represents all citizens of Ottawa-Carleton, the Regional Chair has a unique convening authority and the ability to bring people together. In the past, this has been used to bring players together on everything from economic development to youth services.

An annual forum – where representatives of hospitals, health care agencies, public health and others would be on hand – would be a useful opportunity for the exchange of opinions and identifying public concerns. In a small measure, it would help address some of the public concerns about accountability and accessibility.

It is proposed that the consensus from such a summit be presented to the Ministry of Health, local hospitals and other health care institutions for their follow-up action.

2. THAT the Ottawa-Carleton Health Department's terms of reference be amended to include advocating for a quality, accessible health delivery system as a determinant of health; and

FURTHER THAT the duties of one of Ottawa-Carleton's Associate Medical Officers of Health be revised to include an advocacy role with respect to the health care delivery system.

There was general agreement that there was an important role for the Health Department in monitoring changes to the health care system. This is already done, but on an ad hoc basis. For example, during the past year the Health Department has issued reports on the early discharge of mothers and newborns and about the impact of proposed health restructuring.

Public health is constantly evolving and has always had an advocacy role. One hundred years ago, it public health officials pushed for safe drinking water to prevent outbreaks of cholera. Fifty years ago, municipal dumps were under the jurisdiction of the Medical Officer of Health and 30 years ago, public health was involved in family planning and sex education, even before contraception was legal.

Much research has been done in recent years on what keeps people well. These “determinants of health”, as they are known, have been identified to be essentials like adequate shelter, income and education. Interestingly, an accessible, quality health care system is rarely identified as a determinant of health. Clearly, however, the absence of some health services is affecting the health of many residents.

This discussion paper proposed the creation of a Community Health Advocate position within the Ottawa-Carleton Health Department. This final report modifies that initial proposal by attaching this function to an existing Associate Medical Officer of Health and equipping that person with the resources to fulfill this task. This role would include:

- Supporting community efforts to improve health in Ottawa-Carleton.
- Presenting an annual report to Council on the state of a specific part of the region’s health care system, gaps in service and what needs must be addressed. For example, the Associate Medical Officer of Health might investigate the adequacy of trauma response one year and discharge policies in another.
- Conduct ongoing public health research and analysis.
- Participating in consultation and advocacy with other organizations and government departments on changes to the health care system.

3. THAT Regional Council support the creation of an independent ombudsman function, where patients, their families and residents can access the right of complaint and independent investigation; and

FURTHER THAT such a function exist separately from the region, hospitals and other health care institutions, for example by expanding the jurisdiction of the Ombudsman of Ontario to cover health care services or by attaching this role to another independent agency.

One of the most frequent issues raised by participants in the consultation was the need for a place for individuals to go when they have trouble accessing services or have concerns about their treatment.

The multiplicity of health care boards, councils and agencies makes it difficult for people to know where to turn. While there are complaint processes in place to deal with the actions of an individual doctor, nurse or other health care professional, the institutions within which these professionals work are not subject to accountability measures.

In her 1997-98 annual report, the Ombudsman of Ontario pointed out: *"At a time of dramatic change in Ontario's hospital and health care system, providing an independent and effective recourse of last resort, whether through a separate office or through Ombudsman Ontario, for persons who are not satisfied with the way their complaint was dealt with by hospitals, provides appropriate accountability, and helps ensure public confidence."*

Currently, the Ombudsman has jurisdiction only to handle complaints relating to services directly run by the Ontario government. Arms-length organizations that are entirely funded by the government, like hospitals or home care, are exempted from its reach.

A simple solution would be to expand the jurisdiction of Ombudsman Ontario to cover hospitals. Another would be to mandate hospitals to fund such a function, but have it administered separately. There are many other options, but the bottom line is that the province needs to put in place some clear measures of accountability and transparency. This is particularly necessary at a time when the system is undergoing so many changes and many people are concerned about their ability to access the services they need.

4. THAT the Region work towards the goal of establishing a consolidated 24-hour health information line for Ottawa-Carleton and that funds be allocated for a study that brings community partners together to prepare the detailed proposal for such a line; and FURTHER THAT the region's contribution to operating such a line on a pilot-project basis come from within existing resources dedicated to similar functions, from restructured health care reserve funds (see recommendation 5) and from provincial or federal health funding.

Across the Ottawa River in the Outaouais, a 24 hour/seven-day-a-week phone line has had tremendous success in both keeping people healthy and reducing demand on the health delivery system.

