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An Overview of Bill 36: Has the Landscape Changed or Have the Sands Simply Shifted?

Louise Shap

On November 25, 2005, the McGuinty government introduced Bill 36, the *Local Health System Integration Act*, 2005 (the "Act"). If passed, Bill 36 will shift the landscape across the healthcare sector by moving Ontario in the direction of all other provinces in Canada that have established their own models to devolve health system management from a centralized model to some form of geographically and locally-based organizations.[1]

Bill 36 delineates the boundaries within which the government is determined to reconfigure and re-align Ontario's healthcare sector. Central to the government's "made in Ontario model" is the principle of community-based care that reflects and is responsive to local healthcare needs. In this brave new world of "decentralized" care, Local Health Integration Networks ("LHIN's") are the entities that will be charged with the responsibility of integrating and coordinating care within a specific geographic area.[2]

LHIN's are not-for-profit corporations. The objects of each LHIN are to plan, fund and integrate[3] local health service providers. Health service providers include

1 Under the legislation, a local health system is defined to be the part of the health system that provides services in the geographic area of the network, whether or not the services are provided to people who reside in the geographic area.

2 The Ministry of Health will initially retain responsibility for ambulance services, laboratories, providential drug programs, independent health facilities and public health. Individuals or health profession corporations that practise as a podiatrist, a dentist, a physician or an optometrist are not governed by the Act.

3 The term "integration" is defined to include coordinating services and interactions between entities; partnering with others in providing or operating services; transferring, merging or amalgamating services or operations; starting or ceasing to provide services; and ceasing, dissolving or winding up operations.

hospitals, community care access centres, mental health and addiction agencies, long-term care homes, community health centres and community support service organizations. According to the government's current plan, the roles and responsibilities of the LHIN's are expected to be phased in over time.

Overview of the Legislation
Local Health Integration Networks (Part II)

In June 2005, the government incorporated 14 corporations under the *Corporations Act*, and appointed 14 founding LHIN board chairs and 28 founding board directors. The Act allows the Lieutenant Governor in Council (the "LGIC"), by regulation, to establish other such corporations without share capital.

As Crown agencies, the Act imposes clear limitations on powers of LHIN's. For example, LHIN's must obtain the approval of the LGIC in order to:

- deal with any interest in real property or personal property;
- borrow, lend or invest money;
- create a subsidiary;
- provide an indemnification or guarantee the payment of money for the performance of services; and
- directly provide health services. (Section 6(3))

In addition, a LHIN must obtain the approval of both the Minister of Health and Long-Term Care (the "Minister") and the Minister of Finance to receive money or assets from any person or entity except the Crown, or to conduct any fund-raising activities. LHIN's are further prohibited from making charitable donations, registering as charities, entering into agreements for the provision of services outside Ontario or entering into agreements with any government or government agency outside Ontario, including the federal government, without the approval of the Minister.[4]

Similarly, it is the LGIC who appoints members of each LHIN board and which has the authority to revoke a member's appointment (Section 7(3)(a)) and is responsible for designating the chair and vice chair from amongst the members. (Section 7(6))

The constraints placed on the powers of the boards are further demonstrated by the fact that while the boards may pass by-laws and resolutions, and appoint committees, it is within the

4 This prohibition is particularly interesting in the context of the current government's position on restricting the introduction of privatization.

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discretion of the Minister to require a board to submit a proposed, as well as an existing, by-law to the Minister for approval. The board is also required to establish committees that the Minister specifies by way of regulation. (Section 8(5)(a)) In addition, while the board may appoint members to committees, each such member must meet the qualifications, if any, specified by the Minister. (Section 8(5)(b)) The chief executive officer of each LHIN is appointed by, and subject to the supervision of, the board of directors and is responsible for the management and administration of the affairs of the network. (Section 10(3))

The bill requires that LHIN's be audited by the Auditor General annually. In addition, the Minister may direct an audit at any time. Each board is further required to submit an annual report to the Minister and to provide the Ontario Health Quality Council with the information that the Council requests. (Section 13(6))

Planning and community engagement (Part III)

Under the proposed legislation, the Minister must develop a provincial strategic plan and each LHIN is required to generate an integrated health service plan for its local health system that is consistent with the provincial strategic plan and is based on ongoing consultations with the local community. The proposed legislation stipulates that LHIN's must "engage the community of persons and entities involved with the local health system on an ongoing basis," (Section 16(2)) but how this is to be done is left to be determined by regulation. (Section 36(1)(f))

