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WORKING GUIDE TO THE LOCAL HEALTH SYSTEM INTEGRATION ACT, 2005 (Bill 36)

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I. Introduction

On March 28, 2006, the provincial government proclaimed Bill 36 - the *Local Health System Integration Act, 2005*, as amended by the Standing Committee on Social Policy ("Committee") after limited public hearings into the legislation. The following review and analysis of the Act focuses on the concerns of health care workers and their unions.

The legislation sets out the framework for the government's restructuring of the delivery of health services in Ontario, including the powers to be exercised by the Local Health Integration Networks (LHINs) as well as the powers to be granted to the Minister of Health in respect of this restructuring. Both the LHINs and the Minister are vested with significant powers under the Bill. LHINs are granted the power and mandate to seek opportunities to transfer or merge services, to coordinate interactions and create partnerships (between not-for- profit and/or for-profit health service providers.) The Minister is granted extensive powers to order health service providers to amalgamate, transfer their operations to other entities, or even to cease operating or wind up their services altogether.

The legislation covers a relatively wide range of health service providers including hospitals, certain psychiatric facilities, long term care facilities, community mental health and addiction agencies, community health service providers, community health centres, and other entities prescribed by regulation. However, the legislation either expressly excludes or does not cover other key components of the health system such as doctors, independent health facilities, public health units, dentists, optometrists, labs and certain corporations of health professionals.

Bill 36 is a complex piece of legislation, the details of which have been left to Regulation and which the Ministry admits it has yet to fully work out. However, health care workers and their unions are concerned that, instead of strengthening the public health system, increasing local control and delivering integrated services to patients, the legislation will diminish access to local health care services, threaten employment stability for many health care workers, open the door to health care delivery by private for-profit corporations, and create a further layer of centralized bureaucracy at the expense of front-line services. In particular health care unions have expressed the following concerns with the legislation: the speed with which the government is proceeding with the legislation prior to establishing a strategic plan for the restructuring, the failure to identify public interest criteria that would guide funding and integration decisions under the legislation, the exclusion of key components of the health care system from the legislation's coverage, the lack of substantive guarantees of community and front-line health care worker input into LHIN decision-making, and the lack of safeguards against the use of competitive bidding processes by the LHINs.

The Act provides for the application of the Public Sector Labour Relations Transition Act, 1997 (the "PSLRTA") to restructuring in the health care sector. The PSLRTA is to be amended into permanent legislation (originally it applied only during a specified transition

period), and so as to cover "partial integrations", in which health sector services or programs are rationalized between institutions that otherwise continue to exist. In order to determine whether the PSLRTA applies, and whether an application to the Ontario Labour Relations Board concerning the application of the PSLRTA is available, it will be necessary to look at the new Local Health Systems Integration Act, the PSLRTA and at the instrument that triggers the integration.

Overall, although some small improvements were made to the legislation at the committee stage, the legislation is likely to fall short of the effective implementation of a seamless continuum of health care that the unions representing health care workers advocated in Committee hearings on the legislation. The legislation may also have significant effects on the stability of the employment and practice environment for health care workers.

This guide provides an overview and analysis of the legislation focussing on issues of concern to health care professionals. It begins with a section-by-section review and analysis of the legislation and moves to a review of the amendments to the Public Service Labour Relations Transition Act, 1997 and the circumstances under which it will apply.

At the end of the guide, there is a set of links to documents and statutes related to the legislation, all of which can be accessed directly if the electronic version of the memo is read on a computer with internet access.

In the following, unless otherwise indicated, the legislation has been paraphrased to make for easier reading. The legislation itself should be checked for precise wording.

II. The Local Health System Integration Act, 2005

1. General Provisions - Purpose, Preamble & Key Definitions (Part I of the Act)

Preamble

The preamble of the Act states the government's commitment to various values and principles that should provide a context for the interpretation of the legislation:

> The people of Ontario and their government,
>
> (0.a)confirm their enduring commitment to the principles of public administration, comprehensiveness, universality, portability, accessibility and accountability as provided in the Canada Health Act (Canada) and the Commitment to the Future of Medicare Act, 2004;
>
> (0.a.1) are committed to the promotion of the delivery of public health services by not-for-profit organizations;

(a) acknowledge that a community's health needs and priorities are best developed by the community, health care providers and the people they serve;

(b) are establishing local health integration networks to achieve an integrated health system and enable local communities to make decisions about their local health systems;

(c) recognize the need for communities, health service providers, local health integration networks and the government to work together to reduce duplication and better co-ordinate health service delivery to make it easier for people to access health care;

(d) believe that the health system should be guided by a commitment to equity and respect for diversity in communities in serving the people of Ontario and respect the requirements of the French Language Services Act in serving Ontario's French-speaking community;

(e) recognize the role of First Nations and Aboriginal peoples in the planning and delivery of health services in their communities;

(f) believe in public accountability and transparency to demonstrate that the health system is governed and managed in a way that reflects the public interest and that promotes continuous quality improvement and efficient delivery of high quality health services to all Ontarians;

(g) confirm that access to health services will not be limited to the geographic area of the local health integration network in which an Ontarian lives; and

(h) envision an integrated health system that delivers the health services that people need, now and in the future.

- The preamble of an Act is not part of the binding legislation, and does not provide any rights independent of the legislation. However, the courts will rely on the preamble as showing the purposes of the legislation The first two items in the preamble were added by the Committee following recommendations made by health care unions and other health advocacy organizations. However, the government declined recommendations by the same groups to expressly require decisions to be made with reference to these principles.

Purpose of the Act

The Act states that its purpose is to “provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care in local health systems and across the province and effective and efficient

management of the health system at the local level by local health integration networks."

- The purpose of the Act is significant in three major ways. First, LHINs' decisions are to be aimed at achieving the purpose of the Act (see Section 2 below). Second the purpose of the Act will be used by courts to assist in the interpretation of the rest of the Act. Third, the purpose of an Act defines the limits in which discretionary powers granted by the Act, including regulatory powers, may be used.

Key Definitions

There are two definitions which are of overriding importance throughout the Act.

- **Health Service Provider ("HSP")** is defined so as to include public and private hospitals, psychiatric facilities, the University of Ottawa Heart Institute, charitable homes for the aged, homes for the aged, nursing homes, community care access corporations, community service providers, community health centres, community mental health and addiction service providers and others that may be specified by regulation.

- Because LHINs' funding powers and their direct powers to order integration cover "health service providers", this definition is a key element of the Act. The definition reads as follows:

  "health service provider"... means the following persons and entities:

  1. A person or entity that operates a hospital within the meaning of the Public Hospitals Act or a private hospital within the meaning of the Private Hospitals Act.

  2. A person or entity that operates a psychiatric facility within the meaning of the Mental Health Act except if the facility is,

     i. an institution within the meaning of the Mental Hospitals Act,

     ii. a correctional institution operated or maintained by a member of the Executive Council, other than the Minister, or

     iii. a prison or penitentiary operated or maintained by the Government of Canada.

  3. The University of Ottawa Heart Institute/Institut de cardiologie de l'Université d'Ottawa.

4. An approved corporation within the meaning of the Charitable Institutions Act that operates and maintains an approved charitable home for the aged within the meaning of that Act.

