Hill+Knowlton Strategies

MEMO

To:	Association of Family Health Teams of Ontario
From:	Hill + Knowlton Strategies (H+K)
Date:	February 28, 2019
Subject:	The People's Health Care Act

Background

The Ford government signaled health reform was coming early on with its creation of the Premier's Council on Improving Healthcare and Ending Hallway Medicine. The Council's first interim report, released on January 31st 2019, outlined challenges facing the province's health system. The same day, the opposition NDP leaked an early draft of government legislation, the *Health System Efficiency Act*, which sketched out significant changes in store for care delivery and organization. Days later, additional materials were leaked which provided further detail.

On February 26th, Minister Elliott formally announced the government's plans for health care modernization, tabling the proposed legislation, Bill 74 – now retitled *The People's Health Care Act* – later that day. Other materials as well as comments by the Minister and senior officials gave further shape to the planned changes, in some cases contradicting leaked information.

What's new; what's different

If you have read H+K's previous notes on the leaked documents, you might be wondering what new or different information has now been made available. While further detail will be provided in the full summary and analysis below, here are some key highlights:

+ The "Super Agency" will be branded Ontario Health
+ The "MyCare Groups" will now be called Ontario Health Teams
+ We now know that the plan is to roll out these changes gradually, over many years
+ The Bill would give the Ministry responsibility to create Ontario Health Teams; the previous draft placed this power in the Agency
+ There will be a readiness assessment process for potential Ontario Health Teams, with ongoing support for groups interested in becoming one
+ Health Shared Services Ontario is among agencies to be combined into Ontario Health
+ The process for entering into a Service Accountability Agreement with the Agency is now laid out in the proposed legislation, and it differs from the current process under LHSIA
+ The Bill would give the Minister authority to force amalgamations with any Agency-funded organizations – not just health service providers and Ontario Health Teams
+ The Bill removes a subsection, included in the draft, noting that the Minister would have authority to force health providers to use the Agency for supply chain management and procurement – although even without this the Minister seems to retain that authority
+ Under the new Bill the Minister will not have the authority to appoint investigators to public hospitals; that authority rests with Cabinet
+ The Bill now clarifies that a supervisor appointed to an OHT will have powers over each constituent element of the Team that isn't a hospital or long-term care home

Overview
Bill 74 would enable the Minister to dissolve Ontario's Local Health Integration Networks (LHINs) and several government agencies, including Cancer Care Ontario, eHealth Ontario, and HealthForceOntario, combining their functions into a single agency, Ontario Health. The Agency would have responsibility for the organization and funding of care across the province, with similar powers to those currently held by LHINs. Health service providers (HSPs) would have funding and accountability relationships with Ontario Health.

This would not be a straightforward transfer of powers and responsibilities. Notably, the new agency would not have the same authority to force service integrations that LHINs currently have – this would rest instead with the Minister. On the other hand, the Bill would enable government to make primary care physicians accountable to the new Agency, a measure that has faced strong resistance by doctors in the past. The Agency would also take on a new function providing supply chain and procurement services to HSPs. (Government notes that providers and patients would be engaged on procurement to ensure products are selected that will provide the best outcomes.)

A level below the Super Agency, the legislation allows for the creation of "Integrated Care Delivery Systems", branded by government as Ontario Health Teams (OHTs). The precise mandate and structure of these teams is not detailed in the draft legislation, leaving this to regulation and operational decision-making.

The government has indicated that these teams, up to 50 of them, would bring together providers across the full spectrum of services to provide integrated care to people in a specific geography or patient class (for example, complex pediatric care). Direct care currently provided by LHINs – mainly care coordination – would shift to OHTs. A blended funding model would be used, with OHT providers sharing a single payment for each patient journey, tied to outcomes.

An Expression of Interest will be issued in March 2019 for early adopters, with teams added gradually but continuously toward a goal of full provincial roll-out in the next year or two. The government is being flexible in its approach, encouraging creativity, allowing multiple models, and promising course adjustments based on learnings. That said, it remains unclear whether or how the government would roll all HSPs into this new model.

The Bill would accrue significant new powers to the Minister, including authority currently held by LHINs to force service integrations, while stripping away some obligations to consult that exist in current law. It would also give the Minister broad authority to delegate nearly any of her powers to the new Agency, while also giving her the ability to dismantle the Agency entirely. Leaked documents indicate government is open to folding additional, and possibly all, health agencies into Ontario Health, and a significant reorganization of the Ministry could see many of its divisions and branches move over to the Agency.