Funding and accountability (Part IV)

Under the Act, "the Minister may provide funding to a LHIN on the terms and conditions that the Minister considers appropriate."(Section 17(1))

The Minister further has the authority to decide whether to adjust a LHIN's annual funding to take into account a portion of any savings from efficiencies that the local health system generated in the previous fiscal year and that it proposes to spend on patient care in subsequent fiscal years. (Section 17(2))

Presumably in an effort to curtail the ability of a LHIN to incur an operating deficit, the spending of a LHIN is required to be "in accordance with the appropriation from which the Minister has provided funding to the network." (Section 18(2)(d))

It is worth noting that the Minister is not required to publish a notice or provide for the submission of written comments about a proposed regulation pertaining to accountability agreements. (Section 37(2)(c)) The Act further provides that in the event that the Minister and a LHIN "are unable to conclude an accountability agreement through negotiations, the Minister may set the terms of the agreement". (Section 18(3)) LHIN's are also required to provide the Minister with any plans, reports, financial statements, including audited financial statements, and information that the Minister requires for the purposes of administering the Act. (Section 18(4)) The manner in which this provision is drafted, in effect, places no restriction on the information that the Minister may require a LHIN to provide.

Just as LHIN's are required to enter into accountability agreements[5] with the Minister, a health service provider that receives funding from a LHIN must enter into a service accountability agreement with the network. Consistent with the Minister's powers, a LHIN may audit and require information from a health service provider.

Furthermore, the LHIN may subsequently be required to disclose this information to the Minister, to another LHIN or to the Ontario Health Quality Council if any of these persons or entities request the information for the purpose of exercising its powers and duties. (Section 22(4)(a),(b)) In this regard, it would appear that there is little to preclude the Minister from obtaining from a LHIN essentially any information the Minister deems necessary to exercise his duties under the Act, whether such information pertains to the LHIN or to a health service provider that receives funding from a LHIN.

LHIN's will have the authority to provide funding to health service providers in respect of the services they provide. According to recent reports, $20 billion of the Ministry's $33 billion budget will be transferred to LHIN's annually. What remains unclear is the extent to which LHIN's will be free to determine how these funds will subsequently be allocated to health service providers. For example, the legislation grants the LGIC the

5 Accountability agreements set out performance goals/objectives; performance standards, targets and measures; reporting requirements; a plan for spending within the allocation received; a progressive performance management process; and other items prescribed by regulation.

power to make regulations "governing the funding that a LHIN provides to a health service provider." (Section 36(2)(h)) In this regard, the legislation leaves the door open for the Minister or the LGIC to retain control over the funding that flows from the LHIN's to the health service providers.

Integration and devolution (Part V)

The proposed legislation requires each LHIN and each health service provider, separately and in conjunction with each other, to identify opportunities to integrate the services of the local health system and to provide appropriate, co-ordinated, effective and efficient services. (Section 24) A LHIN may integrate the local health system by:

- providing or changing funding to a health service provider; (Section 25(1)(a))
- facilitating/negotiating the integration of persons or entities or the integration of services between health service providers or between a health service provider and a person or entity that is not a health service provider; (Section 25(1)(b))
- requiring a health service provider to provide all or part of a service or to cease to provide all or part of a service; (Section 26(1))
- requiring a health service provider to provide a service to a certain level, quantity or extent; (Section 26(1))
- requiring a health service provider to transfer all or part of a service from one location to another; (Section 26(1))
- requiring a health service provider to transfer (or receive) all or part of a service to (or from) another person or entity; (Section 26(1))
- requiring a health service provider to carry out another type of integration of services that is prescribed; (Section 26(1))
- requiring a health service provider to do anything or refrain from doing anything necessary to achieve any of the requirements set out above, including transferring property to or receiving property from another person or entity in respect of the services affected by the decision; (Section 26(1)) or
- prohibiting a health service provider from proceeding with an integration. (Section 27(4))

A LHIN is required to issue an "integration decision" whenever it proposes to integrate the local health system in any one of these ways.[6] A health service provider that receives an integration decision may, within 30 days of receiving a decision, make submissions requesting that the LHIN reconsider the decision. A LHIN that receives such a request shall reconsider the decision and may confirm, amend or revoke the decision. Once a decision has been reconsidered, a health service provider does not have any further means of appeal.