5. Each municipality or a board of management maintaining a home for the aged or a joint home for the aged under the Homes for the Aged and Rest Homes Act.

6. A licensee within the meaning of the Nursing Homes Act.

7. A community care access corporation within the meaning of the Community Care Access Corporations Act, 2001.

8. A person or entity approved under the Long-Term Care Act, 1994 to provide community services.

9. A not for profit corporation without share capital incorporated under Part III of the Corporations Act that operates a community health centre.

10. A not for profit entity that provides community mental health and addiction services.

11. Any other person or entity or class of persons or entities that is prescribed.

- The definition of "health service provider" is broad, but does not include:
  - independent health facilities, under the Independent Health Facilities Act, such as free-standing ultrasound and MRI clinics;
  - institutions under the Mental Hospitals Act (the four provincial psychiatric hospitals and the for-profit approved homes);
  - homes for special care;
  - laboratories and specimen collection centres (except to the extent that they are part of another covered entity).
- The definition specifically excludes doctors, optometrists, dentists and podiatrist, including corporations of these professionals offering health services to individuals.
- The Committee rejected union recommendations that the definition be expanded to include key components of the health care system including primary health services delivered by physicians, independent health facilities, medical laboratories, and public health facilities/institutions.

Integrate and **integration** are defined broadly to include:

(a) to co-ordinate services and interactions between different persons and entities,
(b) to partner with another person or entity in providing services or in operating,
(c) to transfer, merge or amalgamate services, operations, persons or entities,
(d) to start or cease providing services,
(e) to cease to operate or to dissolve or wind up the operations of a person or entity.

2. Local Health Integration Networks (Parts II & IV of the Act)

A. Role of the LHINs

- The objects or purposes of LHINs are to "plan, fund and integrate the local health system to achieve the purpose of [the] Act" and expressly include:

(a) to promote the **integration of the local health system** to provide appropriate, co-ordinated, effective and efficient health services;

(b) to **identify and plan for the health service needs of the local health system in accordance with provincial plans** and priorities and to make recommendations to the Minister about that system, including capital funding needs for it;

(c) **to engage the community** of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation;

(d) to ensure that there are appropriate processes within the local health system **to respond to concerns** that people raise about the services that they receive;

(e) to **evaluate, monitor and report on and be accountable to the Minister** for the performance of the local health system and its health services, including access to services and the utilization, co-ordination, integration and cost-effectiveness of services;

(f) to participate and co-operate in the development by the Minister of the provincial strategic plan and in the development and implementation of provincial planning, system management and provincial health care priorities, programs and services;

(g) **to develop strategies and to co-operate** with health service providers, including academic health science centres, other local health integration networks, providers of provincial services and others **to improve the integration of the provincial and local health systems** and the co-ordination of health services;

(h) **to undertake and participate in joint strategies with other local health integration networks** to improve patient care and access to high quality health services and to enhance continuity of health care across local health systems and across the province;

(l) to **disseminate information** on best practices and to promote knowledge transfer among local health integration networks and health service providers;

(j) **to bring economic efficiencies to the delivery of health services** and to make the health system more sustainable;

(k) to **allocate and provide funding** to health service providers, in accordance with provincial priorities, so that they can provide health services and equipment;

(l) to enter into agreements **to establish performance standards** and to ensure the achievement of performance standards by health service providers that receive funding from the network;

(m) to ensure the **effective and efficient management** of the human, material and financial resources of the network and to account to the Minister for the use of the resources; and

(n) to carry out the other objects that the Minister specifies by regulation made under this Act.

- The Minister can make regulations adding to the objects of a LHIN: s.36(2)(a)

Comment

- The objects of the LHINs will be of the utmost significance in any attempt to challenge a LHIN decision since they set out the purposes for which the LHINs were created.

- The legislation includes no other specific criteria to guide LHIN decision-making. Unions representing health care workers recommended that LHINs be expressly required follow public interest criteria such as those set out in the preamble to the Act when carrying out their objects under the Act. This recommendation was rejected by the Committee.

- Geographic maps for LHINs are available here:
  http://www.health.gov.on.ca/transformation/lhin/lhinmap_mn.html

3. Control and Governance of the LHINs

- Cabinet is given authority (through regulation) to create, amalgamate, dissolve, divide and rename LHINs, and is given express power to transfer assets and employees between the Crown, Crown agencies and other LHINs (s.3).

- LHINs are Crown Agencies (s.4).

- LHINs are not to be operated for profit and may receive money only from the Crown (absent the approval of the Ministers for Health and Finance). They must use their money only to further their objects (s.6).

- Members of LHINs' Boards of Directors are appointed by Cabinet. Cabinet will also set Board members' remuneration and designate the chair and vice-chairs of a LHIN Board.[1] (s.7) Recommendations that LHINs Board of Directors members be elected by the public were rejected by the Committee.

- The LHIN board of directors must establish any committees required by regulation and are required to appoint members to those committees who meet the qualifications set out in the applicable regulation (s.8). Cabinet has the power to make regulations specifying the requirements for membership on any committees, including on the health professionals advisory committee as well as the committee's functions (s. 36).

- In principle, LHIN Board of Directors and committee meetings are to be public (s.9). The legislation was amended by the Committee to specify the circumstances in which a LHIN may exclude the public from any part of its meetings. The following is the list of circumstances in which the public may be excluded:

> (a) financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public;
>
> (b) matters of public security will be discussed;
>
> (c) the security of the members or property of the network will be discussed;

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[1] In this document we refer to powers granted to Lieutenant Governor in Council as powers of the Cabinet, since the L-G acts on and with the advice of the Executive Council (the Cabinet).

(d) personal health information, as defined in section 4 of the Personal Health Information Protection Act, 2004, will be discussed;

(e) a person involved in a civil or criminal proceeding may be prejudiced;

(f) the safety of a person may be jeopardized;

(g) personnel matters involving an identifiable individual, including an employee of the network, will be discussed;

(h) negotiations or anticipated negotiations between the network and a person, bargaining agent or party to a proceeding or an anticipated proceeding relating to labour relations or a person's employment by the network will be discussed;

(i) litigation or contemplated litigation affecting the network will be discussed, or any legal advice provided to the network will be discussed, or any other matter subject to solicitor-client privilege will be discussed;

(j) matters prescribed for the purposes of this clause will be discussed; or

(k) the network will deliberate whether to exclude the public from a meeting, and the deliberation will consider whether one or more of clauses (a) through (j) are applicable to the meeting or part of the meeting.

- The list of circumstances in which the public may be excluded is long and each item is framed broadly enough to cover a wide range of circumstances. Significantly, the list of circumstances includes when meetings will involve a discussion of matters that the Cabinet prescribes by Regulation, thereby preserving Cabinet's discretion to add to the already long list of circumstances listed in the legislation.

- However, the legislation requires that, before excluding the public from a meeting, a LHIN must hold a public vote on a motion clearly describing the nature of the matter to be considered at the general reasons why the public is being excluded (ss. 9(6)-(7)).