One of the first of its kind in the province of Quebec, it opened in 1986 and has proved such a success that the Quebec Ministry of

Health has mandated that such 24/7 lines be opened across the province. A 1995 study by the Quebec government showed that of those using such a service, 52% would have gone to an emergency room and 21% would have headed for a physician's office if they had not had access to the line. The study concluded that such lines were an invaluable resource in taking pressure off of the acute care health system.

In West Quebec, the line is staffed by 12 (full-time equivalent) registered nurses and has an annual budget of $850,000. It handles over 64,000 calls annually. It has developed a professional and technical reference system that has been bought and is being pressed into service in the Cornwall area.

In Ottawa-Carleton, we already have the beginnings of such a service. The Ottawa-Carleton Health Department has a health enquiries line which handles an estimated 65,000 calls per year. The cost of this service is part of the existing Health Department budget. The Children's Hospital of Eastern Ontario's "Health Information Line" handles an estimated 34,000 calls annually at a cost of $200,000. The Community Care Access Centre and Ottawa Hospital also handle a heavy load of information calls and fund this out of their current budgets. The Poison Information Line also exists, with a separate mandate and separate funding. These agencies have already been discussing the need to co-ordinate their efforts.

This recommendation proposes working with those agencies to make a 24-hour service – along the lines of the successful Outaouais model – a reality in Ottawa-Carleton. This would involve co-operation, pooling existing resources and possibly making use of the restructured Health Care Facilities Fund on a pilot project basis. To be operated at first as a pilot, local institutions and the Ministry of Health will be able to evaluate the success of the line in taking pressure off OHIP-insured services like hospitals and doctors' offices. Such a line would also function as a powerful public health tool, giving people the information they need to keep themselves and their families healthy.

5. THAT in accordance with provincial legislation banning the use of development charges for public hospitals, the remaining balance of $3.8 million in the Hospital Regional Development Charges Reserve Fund be earmarked for non-hospital health community health services with a priority to those projects that will reduce use of the acute care hospital sector; and

FURTHER THAT this task force report be referred to regional finance staff for their review and that they report back to the Corporate Services and Economic Development Committee on June 15, 1999 regarding the possibility of including a

component in the revised Regional Development Charges by-law for community health needs; and

FURTHER THAT the Finance Department be directed to prepare a report on the feasibility of exempting hospitals, long-term care facilities and other non-profit health care institutions from paying development charges when they undertake new construction or expansion.

Since 1981, regional government has had a Health Care Facilities Fund, funded until 1990 through property taxes, but not contributed to since. Since 1991, the RDC Hospital Reserve Fund has been filled by the development charges paid by developers when they take out building permits. The Health Care Facilities Fund, which has relatively general terms of reference, has a remaining uncommitted balance of just $400,000 and is shrinking. The RDC health reserve fund has a current uncommitted balance of about $3.8 million. Since their creation, these two funds together have disbursed close to $60 million.

The provincial government has changed the rules for development charges, prohibiting their collection or disbursement for public hospitals, although they can still be used to fund community health services. That means that the $3.8 million currently in the fund must be used for other health purposes. Regional finance staff have identified that it would be their intent to pursue the following course, once the new RDC by-law is approved by Council in July: the remaining funds in the current RDC reserve fund could be transferred to a new reserve fund (as required under the Act). These funds could continue to be used to fund growth related projects for both hospitals and health care facilities. This would be in keeping with the current by-law (1994 Review) which identified growth related needs for hospitals. The current by-law also states that *" While future capital requirements to serve the expanding population may not be for new beds, requirements will exist in some different form, possibly in dispersed or community based health facilities."*

It is clear that the most serious issue facing our health care system is the fact that there has been too little investment in non-hospital health services. Our hospitals have been reduced and their budgets cut. But services like home care, public health, long-term care, ambulance service, community mental health and hospices have not seen a commensurate increase in their funding. Much of the pressure being experienced by the acute care hospitals could be alleviated if these non-hospital services were adequately-funded to be able to take more of the load.

This $3.8 million can help finance some of the needs a growing population is putting on the community health sector. This could include the capital costs of the proposed 24-hour health line, new

long-term care beds, new hospice facilities, community mental health facilities or other health services. Proposals should be evaluated on the basis of how they would reduce demand for hospitals and physicians.

Over the past decade, about 90% of this fund has gone to acute care hospitals. It is time to target these dollars very specifically at investments that will bolster our under-funded community health sector so that it can effectively take pressure off the hospital sector.

