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PATIENTS FIRST ACT BECOMES LAW IN ONTARIO

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A. INTRODUCTION

On December 7, 2016, the Ontario government passed the *Patients First Act* ("*Patients First*"),[1] intended to support patient-centred care, promote health system planning and integration, and improve access to high quality health services.

Yet, while the provincial government has promised that *Patients First* will deliver better care and usher in a new era of health transformation in Ontario, it could also pave the way for new involvement into the governance of health service providers by the province's Local Health Integration Networks ("LHINs").

B. HISTORY OF THE *PATIENTS FIRST ACT*

Patients First was originally introduced in June 2016 as Bill 210 and was re-introduced in October 2016 as Bill 41. It is officially titled "*An Act to amend various Acts in the interest of patient-centred care*", but the bulk of the legislation consists of amendments to the *Local Health System Integration Act, 2006* ("LHSIA")[2] that affect the management and administration of the health care system in Ontario.

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[1] Bill 41, *Patients First Act, 2016*, 2nd Sess, 41st Parl, Ontario, 2016 (assented to 08 December 2016), online: http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=4215&detailPage=bills_detail_the_bill.

[2] *Local Health System Integration Act, 2006*, SO 2006, c 4, online: https://www.ontario.ca/laws/statute/06l04.

Following up on commitments made by the Ontario government in a discussion paper released on December 17, 2015, entitled "Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario"[3], the *Patients First Act* greatly expands the role of the LHINs as part of the government's plan for improvement to the provincial health system.

C. NEW ROLE OF LHINS UNDER THE *PATIENTS FIRST ACT*:

Under *Patients First*, the role of the LHINs in the Ontario health care system has broadened considerably from the rather specific mandate they originally possessed. Prior to *Patients First*, the fourteen Ontario LHINs were primarily concerned with planning, funding and integrating the health system in their catchment areas. As a result of *Patients First*, a whole new range of entities has been brought within the scope of LHIN responsibilities.

The definition of "health service provider" in section 2(2) of LHSIA has been expanded to include a variety of not-for-profit primary care providers, as well as palliative care providers, hospices and physiotherapy clinics, allowing LHINs to fund and have accountability agreements with these entities.

The objects of the LHINs as set out in section 5 of LHSIA have been amended to include, without limitation, bringing planning for physician resources, providing health and related social services and supplies and equipment for the care of persons in home, community and other settings and managing the placement of persons into long-term care homes, within the role of the LHINs.

Section 14.1(1) of LHSIA now requires each LHIN to establish geographic sub-LHIN regions for the purposes of planning, funding and integrating services.

D. TRANSFER OF CCAC RESPONSIBILITIES TO THE LHINS

Probably the most anticipated provisions of *Patients First* are those that deal with the transfer of responsibility for home and community care from the Community Care Access Centres ("CCACs") to the LHINs. In its December 2015 discussion paper, the provincial government signaled its intention to transfer responsibility for the delivery and management of those services from the CCACs to the LHINs and to

[3] Ontario, Ministry of Health and Long-Term Care, "Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario", Discussion Paper (Toronto: MHLTC, 17 December 2015), online http://www.health.gov.on.ca/en/news/bulletin/2015/docs/discussion_paper_20151217.pdf .

eliminate the CCACs.[4] Ontario's Auditor General had identified that inconsistencies between CCACs were leading to inequities in service levels and quality of care[5].

Not surprisingly, *Patients First* repeals the *Community Care Access Corporations Act, 2001*.[6] It also adds a new Part V.1 to LHSIA, which creates the framework for the transfer of responsibilities from the CCACs to the LHINs. New paragraphs 34.2(1)(a) and (b) of LHSIA give the Ontario Minister of Health and Long Term Care (the "Minister") the power to order the transfer of all the assets, liabilities and employees of a CCAC to the LHIN within the same geographic boundaries. If such an order is made, the LHIN essentially steps into the shoes of the CCAC, assuming all of its assets, liabilities, operations and activities[7] and taking on a new role in home and community care service delivery. The change would be seamless to employees[8] and to the terms of any charitable gifts or bequests, which would apply to the LHIN as they had to the CCAC.[9] Subsection 34.4(1) contemplates the automatic transfer of all CCAC employees to the LHINs.