- The LHIN Board is to appoint a CEO, who will not be a civil or public servant within the meaning of the Public Service Act. The CEO will be paid within a range fixed by the Minister (s.10)

- LHINs will appoint auditors and, in addition, at any time the Minister may order the auditing of a LHIN or the Auditor General may audit any aspect of a LHIN's

operations. LHINs shall submit annual reports to the Minister which include the LHIN's audited financial statments and data relating specifically to Aboriginal health issues adressed by the LHIN. The Minister shall submit the report to Cabinet and either lay the report before the legislative assembly or deposit it with the Clerk of the assembly. Finally, LHINs also must provide reports on request to the Health Quality Council (s. 13)

A. LHIN Employees

- LHIN CEOs and other LHINs employees will not be civil or public servants (ss. 10 & 11) and since LHINs have not been added to the list of designated agencies under the Public Service Act (PSA), employees of LHINs will not be "Crown employees" within the meaning of the PSA and the Crown Employees Collective Bargaining Act.

B. Funding and Accountability (Part IV of the Act)

- LHIN funding is at the discretion of the Minister, with no specified factors to consider except that the Minister shall consider whether to adjust the funding to "take into account a portion of any savings from efficiencies ... that the network proposes to spend on patient care" (s.17).

- LHINs must enter into public accountability agreements with the Minister. Absent a voluntary agreement the Minister may dictate the terms of the accountability agreement (s. 18(3)).

- The Minister and each LHIN must make copies of the LHIN's accountability agreement available to the public in the offices of the Ministry and the network (s. 18(5)) and on their respective websites (s. 35.1).

- LHINs may fund Health Service Providers (HSPs) in respect of services provided in or for the geographic area of the network. Funding must be in accordance with the network's funding, its accountability agreement, and any requirements prescribed by Regulation. (s. 19) Recommendations that the legislation spell out criteria to be used by LHINs in funding HSPs was rejected by the Committee.

- Where the Minister is a party to an agreement with a HSP, it may assign its rights and obligations to a LHIN, even if a third party who is not an HSP is a party to the agreement. When doing so, the Minister may alter the termination date of the agreement to the date that the LHIN and the HSP enter into a service accountability agreement, or the date at which they have to enter into such an agreement.

- It appears from the context of this provision that it is directed at the assignment of accountability agreements entered into by the Minister under the *Commitment to the Future of Medicare Act, 2004*.

- The legislation expressly provides that agreements between the Minister and physicians or practitioners rendering services under OHIP shall not be assigned to the LHINs (s. 19 (3.1)).

- All HSPs that receive funding from a LHIN must enter into service accountability agreements with that LHIN, as defined in the Commitment to the Future of Medicare Act, 2004[2] and are subject to audit by the LHIN and to reporting obligations (ss. 20, 21, 22).

- Service accountability agreements that either the Minister or a LHIN enters into with a HSP are to be made available to public at the offices of the Ministry or the LHIN, as the case may be, as well as in a public place in the HSPs site of operations. The Ministry or LHIN as well as the HSP are also required to post the service accountability agreement on their respective websites (ss. 42 (49), 35.1).

- A LHIN must not enter into any agreement or other arrangement that prevents an individuals from receiving services in the geographic area in which they reside. An exception is made for LHIN agreements with Community Care Access Corporations.

Comment

It is clear that the government retains a very high level of control over the LHINs, through control of appointments to the LHINs, significant regulation making powers, control of LHIN funding, and accountability agreements which it may impose unilaterally, absent agreement. In addition, as set out below, the LHINs' plans for integration must be consistent with the provincial strategic plan (see below and ss.14 & 15).

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[2] The CFMA, 2004 defines "accountability agreement" in Part III, s.21 as an agreement establishing any one or more of, (a) performance goals and objectives respecting roles and responsibilities, service quality, accessibility of services, related health human resources, shared and collective responsibilities for health system outcomes, consumer and population health status, value for money, consistency, and other prescribed matters, (b) a plan and a timeframe for meeting those goals and objectives, (c) requirements for reporting and the provision of information, including personal information, (d) any other prescribed matter, and (e) the standards to be used in measuring compliance with anything mentioned in clauses (a) to (d).

4. Planning and Community Engagement (Part III of the Act)

A. Strategic Plans

- The Minister is required to develop a **provincial strategic plan** for the health system and each LHIN is required to develop an **"integrated health service plan**" consistent with the provincial plan (ss. 14, 15)

- Pursuant to amendments made by the Committee, the Minister must establish an Aboriginal and First Nations health counsel as well as a French language health services advisory council to advise the Minister about health and service delivery issues as well as priorities and strategies related to these communities. It is the Minister has the power to appoint members to each of these councils from among representatives of organizations that are prescribed by Regulation.

- The Minister must also seek the advice of "province-wide health planning organizations that are mandated by the Government of Ontario" when developing the provincial strategic plan. It is unclear from the legislation which organizations qualify as "province-wide health planning organizations", however representatives of the Ministry have stated that this would include organizations such as Cancer Care Ontario and the Cardiac Care Network of Ontario.

B. Community Engagement

- LHINs are required to "engage the community of diverse persons and entities involved with the local health system". This engagement is to be "on an ongoing basis", and is to include the integrated health service plan and the setting of priorities (s.16).

- Some of the most substantive amendments made by the Committee were aimed at fleshing out the meaning of "community" for the purposes of this requirement, as well as the methods that LHINs will use to engage this community. Notwithstanding these amendments, many details remain to be prescribed by Regulation.

- "**Community**" has been defined to include:

  > (a) patients and other individuals in the geographic area of the network;
  > (b) health service providers and any other person or entity that provides services in and for the local health system; and
  > (c) employees involved in the local health system.

- LHINs are also required to engage the Aboriginal and First Nations as well as the

French language health planning entities for the geographic area of the network. Cabinet has to the power to choose which entities will qualify as Aboriginal and First Nation as well as French language health planning entities, as these entities are to be prescribed by Regulation.

- Although the list of persons and entities forming part of the definition of community is not exhaustive, it does not expressly include unions or any other organization representing the interests of health care workers.

- The legislation does not require that LHINs use any particular **method to engage the community**. However, the legislation provides that the methods that LHINs may use include the following: holding community meetings or focus groups meetings, or establishing an advisory committee.

- **LHINs must establish an advisory committee of health professionals**, who are to be appointed by the LHIN "from among members of the those regulated health professions that the network determines or that are prescribed" by regulation (s.16). The legislation does not spell out the health professionals advisory committee's functions or the parameters of its advisory role. Cabinet has the power to prescribe the committee's functions by Regulation (s. 36(g)).

- Health Service Providers are also obliged to engage local communities, when developing plans and setting priorities (s.16).

5. Integration and Devolution (Part V of Act)

At the core of this Act is the obligation placed on LHINs as well as directly on each HSP to "identify opportunities to integrate the services of the local health system to provide appropriate, co-ordinated, effective and efficient services (s. 24).

- The **"services"** to be integrated include services and programs provided directly to people, but also services and programs that support these direct services and "functions" that support either one of the above.

