



Bill 74, The People's Health Care Act, 2019

OMA Summary and Analysis

The People's Health Care Act, 2019 (Bill 74) was introduced in the legislature on February 26, 2019. The bill includes changes from the previously leaked legislation on January 31, 2019. This memo provides both a summary and analysis.

The bill creates a new overarching Crown agency, called **Ontario Health**, for health care implementation in Ontario, which will replace the Local Health Integration Networks (LHINs).

The following is a list of legislation that will be repealed if the bill is passed into law:

- Local Health System Integration Act, 2006
- Lung Health Act, 2017
- Trillium Gift of Life Network.

The bill introduces two important definitions, **Health Service Provider** (similar to the Local Health System Integration Act but broader) and **Integrated Care Delivery System** (ICDS), and focuses on health systems integration with directives and consolidation of authority over decision-making, etc.

Existing agencies, including Cancer Care Ontario, eHealth Ontario and HealthForceOntario, will be subsumed by the new Ontario Health agency.

As the OMA learns and understands more about the government's plans, information and analysis may be added to this document. This legislation is substantively similar to the leaked version, with several notable exceptions, including the requirement for an ICDS to provide three (formerly two) services, and the removal of language surrounding provincial standards.

1. Ontario Health (Previously the Superagency)

The role of Ontario Health is to implement health system strategies developed by the Ministry of Health and Long-Term Care, manage health service needs across Ontario to ensure sustainability of the system (including health system performance management, and quality improvement), and to engage in the following:

- Knowledge dissemination
- Patient engagement/relations
- Digital health/Information technology
- Health care practitioner recruitment and retention
- Undertake/support tissue donation/transplantation activities
- Supply chain management to Health Service Providers and organizations

In addition, Ontario Health will provide advice, recommendations, and information to the health care system, promote health service integration, and *any other prescribed objects*.

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The Minister can issue operational or policy directives to Ontario Health, HSP(s), or ICDSs. This is further outlined below in the section on HSPs/ICDSs.

Ontario Health will have a Board of, at maximum, 15 members appointed by the Lieutenant Governor in Council. This mirrors the process for LHIN Board selection. Ontario Health will appoint and employ a CEO, responsible for its management and administration.

The by-laws and resolutions, committees, and other details surrounding the corporate administration of Ontario Health are aligned with existing LHIN processes.

Analysis:

Ontario Health is provided with broad scope and authority over the health care system. It becomes the single centralized body that will subsume the roles of HQO, HFO, eHealth Ontario, Trillium Gift of Life, as well as many functions currently performed by the Ministry of Health and Long-Term Care. The Cancer Act is also being repealed, and as such it is unknown how Ontario Health will continue the role and function of CCO.

The scope of authority of Ontario Health seems, in many ways, not dissimilar to the role of the Ministry of Health and Long-Term Care. It had initially been speculated that Ontario Health would fulfil a role similar to Alberta Health Services (AHS). However, the role of Ontario Health seems broader as it extends beyond the delivery of care.

2. Health Services Providers and Integrated Care Delivery Systems

Health Service Providers (HSPs) are defined as including all hospitals under the Public Hospitals Act and Private Hospitals Act, all mental health facilities, long-term care homes, approved entities under the Home Care and Community Services Act, Community Health Centres, Family Health Teams, Nurse Practitioner Led Clinics, Aboriginal Health Access Centres, hospices, Independent Health Facilities, physiotherapy clinics, and “a person or entity that provides primary nursing services, maternal care, or *interprofessional primary care programs and services*.(emphasis added).” It is unclear what this latter term refers to, though this same language previously existed in LHSIA and is therefore not new. The definition is open-ended, including “any other person or entity or class of persons or entities that is prescribed.” Unlike in LHSIA s.2(3), no exemption/prohibition is carved out for physicians. However, physicians are not explicitly included, either. The significance of this is unclear. While LHSIA included an exemption, the government always reserved the power to amend the legislation. Working with government will be important to ensure the exemption continues and to advocate for physicians’ roles as the bill is operationalized.