The government's approach is based on the quadruple aim – better patient/caregiver experience, better patient health outcomes, better efficiency, and better provider experience. Throughout implementation government will measure and report on outcomes including:

+ Patients' knowledge of how to access care needs
+ Patients' ability to access those needs
+ Improved outcomes and quality of life for patients and caregivers
+ Better use of resources
+ Stronger provider confidence in the system and better provider health

DETAILED SUMMARY

The Bill has three schedules. The first and longest is the new *Connecting Care Act*, which describes the new agency, Ontario Health Teams, powers of the Minister, and rules governing transition to the new structure. The second schedule makes small changes to the *Ministry of Health and Long-Term Care Act*, and the third makes amendments (mostly technical) to nearly 30 pieces of legislation affected by the *Connecting Care Act*.

The Bill is structured so that different sections could be proclaimed or repealed at different times. The Ministry has told stakeholders that implementation would be phased over time, lasting several years, with agencies transitioning over to Ontario Health piecemeal, and some LHIN responsibilities transferring to OHTs as they come online.

New to this version, the *Connecting Care Act* includes a preamble setting out guiding principles, similar to one contained in the *Local Health Systems Integration Act* (LHSIA). The new Act stakes out a patient-centred vision of health care with funding directed to frontline services and focused on improved patient experience, better value, best outcomes per dollar, and improved overall health. Principles related to diversity and the role of Franco-Ontarians and Indigenous peoples carry over from LHSIA, but reference to health equity is removed. Also gone from the preamble are LHSIA's commitment to non-profit care, public accountability and transparency, and principles enshrined in the *Canada Health Act* and *Commitment to the Future of Medicare Act*. Unsurprisingly, LHSIA also focused more in its preamble on locally-delivered care; the *Connecting Care Act* speaks at greater length about value and patient-centred care.

Ministry of Health and Long-Term Care

Leaked documents show that the government sees the Ministry of Health and Long-Term Care continuing to act as system steward. It would lay out strategic priorities and drive strategy and policy, with advice from Ontario Health, while setting up accountability frameworks and monitor overall system performance. The Ministry would continue to operate the Ontario Public Drug Programs and the Ontario Health Insurance Plan, and manage its internal corporate services.

Those same leaked documents indicated a large-scale reorganization of the Ministry would follow passage of the legislation, with significant portions downloaded to the Agency. In the draft plan, branches and divisions supporting functions noted above would remain more or less in place. Others – particularly those related to direct services – would move to Ontario Health. The draft reorganization paper also seems to suggest long-term care and ambulance oversight would be broken up and partially outsourced, other functions moved to the private or broader public sector, and no decisions about where the Chief Medical Officer of Health or health professional oversight will land. It should be noted that the Health Minister, in response to the leak, denied plans to privatize or outsource any Ministry functions.

Ontario Health

The legislation provides a framework for the creation and governance of a new agency, Ontario Health, to organize and deliver health care province-wide. Similar to recent moves in other provinces, Ontario intends to consolidate several provincial and regional health agencies into a single organization. This is intended to save money and create efficiencies by eliminating leadership positions and duplicative administration and back-office services. It is hoped that high-performing agency models like Cancer Care Ontario could be applied to other areas of care. The agency would be a single point of standard setting and performance measurment,

with streamlined and improved guidance and support for providers. It would also take a strong role in digital health, with leaked documents suggesting it could operate Ontario's data systems, and offer procurement and supply chain services to HSPs and OHTs. We understand that there would be five regional "sub-agencies" charged with oversight of their geographic area.

Creation
The government recently created a corporation, Health Program Initiatives, which would, should the legislation pass, transition into Ontario Health. In the months and years to come the assets, employees and functions of several existing agencies would transfer to the new Agency:

- Cancer Care Ontario
- eHealth Ontario
- HealthForceOntario Marketing and Recruitment Agency
- Ontario Health Quality Council (better known as Health Quality Ontario or HQO)
- Trillium Gift of Life Network
- Health Shared Services Ontario (this is new to the current version of the Bill)

In addition, assets, employees and functions of LHINs would also transfer, and additional agencies could be added in the future through regulation. (Leaked documents suggest mandate expansion will be considered as soon as early 2020.) The Bill gives the Minister flexibility to transfer functions, assets and employees to any HSP, but the government seems to intend to transfer only to Ontario Health and the OHTs. The Bill would repeal legislation governing the above-noted agencies, erasing references to these agencies and Acts from other laws.

