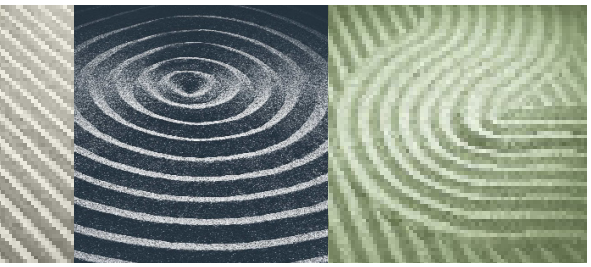

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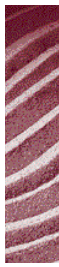

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LOCAL HEALTH SYSTEM INTEGRATION ACT, 2005 - UPDATE AND ISSUES

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In our *Communiqué* dated November 25, 2005, we outlined the principles integral to Bill 36, the proposed *Local Health System Integration Act, 2005*, which gives Local Health Integration Networks ("LHINs") operating authority. As Bill 36 works its way through the parliamentary process, many questions are emerging regarding the potential implications of this draft legislation.

COMMITTEE HEARINGS

Bill 36 passed second reading on December 7, 2005 and was referred to the Standing Committee on Social Policy for consideration. The Committee will hold Public Hearings in Toronto, London, Ottawa and Thunder Bay on January 30, January 31, February 1, and February 2, 2006, respectively.

Health industry clients who are interested in making an oral presentation to the Committee must contact the Committee **by 5:00 p.m. on Friday, January 13, 2006**. Those who wish to make written submissions must do so **by 5:00 p.m. on Monday, February 6, 2006**.

EMERGING ISSUES

The proposed legislation is not intended to replicate the regionalization bureaucracies of other provinces, therefore it is anticipated that the local health systems will evolve individually and with some variation. Nevertheless, there are some general themes that are already apparent, and which merit further consideration:

1. Implications for governance.

Boards of Directors of hospitals and other health industry entities hold a fiduciary responsibility to their clients and the local community they serve to provide appropriate services and to ensure that reasonable standards of care are met. Will the enactment of LHINs interfere or restrict that responsibility? It is our view that it is inevitable that LHINs will have an impact on this responsibility.

2. Responsibility for services.

While the LHIN is responsible for setting performance goals, objectives, standards and targets for the local health system, the direct provision of services, their quality and standards will remain the responsibility of each health service provider. These services will be subject to monitoring and review by the LHIN through, for example, accountability agreements and possible resultant compliance directives.

Expectations could be imposed that the provider believes it cannot meet, as is possible now through Accountability Agreements pursuant to the *Commitment to the Future of Medicare Act, 2004* (CFMA). Further, Bill 36 prohibits any civil action being brought against a LHIN, as a Crown Agent, leaving the provider liable for failure to meet standards, the cause of which could be the imposed performance expectations of such agreements.

3. Adjustments to the Nature, Provision and Location of Services.

The planning and implementation provisions of Bill 36 have generated serious concerns. Although the policy principles of increased access and greater efficiencies can hardly be objectionable, the broad terms of the LHINs to reconfigure services has, as yet unidentifiable, but nevertheless, huge implications for most health service providers in the province.

4. Tertiary and Quaternary Services.

In the current draft of Bill 36, there is no indication of allocation of funds for the transfer of clients to tertiary and quaternary care centres. How this will be accomplished to meet the obligations of these centres without seriously depleting the resources of the referring centres has yet to be addressed.

5. Religious-based Providers.

While there is some protection for health service providers which are religious organizations in the draft legislation, there is concern as to whether or not the protections are adequate. Bill 36 proposes that the LHIN and the Minister are restricted from 'unjustifiably' requiring a religious based provider to provide a service that is contrary to the religious principles of the organization. There is no definition of 'unjustifiable', but it appears that services can be added to or changed or an organization can be ordered to cease operating, to amalgamate with another or to transfer its operations, without regard for the religious value base, as long as they can be justified by either the LHIN or the Minister respectively.

Health service providers that are required to transfer property to another entity are not entitled to compensation for any loss or damages arising from the transfer of property under an integration decision or a Minister's order. They are entitled to compensation for the portion of the loss that relates to the portion of the value of the property that was not acquired with money received from the Ontario government. As many properties of religious based health service providers are owned by religious organizations, this could have significant financial implications for these organizations, depending upon the methodology used, which is to be prescribed.

6. Contractual Rights.

The CFMA provides for a performance agreement to be entered into between the Chief Executive Officer or Executive Director of a hospital, long term care home or community care access centre and the organization's Board of Directors. Since the enactment of this legislation, this has been a matter of concern because of the insinuation of the Minister between the Board and its employee. This issue continues under the proposed LHIN legislation.

Bill 36 allows the Minister to assign his or her rights and obligations to a LHIN, including with respect to agreements that include both health service providers and non-health service providers. This may allow agreements to be adjusted and terminated prior to any termination dates that are contained within the contract. A LHIN could also recommend to the Minister that an exceptional circumstances order be made in respect of CEO compensation.

7. Financial and Fiscal Responsibilities.

Accountability for funding envelopes will be devolved to LHINs. It appears that these envelopes will be finite and LHINs will have no opportunity to borrow or enlarge the envelopes, at least not without the approval of the Lieutenant Governor in Council. How much autonomy each health service provider will have regarding the financing of its affairs is as yet unclear, but it is anticipated to be significantly restricted upon the enactment of this obligation and responsibility to LHINs.

8. Labour Relations Issues.

Under the proposed Bill 36, the *Public Sector Labour Relations Transition Act, 1997* (PSLRTA) will extend to integration decisions involving the transfer of all or part of a service or operations of a health service provider or the amalgamation of two or more persons or entities. The PSLRTA was enacted to establish a framework for resolving labour relations issues resulting from restructuring initiatives in the broader public sector, including hospitals. Currently, it applies upon the amalgamation of two or more hospital corporations, or by order of the Ontario Labour Relations Board, involving the merger of all or part of the operations or administration of two or more hospitals or a substantial restructuring of two or more hospitals during the transition period (defined by regulation as ending December 31, 2007).

This could have significant labour relations implications, with the Ontario Labour Relations Board having discretion to combine bargaining units and to order representation votes, even where there is no intermingling of bargaining units. Further, under Bill 36, the transition period is extended indefinitely.

These issues and many others will require local consideration as they unfold within the jurisdiction of each LHIN. We will continue to monitor the evolution of Bill 36 and to address issues as they arise.

We would be pleased to assist health industry clients to develop strategies to address specific issues, to develop oral presentations or written submissions for the Standing Committee, and to provide legal advice about particular concerns. We are pleased to offer customized education sessions on the potential implications of the legislation. For further information or assistance please contact:

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Our National Health Industry Practice Group is dedicated to providing comprehensive and integrated legal services to health industry clients. For more information about our group, visit our website at www.millerthomson.com or contact one of our regional contacts.

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