- The result of this broad definition of "services" is that the services subject to integration go beyond the direct provision of health care to all functions that support that provision, from laboratory operations through laundry and administrative functions.

A. Powers of the LHINs

- LHINs are authorized to integrate the health system by doing any of the following

(s. 25):

(a) **providing or changing funding** to a health service provider;

(b) **facilitating and negotiating voluntary integration agreements** between health service providers or between health service providers and persons or entities that are not health service providers;

(c) **issuing an integration decision** requiring a health service provider to proceed with the integration described in the decision; or

(d) issuing an integration decision **requiring a health service provider not to proceed with an integration** it has independently planned. (s.25)

- LHINs are required to issue an **integration decision** when the LHIN facilitates or negotiates an integration of services and the parties reach an integration agreement, and also when it either requires or prohibits an integration of health service providers.

- LHIN integration decisions must set out the following:

(a) the purpose and nature of the integration;

(b) the parties to the decision;

(c) the actions that the parties to the decision are required to take or not to take, including any time period for doing so;

(c.1) a **requirement that the parties to the decision develop a human resources adjustment plan in respect of the integration;**

(d) the effective date of all transfers of services involved in the integration, if any; and

(e) any other matter that the network considers relevant.

- The requirement for a human resources adjustment plan to be developed arose from recommendations made by unions to the Committee. However, the requirement falls short of the kind of human resources adjustment planning that was envisaged by unions since it only requires the parties to the integration decision (i.e. the Health Service Providers or other entities being integrated) to develop the plan. It does not require the parties to negotiate the plan with employees affected by the integration or their bargaining agents.

LHINs Powers Devolved from the Government

- In addition to the powers of LHINs set out above, the Cabinet can pass regulations devolving to a LHIN any powers, duties, or functions held by the Minister, a person appointed by the Minister or the Lieutenant Governor under any Act for whose administration the Minister is responsible. The Minister may not devolve to a LHIN the power to make regulations under any of those other Act or any power that applies to physicians or practitioners rendering services under OHIP.

- This is a potentially very far-reaching provision which has the potential to extend the reach of the LHINs beyond the defined "health service providers". We have provided in Appendix "A" a summary of the pre Bill 36 powers held by the Minister under various Acts.

B. Integrations under the Act

There are four types of integrations that can occur under the Act:

(1) integrations required by LHINs (s. 26),
(2) integrations by health service providers (s. 27),
(3) integrations by the Minister (s. 28); and
(4) integrations by Regulation (s. 33).

Each of these is described in more detail below.

Integrations Required by LHINs

- LHINs may issue decisions requiring an HSP to which it provides funding to:

    1. To provide all or part of a service or to cease to provide all or part of a service;

    2. To provide a service to a certain level, quantity or extent.

    3. To transfer all or part of a service from one location to another.

    4. To transfer all or part of a service to or to receive all or part of a service from another person or entity.

    5. To carry out another type of integration of services that is prescribed.

    6. To do anything necessary for the health service providers to achieve the

above, including to transfer property to or to receive property from another person or entity

- Decisions requiring integration may be issued by a LHIN only after the LHIN has made its integrated health service plan public (s. 26(1)).

- The Committee accepted recommendations advanced by unions representing health care workers that **notice of proposed LHINs decisions** be made public and that **any person have the opportunity to make submissions** to be considered by a LHIN before making its final decision.

- The legislation now provides that, at least thirty days prior to issuing a decision, a LHIN must:

  (a) notify a health service provider that the network proposes to issue a decision under that subsection;

  (b) provide a copy of the proposed decision to the service provider; and

  (c) make copies of the proposed decision available to the public.

- Any person may make written submissions about the proposed decision within 30 days of the proposed decision's being made public. The LHIN is required to consider any written submissions prior to issuing its integration decision.

- Upon issuing a final decision, a LHIN is required to give the decision to the parties to the decision and to make copies available to the public at its offices and on its website (ss. 25 (6), 35.1)

- The rights of participation and procedural protections set out in the *Statutory Powers Procedure Act,* and applicable to tribunals with statutory decision-making power, do not apply to the integration decisions of LHINs.

Substantive Limitations on Integration decisions issued by a LHIN

- LHIN integration decisions are subject to the following restrictions:

  - must not be contrary to the LHIN's integrated service plan or accountability agreement with the Minister;

  - must not relate to services provided by an HSP that are not funded (or to be

funded) by the LHIN;

- must not require an HSP to cease operating, to dissolve or wind up, to amalgamate with another HSP or to change the composition of its membership or board of directors. However, all these things can be achieved through a Minister's order.

- must not unjustifiably, as determined under s.1 of the Canadian Charter of Rights and Freedoms, require an HSP that is a religious organization to provide a service contrary to its related religion.

- shall not require the transfer of property held for a charitable purpose to a non-charity;

- shall not require HSPs that are not charities to hold property for a charitable purpose

- LHINs shall not enter into agreements or other arrangement that restrict or prevent individuals from receiving services based on where they live (s.20), though this does not apply to agreements with Community Care Access Corporations that require the CCAC to deliver services in an approved area.

- LHINs may not issue integration decisions that "permit a transfer of services that results in a requirement for an individual to pay for those services, "except as otherwise permitted by law." It is not clear what guarantee is provided by the provision that transfers must not result in a requirement for an individual to pay for services, given the exception "as otherwise permitted by law". Recommendations to delete this restriction were not accepted.

• Significantly, LHINs are not prevented from transferring services from a not-for profit health service providers to for-profit entities. As described further below, the Act expressly provides that the Minister cannot order a not-for profit health service provider to transfer its operations to one or more persons or entities that carries out operations on a for-profit basis. No similar restriction applies to LHINs integration decisions, which in part has fuelled concerns that LHINs will be used as vehicles for privatizing services that were previously carried out by not-for-profit health service providers.

Integrations by Health Service Providers

• A second type of integration involves voluntary integrations by health service providers. The Act provides that a Health Service Provider may voluntarily integrate its services with those of another person or entity (who may not themselves be

"health services providers" for the purposes of the Act) (s. 27).

- Health service providers must give notice of an integration to the LHIN and must not proceed with the integration until 60 days have passed.

- LHINs have the power to order a health service provider not to proceed with an integration, if it considers it "in the public interest to do so" (although "public interest" is not defined in the Act). Before issuing such an order, a LHIN must notify the health service provider of its proposed decision, and provide copies of the proposed decision to the health service provider and also make copies available to the public. As with LHIN integration decisions, discussed above, any person may make written submissions about the proposed decision which are to be considered by the LHIN prior to issuing its final decision.

- In deciding whether or not to order a health service provider not to proceed with an integration, a LHIN must consider the extent to which the decision is consistent with the network's integrated health service plan, as well as any other relevant matters.

- LHINs are required to issue decisions only if they order health service providers and other entities not to proceed with an integration. There is no requirement that LHINs issue decisions to approve voluntary integrations. Therefore, voluntary integrations that a LHIN does not block will proceed without a decision being issued, and with no notice to the public. Also, because no decision is issued, the parties to a voluntary integration are not required to develop a human health resources adjustment plan for the integration (as required for integrations where the LHIN issues a decision).