As noted, these changes could be made at different times, allowing a phased approach. For example, the Bill would first remove provisions in the *Cancer Act* setting a minimum number of Board members for Cancer Care Ontario, to ensure governance continuity through transition, with a provision repealing the entire *Cancer Act* invoked after. Likewise, different sections of the *Local Health Systems Integration Act* can be repealed at different times as LHIN functions move piece-by-piece to Ontario Health and the OHTs.

Rules governing the transfer of assets, employees and functions are nearly identical to those for the transfer of Community Care Access Centres to LHINs, but with a few differences. First, as noted, different LHIN functions could be transferred to different entities at different times. The Minister would need to indicate to impacted parties precisely which assets, liabilities, rights, obligations or employees are to be transferred at a given time.

Second, the CCAC-to-LHIN transfer was exempt from Section 9 of the *Public Sector Labour Relations Transition Act* (PSLRTA) but subject to Subsections 36(2) to (7) of that Act; these references have been removed from the new Bill. The Bill also does not deem the transfer a "sale of a business" under Section 69 of the *Labour Relations Act* and Section 13.1 of the *Pay Equity Act*, as had been the case for the CCAC-to-LHIN transfer. However, the Bill would make amendments so that wherever PSLRTA applies to an action under the Act, including a transfer or integration (see below), sale-of-business provisions apply but Section 36 of PSLRTA and Section 69 of the *Labour Relations Act* do not (which is the status quo).

Finally, in a change from the leaked draft, the Minister could collect information, including personal information (but not personal *health* information), from any organization to inform the content of a transfer order or potential order. This personal information could include things like payroll and benefits information. The Minister would not have to inform individuals that their personal information is being collected.

Governance
Ontario Health would be governed by a 15-person Board of Directors, with members – including Chair and Vice-Chair – appointed by Cabinet. We believe the Agency's directors have been appointed, with few having health care backgrounders; a CEO search continues, focusing on people with a business background.

The Agency's governance rules would be the same as those for LHINs, with a few small changes:

- Now if a Board Director leaves before the end of his or her term, a replacement Director will only serve out the remainder of that term, rather than beginning a new full term
- Powers of the Board can be delegated to Agency "employees", not "persons" (correcting a drafting error in existing law), however in the latest draft the Board cannot delegate its power to appoint investigators; other restrictions could be added in regulation
- Significantly, unlike LHINs, the Agency's Board meetings will not be open to the public.

Mandate and powers
The legislation lays out the objects of the new Agency, which would include:

- Implementing health system strategies developed by the Ministry
- Functions currently performed by LHINs, including operational management and coordination as well as promoting integration
- Functions currently provided by Health Quality Ontario, including performance measurement and reporting, quality improvement, clinical and quality standards development, knowledge dissemination, patient engagement and relations, and supporting the Patient Ombudsman
- Functions currently provided by eHealth Ontario, including digital health, information technology and data management services
- Functions currently provided by HealthForce Ontario, supporting health care practitioner recruitment and retention
- Functions currently provided by the Trillium Gift of Life Network, planning, coordinating, undertaking and supporting activities related to tissue donation and transplantation
- Supply chain management services provided to HSPs and related organizations
- Providing advice, recommendations and information to the Minister and other health system stakeholders on issues that arise, as specified by the Minister

Additional roles can be specified through regulation. Also, the Minister would have the authority to delegate any of her powers under any legislation, aside from the power to make regulations, to the Agency – giving the government enormous flexibility to shape Ontario Health's powers and functions. The Minister could set conditions on any such delegation.

As currently drafted, however, the legislation would give less authority to Ontario Health when it comes to health system integration than LHINs currently have. Ontario Health would not be able to force or prevent service integrations; it could only help facilitate or negotiate an integration, issuing a "facilitation decision" (formerly called an "integration decision"). New to this draft are mechanisms for amendment and revocation similar to those in existing legislation for LHINs.

Unlike LHINs, Ontario Health would not be able to issue directives or appoint supervisors, but it would retain the authority to issue audits or require a funded HSP or OHT to provide requested information. Ontario Health can also appoint investigators (see below).