In keeping with the transfer of responsibilities from the CCACs to the LHINs, sections 39 and 40 of LHSIA provide for the transfer of assets, liabilities and employees from the Ontario Association of Community Care Access Centres ("OACCAC") to a new not-for-profit entity incorporated to provide shared services to the LHINs. As with the transfer from CCACs to the LHINs, the new provisions seem to contemplate the transfer of all existing OACCAC functions and employees from the OACCAC to the new entity.

[4] *Ibid* at 6.
[5] Office of the Auditor General of Ontario, *Annual Report 2015*, at 77-78 , online http://www.auditor.on.ca/en/content/annualreports/arreports/en15/2015AR_en_final.pdf
[6] *Supra* note 1, at s34, repealing the *Community Care Access Corporations Act*, 2001, SO 2001, c 33, online https://www.ontario.ca/laws/statute/01c33.
[7] *Ibid* s 34.3(1).
[8] *Ibid* ss 34.4(1)-(2).
[9] *Ibid* ss 34.3(10)-(11).

E. NEW OVERSIGHT POWERS OF LHINS

The most noteworthy provisions of *Patients First* are those giving the LHINs various broad oversight powers over providers to which they provide funding where they consider it to be in the public interest to do so.

Section 20.2 of LHSIA gives LHINs the power to issue operational or policy directives that are binding on health service providers to which they provide funding, where they consider it to be in the public interest to do so. This power does not apply to long term care homes, public hospitals or the University of Ottawa Heart Institute. Further, the LHINs' powers under this section are somewhat circumscribed by subsection 20.2(4), which provides that a LHIN will not unjustifiably require a religious health service provider to provide a service that is contrary to the religion of the organization.

Section 21.1 of LHSIA gives LHINs the power to appoint investigators to investigate and report on the quality of the management, care and treatment or any other matter relating to a health service provider to which they provide funding, other than long term care homes, where they consider it to be in the public interest to do so. These investigators have broad powers to enter premises without a warrant, to require the production of documents, things and persons and to question individuals on matters relevant to the investigation.

Finally and most notably from the health service provider perspective, section 21.2 of LHSIA gives LHINs the power to appoint a person as the supervisor of a health service provider to which they provide funding, other than a public hospital, a private hospital or a long term care home, where they consider it to be in the public interest to do so. The appointment of a health service provider supervisor is valid until it is terminated by the LHIN. The health service provider supervisor may displace the board of directors and the members or shareholders, as the case may be, of the health service provider and exercise all of their powers. A supervisor also has the same rights as the health service provider's board of directors and its chief executive officer in respect of the documents, records and information of the health service provider and its board.

These powers are subject to various notice and privacy requirements but they do not substantively limit the LHINs' ability to interfere in health service provider operations or governance. Further, the requirement that the decision to exercise one of these powers must be "in the public interest" is of little assistance.

Certain LHIN materials indicate that these powers would only be exercised in particular circumstances, such as where a health service provider is acting in contravention of legislation, directives or policies, is experiencing governance and accountability challenges or is persistently underperforming on its accountability agreement indicators and/or obligations.[10]

In reality however, under section 35 of LHSIA, a LHIN may consider any matter it regards as relevant in determining whether a decision is in the public interest including, without limitation:

- the quality of the management and administration of the health service provider;
- the proper management of the health care system in general;
- the availability of financial resources for the management of the health care system and for the delivery of health care services;
- the accessibility to health services in the geographic area or sub-region where the health service provider is located; and
- the quality of the care and treatment of patients.

[10] Central West Local Health Integration Network, "LHIN Renewal Questions and Answers for LHIN Use", (Brampton: Central West LHIN, 2016) at 5, online: http://www.google.ca/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwic0_i_0PXSAhWD6xQKHZ6mDxQQFggaMAA&url=http%3A%2F%2Fwww.centralwestlhin.on.ca%2F~%2Fmedia%2Fsites%2Fcw%2FDocuments%2FNews%2520and%2520Events%2FPatients%2520First%2520Discussion%2520Paper%2FRolling%2520LHIN%2520Renewal%2520Q%2520%2520A%2520(2016-07-29).pdf%3Fla%3Den&usg=AFQjCNEuK4RJOsLWmuY1yK3tZNvsyBZZJg&sig2=56Noyd0xwYkpxeCyBTWfUA&bvm=bv.150729734,d.amc.

Section 35 could theoretically enable LHINs to take over the governance of health service providers on potentially minimal grounds, as there will be little that does not fall within the scope of this broad and open-ended language.