The Minister may similarly "integrate" a local health system by ordering a health service provider that receives funding from a LHIN, to cease operating, dissolve or wind up its operations, to amalgamate or to transfer its operations and any property related to the operations affected by the order.

As in the case of a decision issued by a LHIN, a health service provider that receives an order from the Minister may request that the order be reconsidered. Similarly, upon reconsideration, the Minister may confirm, amend or revoke the order.

It is important to note that LHIN's are prohibited from integrating a local health system by requiring a health service provider to cease to operate, dissolve, wind-up or amalgamate.[7] Only the Minister has the authority to render such an order. (Section 28(1)) In addition, the LGIC may, by regulation, amalgamate, dissolve or divide one or more LHIN's. It would therefore appear that although the legislation provides LHIN's with the ability to require a health service provider to cease to provide all or part of a service, or to transfer the provision of services from one provider to another, the power to substantively restructure the healthcare system at both the macro and micro levels remains within the jurisdiction of the government.

6 An integration decision issued must set out: the purpose and nature of the integration; the parties to the decision; the actions that the parties to the decision are required to take or not to take, including any time period for doing so; the effective date of all transfers of services, if any; and any other matter that the network considers relevant.

7 Section 26(2) (c) and (e). In addition, integration decisions may not require a health service provider to change the composition or structure of its membership or board; amalgamate with another provider; or transfer property held for a charitable purpose to a person or entity that is not a charity. Further, where the provider is a religious organization, the LHIN cannot "unjustifiably" require it to provide a service that is contrary to the religion of that organization.

The legislation further stipulates that a person or entity that is a party to an integration decision or a Minister's order shall comply with it. (Section 28(1)) In the event that a LHIN has issued an integration decision or the Minister has made an order and the person or entity that is a party to the decision, or the Minister's order fails to comply within the time specified in the proposed legislation, then the LHIN or the Minister may apply to the Superior Court of Justice for an order directing the person or entity to comply. Under the Act, while both the LHIN and the Minister have recourse to the Superior Court of Justice for the purpose of enforcement, no such privilege is granted to a health service provider. The only option available to a health service provider that does not wish to comply with an integration decision or a Minister's order is to request that it be reconsidered by the LHIN or by the Minister, as the case may be.

Should an integration decision or a Minister's order direct a health service provider to transfer property that it holds for a charitable purpose, "all gifts, trusts, bequests, devises and grants of property that form part of the property being transferred shall be deemed to be gifts, trusts, bequests, devises and grants of property of the transferee" (Section 30(1)) and no person or entity is entitled to compensation for any loss or damages arising from any transfer of property or the issuing of an integration decision or a Minister's order except for the portion of the loss that relates to the value of property that was not acquired with money received from the government or its agencies. (Section 31(3)) The legislation further provides the LGIC with the authority to make regulations governing such compensation, including who pays the compensation, the amount payable, how the loss for which compensation is payable is to be determined and how the portion of the value of the property that was not acquired with money from the government will be assessed.

The LGIC may also, by regulation, order one or more hospitals to cease performing non-clinical services and to transfer the service to a person or entity that the regulations prescribe. As in the case of an integration decision or a Minister's order, a person or entity that is a party to an integration order issued by the LGIC must comply with the order and if such person or entity fails to do so, the LGIC may apply to the Superior Court of Justice for an order directing the person or entity to comply. However, in the case of an order made by the LGIC, a public hospital does not have the option to request that the decision be reconsidered. Under the regulations, the LGIC may also devolve to a LHIN any powers, duties or functions of the Minister under any act for whose administration the Minister is responsible. Bill 36 further provides that the *Public Sector Labour Relations Transition Act, 1997* will apply, with some exceptions, where an integration involves a transfer of services of persons or entities, a transfer of operations of a health service provider, or the amalgamation of two or more persons or entities, within the health services sector. Bargaining agents and successor employers may agree that the *Public Sector Labour Relations Transition Act, 1997* will not apply, and there is also provision for the Ontario Labour Relations Board to issue an order declaring that such legislation does not apply, provided that such agreement or order will not affect the applicability of rules for determining seniority contained in the *Public Sector Relations Transition Act, 1997*.