Integrated Care Delivery Systems are a new concept introduced in this bill. Ontario Health can designate a person or entity an ICDS if it delivers at least three of a list of services including: hospital, primary care, mental health/addictions, home/community, long-term care home, palliative care, or *any other prescribed*

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services. Hospitals, FHTs and CHCs are some institutions that could, presumably, be named as ICDSs. Any obligation or decision that applies to an ICDS applies to and is binding on each constituent person/entity of the ICDS, which presumably applies to anyone working in an ICDS. This would include physicians.

The Minister may issue directives to ICDSs or HSPs on policy or operational priorities. This includes, though is certainly not limited to, procurement or supply chain services (explicitly referenced). ICDSs and HSPs must comply with every directive.

HSPs and ICDSs are all required to separately and together, identify opportunities to integrate services to provide 'appropriate, co-ordinated, effective and efficient services'.

The name given to the ICDSs is **Ontario Health Team**.

Analysis:

The OMA supports the notion of care integration, and welcomes the opportunity to participate in innovation with respect to the health care system. The role and integration of primary care in this new model will be instrumental. The OMA is strongly advocating for physician-led ICDSs, with primary care being at the core. We are closely monitoring developments within government as they become available and to try to ensure OMA has a seat at this new table.

3. Funding, Accountability Agreements

The language at Sections 18 and 19 indicates the Minister will fund Ontario Health according to a service accountability agreement. Similarly, Ontario Health will in turn fund the HSPs and ICDSs and "other persons and entities" with its own accountability agreements.

The bill also states that Ontario Health provides funding to HSPs or ICDSs in respect of services provided.

The bill also permits Ontario Health to issue directives to audit accounts and financial transactions, and/or engage in an operational review of the HSP/ICDS. In addition, Ontario Health may require HSPs/ICDSs to provide plans/reports, and any other information (other than personal health information) for the purposes of its role.

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Analysis:

The bill provides Ontario Health with the authority to audit accounts and review the operations of HSPs, as well as the ability to compel HSPs to provide any information (with the exception of personal health information) to Ontario Health for its own purposes. This will likely include all practice level information. We anticipate this will include data such as patient volumes, services accessed, hours of operation, among others.

Physicians continue to avoid designation as HSPs. Therefore, for the interim, physician funding will continue through the usual channels. It is unlikely that physicians will be designated as HSPs at any point in the foreseeable future, as this would violate the terms of the Representation Rights Agreement and this government has, in accepting the recent arbitration award, indicated a willingness to co-operate and work with the profession.

4. Emphasis on Integration and Power to Order Integration

Integrating services is a main priority of the bill. Sections 29 and 30 stipulate that the Agency, the HSPs and the ICDSs shall all identify opportunities for integration, both together and separately.

The Minister has very broad powers of required integration under section 33. Essentially, the Minister can order HSPs and ICDSs to integrate and provide services according to specifications. The Minister can do this within 30 days and no consultation is required (though submissions may be made within the 30-day period).

Note that integration/amalgamation orders must be complied with, regardless of the decisions or process required by a corporate board at section 36 (2). This may compromise hospitals' self-governance given the Agency's authority to compel transfers, amalgamations etc.

Analysis:

As previously mentioned, the OMA has long supported the notion of health system integration. The process and implementation of any integration will be fundamental to effective execution. The OMA is advocating for physicians and other providers to be supported to develop innovative ideas that are reasonable in their local communities.

Ontario Health has power to change funding to HSPs/ICDSs for the purposes of integration. Effective system change comes from partnerships. The mechanisms by which integration will be achieved are still to be determined. The OMA looks forward to further information on implementation and execution so that it and its member physicians may take an active role in leading future initiatives.

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5. Other Power and Directives

Generally, the bill gives the Ministry and Ontario Health considerable power over the health care system broadly. Ontario Health is also not at arm's-length from the Ministry. The Agency has a board of directors, but proposed by-laws must be submitted to the Minister.