Integrations by the Minister

As a third type of integration, the Act gives express authority to the Minister to issue orders to integrate.

- Upon receiving advice from a LHIN, the Minister can order HSPs that receive LHIN funding to do any of the following, where the Minister "considers it in the public interest to do so":

  - to cease operating, dissolve or wind up the HSP;

  - to amalgamate with one ore more health service providers that receive funding from a local health integration network;

  - to transfer all or substantially all of its operations to one or more persons or entities;

- to do anything or refrain from doing anything to achieve the results above including transferring or receiving property to/from another person or entity.

- In the second reading version of the Bill, the Minister only had the power to make orders to not-for-profit health service providers. The Committee accepted recommendations that the Ministers powers apply also to for-profit health service providers. However, a number of exceptions were also introduced that undercut the effect of this change by exempting sectors which represent the bulk of for-profit providers. The following were excluded from the Minister's powers:

  - homes for the aged;
  - charitable homes for the aged;
  - nursing homes; and
  - municipalities.

- The requirement for notice and the right for persons to make submissions relating to LHINs decisions discussed above is also made applicable to Minister's orders.

- The Minister must make its orders available to the public at its offices and on its website (ss. 28 (3), 25 (6), 35.1)

Substantive Limitations on Minister's Orders

The following restrictions apply to Minister's orders under the Act:

- **cannot order a not-for-profit health service provider to amalgamate with a for-profit health service provider**. The Minister also cannot order a not-for profit health service provider to transfer its operations to one or more persons or entities that carries out operations on a for-profit basis. As noted above, there is no similar restriction on LHINs decisions.

- must not unjustifiably, as determined under s.1 of the Canadian Charter of Rights and Freedoms, require an HSP that is a religious organization to provide a service contrary to its related religion.

- shall not require the transfer of property held for a charitable purpose to a non-charity;

- shall not require HSPs that are not charities to hold property for a charitable purpose

- may not issue integration decisions that **"permit a transfer of services that results in a requirement for an individual to pay for those services**, **"except as otherwise permitted by law"**. As with the similar restrictions on LHINs decisions described above, it is not clear what guarantee is provided by the provision that transfers must not result in a requirement for an individual to pay for services, given the exception "as otherwise permitted by law".

Integrations by Regulation

- The Cabinet may, by regulation**, order public hospitals to cease performing any "non-clinical service"** and to "integrate" the service by transferring it to another person or entity (s.33).

- A public hospital that is ordered to cease performing a non-clinical service must develop a human resources adjustment plan in respect of the transfer. As with the human resource plans required as part of LHIN integration decisions, there is no requirement that the plan be negotiated with affected employees or their bargaining agents.

- The Committee reviewing the bill amended it to include a deadline of April 1, 2007 for any integration of non-clinical services by Regulation.

Comment

Representatives of the Ministry have stated that this provision is aimed at permitting the contracting out of "back office" services, such as payroll services; however, the authority to transfer "any non-clinical service" has far broader potential implications.

We note in this regard that there is no definition in the Act of "non-clinical service" and that this definition may be a matter of considerable controversy, as it was in British Columbia, whose Health and Social Services Delivery Improvement Act defines "non-clinical services" as "services other than medical, diagnostic or therapeutic services provided by a designated health services professional to a person who is currently admitted to a bed in an inpatient unit in an acute care hospital, and includes any other services designated by regulation."

Under the B.C. definition any services provided in an out-patient setting or outside an acute care hospital are "non-clinical". While in our view this definition is counter-intuitive and could not reasonably be inferred into legislation that does not expressly include this definition, its existence does, at the very least, indicate that there is a wide zone of potential dispute about the meaning of the term "non-clinical service".

C. Compliance with Integration Decision, Orders, and Regulations

- The Act provides that a person or entity that is a party to an integration decision or Minister's order is required to comply with the order (s.29).

- All persons and entities "mentioned" in an integration regulation requiring the outsourcing of non-clinical services from a public hospital are required to comply with the regulation (33(2)).

- A LHIN or the Minister may apply to the Superior Court for an order directing "a person or entity that is a party" to the decision or order to comply with it (s. 29).

D. No Appeal or Review of Integration Decisions or Orders

- There is no appeal procedure in the Act. The only route available to challenge decisions made under authority of this legislation is therefore judicial review - a limited remedy under which decisions will be examined only to see whether the decision-maker has acted within the scope of the authority they were given by the Act. In making that determination the Courts will look closely at the purpose provisions of the Act and any objects provision that applies to the decision-maker involved. Courts on judicial review will not look at the relative merits of a decision.

6. Information for Public

- The Minister and each LHIN is required to establish and maintain websites on the Internet. They are also required to publish on their websites any documents that they are required to make public under the Act (e.g. LHIN integration decisions, Minister's orders, Provincial Strategic Plan, LHIN integrated health service plans, service accountability agreements, etc.)

7. Regulations

- The Lieutenant Governor in Council is required to publish proposed regulations and "consider" comments that are made before making regulations under the Act, although this process can be waived under certain conditions, with judicial review of the decision to waive available only within 21 days of the notice of waiver.

8. Review of Act and Regulations

- The Act requires that a comprehensive review of the Act and the Regulations be

launched between three and four years after it is passed. A government committee is to make recommendations concerning amendments to the Act within a year of the commencement of the review.

III. The Application of the Public Sector Labour Transition Act, 1997

1. The Local Health System Integration Act

- The LHSIA provides that the Public Sector Labour Relations Transition Act, 1997 (PSLRTA) will apply to the following types of integration:

    a) where services are transferred under an integration decision;

    b) where all or substantially all of an HSP's operations are transferred under a Minister's Order;

    c) where there is an amalgamation under a voluntary agreement facilitated by a LHIN or under a Minister's Order (s.32(1)).

BUT the **PSLRTA will not apply** to one of these events where:

    a) the successor employer (i.e. the entity receiving the transferred service or operation, or the newly amalgamated entity) **is not a health service provider and the primary function of that person or entity is not the provision of services within or to the health sector** (s.32(3)); or

    b) where the successor employer and all the bargaining agents that have (or would have) bargaining rights with that employer **agree that the Act does not apply.**

- The PSLRTA will also not apply **where the Ontario Labour Relations Board (the Board) issues an order declaring that it does not apply**, at the request of any bargaining agent or potential successor employer (s.32(7))

- In ruling on such a request the Act states that the OLRB is to consider the factors set out in s.9(3) of the PSLRTA, and any other matters that it considers relevant. Section 9(3), as amended by Bill 36, sets out the following factors to be considered in determining whether the Act should apply

    1. The scope of agreements under which services, programs or functions are or will be shared by employers subject to the health services integration.

    2. The extent to which employers subject to the health services integration have

rationalized or will rationalize the provision of services, programs or functions.

3. The extent to which programs, services or functions have been or will be transferred among employers subject to the health services integration.