It should be noted that the legislation contains mirror provisions empowering the Minister to make the same orders in respect of LHINs, including orders to appoint a supervisor, displace the governing body and exercise the powers of the governing body and chief executive officer of the affected LHIN, all where the Minister considers it to be "in the public interest".

However, the LHINs are creatures of statute and of the provincial government. They are fully funded by the Ministry of Health and Long Term Care and exist solely to further the objects of the provincial government in respect of the administration and management of and planning for the province's health care system. The provincial government has almost identical powers to intrude into the governance and operation of public hospitals under the *Public Hospitals Act*[11], where again the entities in question are fully funded by and operate under the authority of the Ministry of Health and Long Term Care.

For the provincial government to issue binding operational or policy directives, appoint an investigator or displace the governing body of a LHIN or of a public hospital would be more reasonable given the essentially public nature of these bodies and their mandates than it would be for a LHIN to do the same in respect of an independent entity that is essentially private in nature.

Moreover, while most health service providers possess multiple sources of funding, the LHINs' power to appoint a supervisor over health service providers is not restricted to programs or operations that are funded by the LHINs. As noted by organizations such as the Ontario Community Support Association[12] ("OCSA") and the Ontario Nonprofit Network[13] ("ONN"), a LHIN could appoint a supervisor to take control over all assets and funds of an organization, regardless of their provenance. Further, while subsection 21.2(6) provides that the supervisor has the exclusive right to exercise all the powers of the

[11] *Public Hospitals Act*, RSO 1990, c P.40, online: https://www.ontario.ca/laws/statute/90p40.
[12] Ontario Community Support Association, "Patients First Act: Preliminary Response", (Toronto: OCSA, 2016) page 3, online: http://www.ocsa.on.ca/uploads/9/8/9/9/9899852/patients_first_act_-_preliminary_response_-_ontario_community_support_association_-_september_2016.pdf.
[13] Letter from Ontario Nonprofit Network to The Honourable Monte McNaughton, Chair of the Standing Committee on the Legislative Assembly for the Ontario Legislature (14 November 2016), online: http://theonn.ca/wp-content/uploads/2016/11/FINAL_ONNLetter_Bill-41-Patients-First_2016-11-14.pdf.

governing body of the health services provider, it does not explicitly state that the supervisor is subject to the same obligations and liabilities as the governing body. It is therefore not clear whether a supervisor would be required to abide by any restrictions on use or disposition of charitable funds and assets held by a charitable entity. In a case in which a supervisor is appointed for a charitable health services provider, it would be necessary for the LHIN to specify that the supervisor is subject to those charitable requirements pursuant to subsection 21.2(7) of LHSIA, which permits the LHIN to specify the terms and conditions governing the powers and duties of the supervisor. If the LHIN does not do so, the charity's stakeholders may want to consider seeking legal advice in order to ensure that its charitable assets are protected.

The definition of "health service provider" in subsection 2(2) of LHSIA includes a person or entity approved under the *Home Care and Community Services Act, 1994* (HCCSA) to provide services. Approved agencies under HCCSA can only be not-for-profit entities.[14] LHINs may purchase community services from for-profit providers but these entities are expressly excluded from the definition of "health service provider" by subsection 2(4) of LHSIA.

The risks to the not-for-profit sector – largely community-based organizations serving vulnerable communities and already under pressure from for-profit competitors – are significant. Both OCSA and ONN have raised concerns about the lack of appeal mechanisms, due process and other safeguards in the legislation.

It should be noted that section 20.2 (the power to issue binding directives), section 21.1 (the power to appoint investigators) and section 21.2 (the power to appoint supervisors) are not yet in force and will not come into force until a future date to be named by proclamation of the Lieutenant Governor. It would be useful if the Ministry of Health and Long Term Care were to provide additional guidelines and safeguards to outline what would constitute an appropriate exercise of the LHINs' new supervisory and other powers before these provisions are proclaimed in force.

[14] *Home Care and Community Services Act, 1994*, SO 1994, c 26, ss 2(1), 5(1), online: https://www.ontario.ca/laws/statute/94l26.

Finally, not-for-profit health service providers still have some time to prepare for the LHINs' new powers. They should be taking steps to minimize their risks including, without limitation, ensuring that they are not in contravention of any legislation, directives or policies, that their governing bodies are functioning appropriately and in accordance with governance best practices and that they are meeting all obligations set out in their accountability agreements with the LHINs.

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