In addition, Bill 36 permits the LGIC and the Minister to change Community Care Access Centres (CCAC's) and return them to non-profit corporations under the *Corporations Act*. CCAC's would be permitted to select their own members and directors, establish committees of the board, hire an executive director, and the requirement for a community advisory council would be repealed. The Act also provides authority to the LGIC to amalgamate, dissolve or divide CCAC's. (Section 39)

Consequential amendments (Part VIII)

This part makes amendments to several acts. Of particular significance are the proposed amendments to the *Commitment to the Future of Medicare Act, 2004* and the *Public Hospitals Act*. Under the former, Ministerial powers under Part III of the Act, respecting health service providers, are transferred to LHIN's, except the provisions dealing with hospital CEO compensation which will continue to rest with the Minister and are now explicitly applicable to hospital CEOs. With respect to the *Public Hospitals Act*, Section 6, which provides the Minister with the authority to issue certain directions to hospitals, would be replaced with transitional provisions to deal with directions that remained outstanding.

Integration decisions or orders issued under sections 25(2) and 28 of Bill 36 would prevail over a direction under section 6 of the *Public Hospitals Act*.

Conclusion

The transformation of Ontario's healthcare sector, as outlined in Bill 36, raises a number of questions. For example, have LHIN's been provided with the com-

mensurate authority to exercise their responsibilities and satisfy their objectives? Has there been a true devolution of authority such that decisions about how healthcares services should be structured and delivered within a particular community can be made locally? Has "one of the public's most precious assets been returned to them (the community)," (notes from the remarks made by the Minister at the Empire Club of Canada on November 25, 2005) or has the Minister effectively retained his ability to impose limitations on a LHIN's authority when a community's "priorities" do not fall within the spectrum of the Minister's overarching plan? A preliminary review of the legislation suggests that many of the Minister's powers will remain with the Minister. While LHIN's will have the authority to implement changes to the healthcare sector, the scope of these powers are limited and any substantive systemic changes remain within the jurisdiction of the Minister. L&G

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A Brave New World of Hospital Board Governance

Louise Shap

Background

The Ontario healthcare sector can be described as an intricate system of bureaucratic processes where fragmentation and duplication are endemic to its structure. The sector lacks an overarching vision that articulates a clear direction; roles, responsibilities and accountabilities are not adequately defined or aligned and there are few formal relationships or clearly established expectation levels between the different components of the system.

Over the past decade, various initiatives have been undertaken to create a more integrated and efficient system of healthcare delivery. For example, between 1996 and 2000, the Health Services Restructuring Commission introduced significant reforms into the healthcare sector. In addition, various incentives such as family health networks and alternative funding plans were advanced to encourage providers to work in a more integrated fashion.

A number of "networks" such as the Cardiac Care Network were also established to encourage voluntary alliances between providers at the local or regional level and to improve coordination of service delivery. More recently, there has been a strong emphasis on primary care reform. For example, family health teams have been introduced to provide comprehensive patient-centred primary healthcare, and greater continuity of care.

The emphasis on primary care reform is further reflected in the creation of Local Health Integration Networks (LHINs). LHINs represent a structure for managing health system planning, funding and coordination at a more local level. One of the responsibilities of LHINs will be to establish a strategic health system plan for providers within a specific geographic boundary. These health system plans will create new accountability relationships across the healthcare sector and will require more collaborative planning among providers. Similarly, these rela-

tionships will necessitate the development of new methods for dialogue amongst hospital boards and CEOs, as well as clearly defined accountability arrangements between boards and administrators of organizations within a LHIN, as well as between hospitals and LHINs.

The evolution from acute care to primary care reform has been accompanied by a shift from a focus on process to outcomes. In addition, there has been a growing recognition of the need for greater accountability supported by evidence based decision-making, including the use of performance measures and best practices to monitor and evaluate output against expectations.

The need for clearly articulated expectations, measurable outcomes, consequences and incentives for performance has become the "new norm", and consumers have come to expect "evidence" that the healthcare system is both efficient and effective. A prerequisite for evidence based decision-making and continuous quality improvement is the establishment of clearly defined roles, responsibilities and accountabilities. *The Commitment to the Future of Medicare Act* ("Bill 8") introduced hospital accountability agreements as a tool for clearly identifying roles and responsibilities and developing performance measures to monitor the achievement of specific standards. Accountability agreements reflect the joint responsibility of the Ministry and hospitals for improving the healthcare system and ensuring patients receive high quality, timely care.