4. The extent of labour relations problems that have resulted or could result from the health services integration (s. 32(9), 40(4))

- The OLRB can make interim orders in such applications (s. 32(17))

- The PSLRTA will also apply to integrations resulting from Cabinet regulations ordering the transfer of non-clinical services currently provided by hospitals, unless the regulation expressly states that the PSLRTA will not apply (s.33)

- Where the PSLRTA applies, the changeover date is the effective date of the integration, as set out in the decision, order, integration or other date prescribed in a regulation. Under the PSLRTA, as of the changeover date, bargaining rights for employees of a predecessor employer are continued with the successor employer, who is bound by the then-current collective agreement, and the process of finalizing the scope of the final bargaining units begins.

- The following sections of the Labour Relations Act apply to proceedings at the OLRB under the LHSIA: s. 96(6) concerning the filing of orders in Court; s.96(7) providing that the violation of signed settlements of proceedings under the Act are violations of the Act; s. 122 concerning notice and s.123, providing that proceedings shall not be set aside for technical irregularities absent a substantial wrong or miscarriage of justice (s. 32(20)).

- If the PSLRTA does not apply to a health sector restructuring initiative because of one of the exceptions set out in the Act, sections 12 and 36 of the PSLRTA will still apply, if applicable to the integration in question. Sections 12 and 36 of the PSLRTA deal with seniority issues in the event of a sale of business to public sector employers that is not otherwise covered by the PSLRTA.

- In addition, the PSLRTA will apply to amalgamations of Community Care Access Corporations, under amendments to the CCAC Act, set out in more detail below.

2. Bill 36 Amendments to the PSLRTA, 1997

The PSLRTA, 1997 has been amended by the LHSIA, 2005 so as to cover this round of public sector restructuring and so as to add the new sections necessary for it to deal with transfers of service, rather than restructuring at the corporate level.

- The PSLRTA previously applied in the municipality and hospital sectors only during a specified "transitional period" (which has been progressively extended by Regulation). Bill 36 removes all references to the transitional period and **the PSLRTA now applies permanently to all sectors and circumstances that it covers**: Bill 36 s.40(2) amending ss.3, 8 PSLRTA

- The PSLRTA continues to apply in the municipal and school sectors, as well as to hospital amalgamations: s.3,7,8 PSLRTA

- In addition to the listed circumstances set out in Bill 36 in which the PSLRTA will apply, the PSLRTA can now apply, upon application by an employer or bargaining agent, to employers that are or will be subject to a"health services integration", as set out in sections 2 and 9 of the amended PSLRTA. (This section replaces a prior section concerning hospital restructuring other than amalgamations): Bill 36 s.40(4), s.9 PSLRTA.

- **Health Services integration** is defined in s.2 of the PSLRTA to include:

> an integration that affects the structure or existence of one or more employers or that affects the provision of programs, services or functions by the employers, including but not limited to an integration that involves a dissolution, amalgamation, division, rationalization, consolidation, transfer, merger, commencement or discontinuance, where every employer subject to the integration is either,
>
> (a) a health service provider within the meaning of the Local Health System Integration Act, 2005, or
>
> (b) an employer whose primary function is or, immediately following the integration, will be the provision of services within or to the health services sector.

This is a broad definition which, however, excludes transfers of work outside the health sector, as will likely take place with respect to some non-clinical services. This limitation mirrors the similar express limitation set out in the LHSIA. There is no express definition of "health services sector" in either Act.

- As before, by regulation, the Cabinet may pass regulations specifying "other circumstances" in which the PSLRTA applies (s.10 PSLRTA). Bill 36 adds a further more specific power to specify by regulation a health services integration as an event to which the PSLRTA applies: s.40(3.1).

The effect of a regulation specifying that the Act applies to a health services integration would be to pre-empt the necessity of an application under the PSLRTA to that effect. In light of s.39 of the PSLRTA, which provides that a Regulation under the PSLRTA prevails over any other Act, it may also serve to bar an application to the Board requesting a declaration that the PSLRTA does not apply to an event listed in the LHSIA as otherwise triggering its application.

- The Labour Board's order can be made before or after the integration, on terms it considers appropriate and is discretionary. In exercising this discretion the Board must consider several factors (scope of sharing agreements between employers subject to the integration; extent of rationalization by employers subject to the integration; extent of transfers between employers subject to the integration; extent of labour relations problems due to the integration). Finally, the Board must specify the predecessor and successor employers in its order. The section does not apply to Crown employers: s. 9(1)-(7) PSLRTA.

- The PSLRTA has been amended to recognize that the circumstances in which it will apply are now set out in the Local Health System Integration Act, 2005, as well as in the application sections of the Act itself. Sections have been added to PSLRTA specifying that successor rights provisions under the Labour Relations Act do not apply to events described in the application sections of the PSLRTA or in accordance with the LHSIA, 2005: PSLRTA s. 13, also s.22.

A. Partial Integrations in the Health Sector

- An entire new section has been added to the PSLRTA setting out how the Act will be modified for the **partial integrations** in the health sector to which it now applies: s. 19.1(1) PSLRTA.

- A partial integration takes place when an employer continues to operate after an integration in which some services it provided are moved elsewhere. The Act defines "partial integration" as follows:

  a) some or all of the programs, services or functions performed by employees in a particular bargaining unit at a predecessor employer are transferred to or otherwise integrated with a successor employer, and

  (b) on and after the changeover date, the predecessor employer continues to operate: s. 19.1(2)

- In a partial integration, the provisions of the PSLRTA that continue bargaining rights at the successor employer for employees that were represented by the bargaining

agent at a predecessor employer, and for their replacements, continue to apply. However, new sections have been added:

- to specify that, in a partial integration, bargaining rights cover only the employees who were employed in the delivery of the programs, services, functions that are being transferred or integrated with the successor employer: s.19.2(1) and (2))

- to clarify that bargaining agents with bargaining rights for non-affected bargaining units do not obtain any bargaining rights with a successor employer. A "non-affected bargaining unit" is a defined term in the Act that refers to bargaining units that are unaffected by a partial integration, in the sense that their bargaining unit work is not subject to transfer to or integration with a successor employer: ss. 19.1(2), 19.2(3).

- As before, bargaining units that are continued at a successor employer will not include those who, prior to the transfer or integration, were non-unionized or Crown employees: s.19.3

- Existing provisions continuing collective agreements after changeover will apply to partial integrations: s. 19.3

Comment

These provisions of the Act might be read as assuming that the employees who are to be transferred are those who happen to be delivering the service that is affected by a partial integration. This assumption does not accord with the principle of seniority in existing collective agreements. Bargaining agents will, in general, have, or wish to see, arrangements in place which allow transfers to be implemented first by choice, and then seniority, among those qualified for the positions at issue.

B. Impact of partial integrations on other proceedings

- On a partial integration, the provisions of the PSLRTA terminating the appointments of **conciliation officers** apply in a modified form, so that existing conciliation officer appointments continue to be valid on the changeover date in relation to the predecessor employer, but have no status with respect to successor employers or bargaining agents with bargaining rights in respect of successor bargaining units. As before, no new conciliation officers are to appointed for a successor bargaining unit in a partial integration until the description of the restructured unit is finalized: s. 19.4.