The Minister has significant power to issue directives. Where it is considered to be in the public interest, the Minister may issue operational or policy directives to the Agency, HSPs, and ICDSs. These powers appear to be new. Under LHISA, the Minister could issue these directives to LHINs and LHINs to the HSPs. Hence, the new bill affords the Minister with increased direct top-down authority.

Sections 24 and 25 permit the Agency to direct HSPs, ICDSs, and others receiving funding to submit to audit, operational review, and peer review. These are similar to what the LHINs could require under LHSIA.

Section 26 permits the appointment of investigators to inspect and investigate HSPs, ICDSs, and other funded entities. Some of the language is similar to the Public Hospitals Act and LHSIA. Notably, section 31.1 allows investigators to access records of "any person performing services for the providers, system, person or entity." This would include physicians. All investigators' reports will be made public by the Agency.

Section 26 (5) permits the Minister to appoint a supervisor of HSP/ICDS. This language is reminiscent of similar powers under the Public Hospitals Act. Supervisors' reports will also be made public.

Analysis:

The bill provides for the appointment of a supervisor for any HSP or ICDS if deemed in the public interest, and all supervisors' reports are to be made public. It is unclear as to what extent this will affect physicians, should physicians assume roles within or at the forefront of ICDSs. Moreover, it is unclear what the scope of the Ministerial Supervisor's role is as opposed to the overall jurisdiction of the CPSO.

Other

No arrangements are permitted under the bill that would restrict an individual from receiving services based on the geographic area in which the individual resides, except for home care services (see Section 29). This is consistent with LHSIA.

The NDP originally claimed in the media that this bill is intended to permit "privatization." We saw no evidence of this in the language in the leaked bill and we continue to see nothing to support that contention in the final draft. The only section that references paying for care is section 34 (1) which states that "no integration decision shall permit a transfer of services that results in a requirement for an individual to pay for those services, except as otherwise permitted by law." The latter part, however, is

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necessary as physiotherapy clinics and other allied health professionals' practices captured by the HSP definition are not funded by OHIP and are paid for out of pocket by the public.

Next Steps

1. Physician-Led ICDSs

The government is committed to building an integrated care system, with some similarity to the U.S. Accountable Care Organization model. We know from the limited literature available that physician-led ACOs are more effective both in terms of cost and patient outcomes. The OMA is advocating to government the importance of physician-led ICDSs to long-term success. It will be crucial to be proactive in terms of our dealings with government on this matter and to behave in a collaborative manner.

The theme of the bill generally speaks to consolidation of power and mandated integration. Physicians and patients have been calling for integration for many years, and this is an important priority. Physicians should be prepared for increased collaboration in the workplace. The OMA is working to position physicians as the leaders of this new model.

2. Investigations

Section 26 allows investigators to access records of "any person performing services for the providers, system, person or entity." This would presumably include physicians, even when the physician is the Health Information Custodian and not the FHT or other entity.

It is important to note that this existed previously (for HSPs) under LHSIA, and has not been an authority that has been readily used. However, depending on physicians' contractual obligations with ICDSs, this authority may apply to physicians in these systems. We will seek clarity and flag this issue for further discussion as it raises larger issues related to data custodianship and governance. For example, within an integrated entity, who is custodian? Amendments to the Personal Health Information Protection Act (PHIPA) may be required and OMA will want to be involved in any such changes as well.

3. Provincial Standards

The language on provincial standards has been removed from the leaked version. This is a welcome modification, as this may have had serious implications for physicians on practice autonomy and for the legal definition of standard of care.

The final draft includes Health Quality Ontario as an amalgamated entity. It is unclear what role it will have in prescribing standards going forward. OMA is pleased with the removal of the language regarding

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top-down provincial standards. Future discussions with the Ministry will help to clarify this further and to discern what the Ministry's next steps may be in this regard.

4. Funding

Ontario Health plays a funding role for ICDSs and HSPs. Given that physicians are not named as HSPs suggests that the remuneration models will not change, at least for time being. That being said, it remains to be seen how physicians will operate within a new model. OMA negotiations counsel are aware of this issue and will provide comment as needed going forward.

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