But the need will not go away. It is reasonable to say that just as a growing population generates the need for more roads, sewers and other hard infrastructure, a similar growing need will exist for non-hospital community health facilities. This fund could help the region directly deal with some of its own expenses in public health, ambulance, and homes for the aged. It could also deal with growing need for community-run services managed and operated by community agencies. For example, the fund's most recent disbursements were to the Hillel Lodge and Villa Marconi. This report recommends that regional Finance Dept. staff be requested to bring a report back to the Corporate Services and Economic Development Committee of June 15, 1999 regarding the possibility of keeping a health-related RDC.

Regional finance staff have advised that in their June report to Committee and Council, a section could be included which would speak generally to the need for more health facilities in Ottawa-Carleton but that the specific identification of such projects is uncertain given that the health restructuring exercise is not complete. Staff could be directed over the next several months to examine the needs with the objective of preparing a report to Committee which would identify specific needs/projects over the next 10 years (timeline for heath facilities per the DC Act) and would also include the calculation of the RDC component. If a RDC rate for health facilities is adopted by Council, revenues collected from development would be contributed into a new RDC Health Facilities Reserve Fund.

6. THAT Regional Council reaffirm the position it took in 1996 that it is prepared to take on the health planning and co-ordination function currently performed by the District Health Council in order to increase accountability and transparency in the health care system; and

FURTHER THAT Council call on the provincial government to investigate the options for increasing the level of real decision-making in health care at the local level, examining the model of regional health authorities in existence in other places in Canada.

In late 1996, Ottawa-Carleton's Regional Council offered to take on an expanded role in health care policy and planning. Councillors voted in favour of a proposal that would see the Region assume the advisory function until recently performed by the District Health Council. The proposal envisaged that role evolving over time to a more direct governance in health care matters over time. It also included the provision that the province would provide the dollars for health planning currently committed to the District Health Council to the region instead. Unfortunately, the Ministry of Health never officially responded to this proposal.

The model of elected health authorities is in place in numerous other jurisdictions, including Alberta, Saskatchewan and British Columbia. In Victoria, for example, the capital district's regional government -- responsible for a wide range of municipal services region-wide -- also does health planning and co-ordination.

Locally, various models of health authorities have been discussed. For example, Dr. Wilbert Keon has recommended that all health services be co-ordinated under one body. A May 1996 public opinion poll showed that 73 per cent of Ottawa-Carleton residents believe a common administration for all hospitals would be a good, very good or excellent idea. Public consultation during the District Health Council's reconfiguration process produced extensive requests for region-wide co-ordination in areas as diverse as child and family health, palliative care, hospital support services, home care, rehabilitation, discharge planning and emergency services.

Regional municipalities have a complete infrastructure, including resources and expertise in planning, communications and public participation. Regional municipalities, by virtue of the composition of their Council and of the expertise of their staff complement, have evolved in their planning and administrative approaches.

If ideas such as resource allocation are to be tested, the test must occur in a strongly accountable structure. Regional councillors are elected and therefore accountable and representative. A special memorandum of understanding could be developed for the pilot project, to ensure compliance with the provincial policy framework.

Consultation in the preparation of this report has revealed that the issue of health care governance has moved to the front of the public agenda. This often resulted in this task force's consultation being focused on the issue of how hospital boards hire and fire senior personnel. While this is an important question, it pales in comparison to the much larger issues of how our system will grow and adapt to the changes it faces and how to rebuild community confidence.

The health authority model is one that has worked successfully in other provinces. Clearly, the issue is between ensuring enough

devolution that local communities can decide priorities but not so much that a checkerboard health care system is created.

Ottawa-Carleton does not yet appear ready for this step. The institutions strongly resist it and the public appears divided. However, it is also clear that hospitals – which have traditionally dominated the health delivery system – must change the way in which they conduct their business.

Separate (sometimes warring) hospital boards also make it difficult to shift services between hospitals and, more importantly, from hospitals to the community health sector like nursing homes or home care.

Placing the health planning and co-ordination function at the regional government level is a first step in trying to bring some better accountability to the system. The District Health Council now spans a territory from Cornwall to Algonquin Park, straddles a confusing mandate between advising the minister of health and representing the community, has now power to implement decisions and is hand-picked by the political party in power at any given point. This structure is not working and must be replaced.

Having Regional Council take on this planning and co-ordination role is also the first step in moving towards a system where big-picture decisions about how services are delivered and how budgets are set are made locally, in a public and accountable way.

Once there has been an opportunity to assess this model, it would then be possible to assess what next steps could be taken to improve co-ordination and accountability.