- Similarly, **notice to bargain** given before the changeover date continues to be valid with the predecessor employer, but will not apply in respect of the successor employer and a bargaining agent whose rights with a predecessor employer are continued with the successor employer: s.19.5

Interest Arbitrations

- On a partial integration, interest arbitrations in which a final decision has not been issued are not terminated "unless the arbitrations are otherwise lawfully terminated": s.19.6(2).

- Where an interest arbitration is underway between a predecessor employer and a bargaining agent, no final decision shall be issued without the parties having been given an opportunity to make further submissions that address the partial integration. However, the arbitration will not apply in relation to the successor employer: s.19.6.

We have included as Appendix B a revised version of a **Working Guide to the Public Sector Labour Relations Transition Act, 1997** (originally drafted at the time that Act was introduced) that incorporates the Bill 36 amendments to PSLRTA.

3. Comment re: Application of the PSLRTA

When an integration takes place, in order to determine the application of the PSLRTA it will be necessary to review the LHSIA, the PSLRTA, the nature of the legal instrument requiring the integration (i.e. LHIN integration decision, Minister's order, Regulation, agreement etc.), and the nature of the entities to be integrated (e.g. whether a health service provider, whether its primary function is the provision of services to the health sector, etc.) Some examples follow, by way of illustration only:

A. Health Service Provider (HSP) to Health Service Provider by LHIN Integration Decision

If a LHIN issues an integration decision requiring a health service provider to transfer a program or service to another health service provider (e.g. a public hospital to a community care access centre), the PSLRTA will apply, by virtue of section 32(1)(a) of the LHSIA, unless either:

a) all the affected employers and bargaining agents agree that it will not apply, or,

b) an affected employer or bargaining agent makes an application to the OLRB for a declaration that the PSLRTA should not apply, and the Board issues that

declaration.

B. HSP to HSP by voluntary agreement (not the subject of an integration decision)

If two Health Service Provider employers (e.g. two hospitals) agree to integrate some of their services programs or functions the PSLRTA will not automatically apply, but either employer or any bargaining agent representing their employees can make an application to the Ontario Labour Relations Board under s.9 of the PSLRTA requesting a declaration that the PSLRTA will apply.

C. HSP to non-HSP by Voluntary Agreement (not covered by an order or integration decision)

The PSLRTA will not automatically apply. An application to the Board for a declaration that the PSLRTA applies may be made only if the primary function of the non-HSP is (or will be immediately following the integration) the provision of services within or to the health services sector: s.9 PSLRTA.

D. HSP to non-HSP by LHIN Integration Decision

The PSLRTA will not apply if the primary function of the non-HSP successor employer is other than the provision of services within or to the health sector. If the non-HSP successor is within the health sector then the PSLRTA will apply by virtue of section 32(1)(a) of the LHSIA, unless either:

a) all the affected employers and bargaining agents agree that it will not apply, or,

b) an affected employer or bargaining agent makes an application to the OLRB for a declaration that the PSLRTA should not apply, and the Board issues that declaration.

E. CCAC Amalgamation by Regulation or Minister's Order under the CCAC Act

The PSLRTA will apply, pursuant to section s.15.3(6) of the CCAC Act, as amended by Bill 36.

IV. Amendments to the Community Care Access Corporations Act, 2001 (note: this link is to the current, and unamended version of the Act)

- The CCAC Act, 2001 defines the structure of CCACs and the manner in which they fit into the scheme of the Long Term Care Act

- Bill 36 amends the Community Care Access Corporations Act to continue existing CCACs as corporations without share capital, while extinguishing their existing letters patent. The members of CCACs will be the members of the existing board of directors.

- Other CCACs may be incorporated by Cabinet regulation as corporations without share capital: s.2.

- The objects of CCACs remain the same, except for one addition, as follows:
  1. To provide, directly or indirectly, health and related social services and supplies and equipment for the care of persons.
  2. To provide, directly or indirectly, goods and services to assist relatives, friends and others in the provision of care for such persons.
  3. To manage the placement of persons into long-term care facilities.
  4. To provide information to the public about community-based services, long-term care facilities and related health and social services.
  5. To co-operate with other organizations that have similar objects.

- The object added by Bill 36 is to carry out any charitable object that is prescribed, and is related to the other objects.

- The Cabinet may make regulations prescribing objects for the purposes of the additional object: s.22(0.1) amended CCAC Act.

- Existing provisions that require community advisory councils are repealed and replaced with the provision that a board of directors "may establish committees of the board as it considers appropriate: 39 (12).

- When a CCAC is amalgamated, dissolved or divided, its Executive Director is terminated unless re-appointed: 39 (13).

- The Executive Director of a CCAC is to be appointed by its Board (rather than, as previously, the Cabinet): 39 (14).

1. Powers re CCAC Restructuring

- Cabinet is given authority, by regulation, to amalgamate, dissolve or divide CCACs: s.39(18).

- Where Cabinet amalgamates, dissolves or divides CCACs, it may, by further regulation "establish processes or requirements" dealing with CCAC assets and with "transferring employees" of CCACs: 39(18), amending s.15(2) of the CCAC Act.

- Cabinet may also provide by regulation "for any transitional matters necessary for the creation, amalgamation, dissolution or division of CCACs.

Minister's Orders

- Subject to the "processes" set out by Cabinet Regulation the Minister may order the transfer of assets in the restructuring of CCACs.

- Similarly, the Minister may order the transfer of some or all of the employees of a CCAC "to one or more other CCACs": 39(18), amending s.15(3) CCAA.

- In an order the Minister must specify the date of the transfer of employees and assets, and may specify that issues arising out of the interpretation of the order be resolved by a method specified in the order.

- Orders made under this provision are to be provided to affected CCACs, who are, in turn, required to give notice of the order to employees and their bargaining agents and to others whose contracts are affected by the order, and make copies of the order available to the public.

- Before the Minister issues an Order the Minister is required to notify the affected CCACs and may require them to jointly prepare and submit a report containing proposals for:

    - the reorganization of the CCACs
    - the transfer of assets, etc;
    - the transfer of employees

- If the affected CCACs cannot agree on a proposal, the report is to set out the basis of the dispute. The Minister can make directions as to the required content of the report: s.15(1) amended CCAC Act

- The Minister will set the deadline for the submission of a joint CCAC report. If the deadline passes without a report the Minister may make the order. Where a report

is received the order "may implement, with the modifications that [Cabinet] considers necessary, the proposals it contains: s.15.2 amended CCAC Act

- Bargaining agents are given no formal role in this process.

- There is no appeal or reconsideration of a Minister's order set out in the Act.

- There is no compensation to a CCAC for losses arising from a Minister's Order, and no compensation to anyone for losses arising from the transfer of property under a Minister's Order, except in respect of losses relating to property not acquired with government money. The Cabinet may make regulations governing such compensation. s.16.2 & s.22(0,1(b) amended CCAC Act.

- The Act sets out some ground rules for the amalgamation of CCACs. Any Regulations or Minister's Orders must be consistent with these rules:

    - The amalgamated CCAC stands in the place of the predecessor CCACs for all legal purposes.

    - The PSLRTA, 1997 applies, with the date of amalgamation serving as the changeover date; s.15.3(6) amended CCAC Act.