Effect On Board Governance

In the context of the changes noted above, hospital boards will have to position themselves to function in a significantly different and continuously evolving environment with multiple lines of accountability and ensuing responsibilities. In a culture of evidence based decision-making and continuous quality improvement, hospital boards will have to be flexible, responsive and innovative in order to evolve in tandem with the healthcare system.

As the mandates of hospitals change, so too will the roles, responsibilities and accountabilities of hospital boards. For example:

- Hospitals will be required to meet expectations established through accountability agreements with LHINs and to report on their performance to the public and to government.
- Hospital boards will be responsible for ensuring the provision of quality patient services in measurable cost efficient ways and for overseeing the performance of the organization against defined indicators. In order to do this, board members will have to acquire the knowledge and skills necessary to assist the institution in becoming a "learning organization" where decisions are based on feedback from the outcomes that have been measured.

Calendar

2006 Annual Healthcare Information Management Systems Society (HIMSS) Conference
February 12-16, 2006
San Diego, California
www.himss.org/ASP/annualConfHome.asp

Creating a Place of Belonging: 7th Annual Alberta Harm Reduction Conference
February 14 – 15, 2006
Lethbridge, AB
info@albertaharmreduction.ca

Canadian Critical Care Conference
February 22 – 25, 2006
Whistler, British Columbia
www.canadiancriticalcare.ca

2006 Government and Health Technologies Conference and Expo.
March 8-9, 2006
Ottawa, ON
http://gov.wowgao.com/

QHR 2006: 12th International Qualitative Health Research Conference
April 2-5, 2006
Edmonton, AB
www.uofaweb.ualberta.ca/iiqm

3rd Annual World Healthcare Congress
April 17-19, 2006
Washington, D.C.
www.worldcongress.com

e-Health 2006
April 30 - May 3, 2006
Victoria, BC
www.e-healthconference.com

7th National Conference on Shared Mental Healthcare
May 11-13, 2006
Calgary, Alberta
www.shared-care.ca/calgary_conf.shtml

- Hospital boards will assume a pivotal role in negotiating the terms of the accountability agreements and will have to become proficient at interpreting the performance measures that will be applied to evaluate their institution's success at meeting the defined goals.
- Hospital boards will have to be prepared to negotiate accountability agreements that include multiple parties. Section 23(1) (b) of Bill 8 provides the Minister with the power to "propose" that a hospital enter into an accountability agreement with one or more other health resource providers. This will require board members to work in conjunction with boards from other provider institutions.

Further, hospital boards will be required to make decisions in a manner that balances the interests of multiple stakeholders. For example, hospital boards have always had, and will continue to have a fiduciary duty to act in the best interests of the corporation. Hospital boards are also responsible for acting in the best interests of, and are accountable to, the communities that they serve. In addition, under the *Public Hospitals Act*, hospital boards are accountable to the Ministry. In time it is expected that hospitals will be accountable to LHINs for funding, but will remain accountable to the Ministry for other matters. For example, under Part III of Bill 8, the Minister may impose penalties for the failure of a health service provider to comply with the terms of its accountability agreement. As such, while hospital boards will be accountable to the LHINs for meeting the terms set out in the accountability agreement, they will be accountable to the Ministry for the consequences of non-compliance.

In addition, under Section 9 of Bill 8, a health resource provider has a duty to take all reasonable care to ensure that its chief executive officer (CEO) complies with the terms set out in his or her performance agreement and his or her duties under Section 23(9) of Bill 8.

While CEOs have always been accountable to the hospital board, Bill 8 imposes an additional level of accountability between the CEO, the hospital board and the Ministry. This could place the board in the difficult position of being accountable to the Ministry for ensuring that the CEO meets the requirements set out in his or her performance agreement, but lacking the requisite authority to enact the sanctions under Bill 8 (i.e. such authority resides with the Ministry). In other words while the hospital board will be responsible for monitoring the performance of the CEO, and will be accountable to the Ministry for so doing, it may not have the substantive control to ensure that it can meet this legislated requirement.

The specifics of how a regionalized "made in Ontario" model of health sector reform will be structured remains unclear. Nonetheless, what has become unmistakably apparent is that the roles and responsibilities of hospital boards will change, and hospital boards will have to be prepared to adapt to these changes as they evolve. L&G

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