    - The Act specifies that, without limiting the application of the PSLRTA, employment contracts, terms and conditions of employment, and rights and benefits of employment, along with the employment obligations of the employee are continued with the CCAC to which the employee is transferred and that the employment of a person transferred shall not be considered terminated for any purpose: s. 2(18), s.17.2 amended CCAC Act.

2. Annual Reports

- Each CCAC must give an annual report to the Minister, which must include the information that the Minister specifies.

3. Information for the Public

- The Minister must make the following available to the public:

    - every report of a CCAC on its affairs given to the Minister under the CCAC Act;
    - every report of the auditors of a CCAC.

V. Public Hospitals Act - Amendments (link is to the current version of the Public Hospitals Act)

- The definition of “hospital” and “patient” are amended by Bill 36 as follows:

  - "hospital" means any institution, building or other premises or place that is established for the purposes of the treatment of patients and that is approved under this Act as a public hospital;

    "patient" means an in-patient or an out-patient

- Bill 36 adds a new definition of “in-patient”:

  "in-patient" means a person admitted to a hospital for the purpose of treatment;

- There are also a series of amendments that reflect this re-definition of “patient”.

- The government’s Compendium accompanying the legislation indicates that the amendments to the definition of hospital and patient were made in order that Women’s College Hospital could continue to be a hospital if, after its de-merger with Sunnybrook, it no longer has in-patient beds.

Comment re: Application of HLDAA

- We note that the definition of “hospital” in the *Hospitals Labour Disputes Arbitration Act* (“HLDAA”) is broad, and does not turn solely on the definition in the *Public Hospitals Act*. HLDAA provides that:

  > "hospital" means any hospital, sanitarium, sanatorium, nursing home or other institution operated for the observation, care or treatment of persons afflicted with or suffering from any physical or mental illness, disease or injury or for the observation, care or treatment of convalescent or chronically ill persons, whether or not it is granted aid out of moneys appropriated by the Legislature and whether or not it is operated for private gain, and includes a home for the aged;

- In applying the definition of “Hospital” under the Hospitals Labour Disputes Arbitration Act (HLDAA) decision-makers have not looked to the definition in the PHA, but rather have focussed on the language of HLDAA itself, and on the purpose of HLDAA, which has been held to be the protection of those who may not

adequately be able to protect themselves if services provided by the institution were unavailable in the event of strike or lockout. It therefore appears that, where services are transferred from an institution to which HLDAA applies to another institution, whether HLDAA will apply to the receiving institution will turn on HLDAA's definition of "hospital" and on the facts concerning the services provided, or to be provided, by the successor institution. However, the reference to "hospital" in the course of the HLDAA's definition does refer to hospitals as understood elsewhere, and we would therefore take the view that any approved hospital under the PHA ought to be held to fall within the HLDAA definition without further analysis.

VI. Effective Dates for *Local Health System Integration Act, 2005*

Bill 36 comes into force on the day it receives Royal Assent, except for the following provisions which come into force on a day to be named by proclamation:

Subsections 9 (3) and (4)	Requirement in LHSIA, 2005 that LHIN Board of Directors and committee meetings shall be public
18 (1), (2), (3) and (5)	Requirement in LHSIA, 2005 for accountability agreements between LHINs and the Minister
section 19,	LHSIA, 2005 provisions re: funding of health care providers by LHINs
subsection 20 (1),	LHSIA, 2005 requirement for health service providers to enter into accountability agreements with LHINs
section 21,	LHSIA, 2005 provision re: power of LHINs to require audits of health service providers
subsections 39 (4), (6), (8), (9), (11), (14), (15), (16), (21), (24) and (27)	Various amendments to the Community Care Access Corporations Act
section 41	Amendments to the Charitable Institutions Act
subsections 42 (2) to (54)	Amendments to the Commitment to the Future of Medicare Act, 2004
section 44	Amendments to the Homes for Aged and Rest Homes Act
section 45	Amendments to the Long Term Care Act, 1994
section 47	Amendments to the Nursing Homes Act

VII. List of Acts Affected by Amendments contained in Bill 36

The above memo has not reviewed Bill 36's amendments to all the Acts it affects. The full list of amended legislation is as follows:

Charitable Institutions Act
Commitment to the Future of Medicare Act, 2004
Community Care Access Corporations Act, 2001
Health Facilities Special Orders Act
Homes for the Aged and Rest Homes Act
Long-Term Care Act, 1994
Ministry of Health and Long-Term Care Act
Nursing Homes Act
Pay Equity Act
Personal Health Information Protection Act, 2004
Public Hospitals Act
Public Sector Labour Relations Transition Act, 1997
Social Contract Act, 1993
Tobacco Control Act, 1994

VIII. Resources

Text of Bill 36 (including Committee's amendments) - Local Health System Integration Act, 2005 (third reading version not available on-line at time of printing)

Hansard Debates on the Legislation

First Reading:
November 24, 2005: Minister's Statement and Mrs. Witmer and Ms. Martel

Second Reading:
November 29, 2005 - Mr. Smitherman, Mr. Martiniuk, Ms. Martel, Mr. Ramal, Mr. Tascona, Ms. Mossop, Mr. O'Toole, Mr. Runciman, Mr. Arthurs, Mr. Miller

December 5, 2005 - Mr. McNeely, Mr. Miller, Mr. Bisson, Mr. Delaney, Mr. Sterling, Mrs. Witmer, Mr. Marchese, Mr. Levac, Mr. Jackson, Mr. Dunlop, Mr. Brownell

December 6, 2005

December 07, 2005

Social Policy Committee: February 15, 2006 (Reported to the House)

Third Reading:

March 01, 2006

Background information provided by the Ministry of Heath and Long-Term Care

Government Compendium: Local Health System Integration Act, 2005
Section by section summary of the legislation.

McGuinty Government Gives Local Communities Real Power Over Delivery of Health Services - Press release, November 24, 2005.

LHIN Endorsements - Backgrounder, November 24, 2005

McGuinty Government Introduces Legislation to Address Local Health Care Needs -Backgrounder, November 24, 2005

McGuinty Government Announces Leadership Of Local Health Integration Networks
Press release and backgrounders, June 28, 2005.

McGuinty Government Moves Forward On Building A True Health Care System For Patients - Press release, October 6, 2004.

Other Documents of Interest

Revitalizing Ontario's Public Health Capacity - Interim Report - November 2005

The newly formed Local Health Integration Networks (LHINs) will be responsible for planning and funding a range of healthcare services in their communities, not including primary care and public health. The creation of LHINs themselves will provide both opportunities and challenges for public health in the years ahead. The planning boundaries for the 14 LHINs do not easily align in a number of health unit areas. Even where they do coincide, there is usually a one-to-many relationship between the LHIN and component health units. A challenge faced by the Public Health Capacity Review Committee is how to define a successful interface between public health and LHINs that will work in the best interests of all. Effective collaboration between LHINs and public health regarding population health assessment mandates is particularly important.

Part of the Committee's mandate is to reconsider the structures through which public health services are delivered and in particular to consider the pros and cons of further consolidation and amalgamation, and the proper role of municipalities.