Oversight
Ontario Health would be an agency under the *Broader Public Service Accountability Act*, similar to LHINs. While LHSIA includes a legislative requirement for LHINs to submit annual reports, the new Bill leaves reporting requirements to be spelled out in the Agency's accountability agreement. The Minister can require reports at her discretion, and new to this version of the Bill, Ontario Health would be audited annually by the Auditor General. While its other reporting requirements would be similar to LHINs, its accountability agreement with the Minister would not need to set performance goals or standards for the province's health system – just the Agency itself. This is a change from the previously-leaked draft.

The Bill specifies that the Ministry of Finance will pay unpaid judgments against the Agency from the general revenue if the Agency is unable to, even after liquidation. It also has a new prohibition against the Agency investing money, generating revenue, or receiving money or assets from any person or entity other than the Ontario government (save for transfer orders) without Cabinet approval. (This replaces controversial language in the previous draft about selling Agency services.) Outside fundraising would require the Minister's approval; under the earlier draft and existing legislation the Minister of Finance's sign-off is also needed.

The Minister would have authority to dissolve the Agency – not Cabinet, as in the earlier draft.

Patient Ombudsman
The previous version of the Bill would have moved the Patient Ombudsman's under the new Act, taking the opportunity to make some changes to the office. The final tabled Bill, however, simply updates references in existing legislation to reflect the new structure. The Ombudsman, currently lodged in HQO, would now operate out of Ontario Health, with only small changes (such as stricter rules on the collection and use of personal and personal health information).

Ontario Health Teams
The Bill would allow the Minister to designate an entity or group of entities as an Integrated Care Delivery System. (This is another change from the leaked draft, which lodged that power with the Agency.) These groups, branded Ontario Health Teams, are intended to organize and deliver care at a local level. The proposed legislation sets out only a broad framework for the OHTs, with details to be laid out in regulation and through operational decision-making.

That said, the Bill does note that an OHT would need to deliver, in an integrated and coordinated manner, at least three of the following types of health services:

+ Hospital care
+ Primary care
+ Mental health or addictions care
+ Home care or community services
+ Long-term care
+ Palliative care

Additional types of services, including non-health services that support care delivery, could be added to that list through regulation. The potential inclusion of non-health services is a change from the previous draft of the Bill; after the legislation was announced, the Ministry indicated that it wants providers to come forward with innovative ideas about services that could be integrated – for example, medical transportation services.

The legislation would also allow for the transfer of some of the assets, obligations, and employees of LHINs to an OHT – we anticipate this is intended for care coordination. It would allow for Ontario Health to flow funding to OHTs, and stipulates that an obligation, decision or power that applies to an OHT would also apply to and bind all of the entities that make it up.

Roll-out

Additional information about OHTs has been provided by government since the legislation's announcement. There will be an Expression of Interest released in March for early adopters with more information about requirements for becoming an OHT, followed by a continuous application process. There will be a multi-step readiness evaluation, and the Ministry will provide support for groups that seem likely candidates to become OHTs but need further maturation of their plans. While teams will need to provide a core basket of services, ability to offer smooth transitions will be paramount in the government's consideration.

OHTs would have a variety of supports from government, including identifying legislative and regulatory barriers to success, other barriers to integration, sharing or best practices, tools for digital health, and communications and change management assistance. However, the government claims that there will be "no additional cost" to set up OHTs.

The Minister indicated that about 30 unsolicited proposals have already been submitted; we understand that government had quietly let some stakeholders know what would be required to move forward. The government is eager to have successful early adopters, many of which we expect will be hospital-led and based in the Greater Toronto Area, where they can serve diverse patient populations. Assuming the legislation passes, the first OHTs could be in place by summer 2019.

Leaked documents indicate the Minister would report back to Cabinet in early 2020 on lessons learned and bring forward a plan for full implementation. Once completely rolled out, the government anticipates there will be between 30 and 50 OHTs across the province, each serving patient populations of between 50,000 and 500,000 with an average around 300,000.

The government is taking a flexible approach to OHTs, looking to learn from providers and take lessons from experience. The number of OHTs will gradually increase and individual OHTs may see their mandates grow over time – serving more patients, broadening the scope of integrated services, or both. Different models are being looked at, with most OHTs geographically-defined but some intended for specific populations like complex pediatric patients. Existing providers offering this kind of integrated care already are being closely examined.

Function and funding

The government intends that these teams will be able to provide better-integrated, locally-organized and delivered care, and is particularly concerned with smoothing transitions in care. There is a strong customer experience angle to the plan, with 24/7 support, help with system navigation, and better use of digital tools being key objectives. Government expects that communication will be improved among providers and between providers and patients. OHTs would be measured against standards, with performance reporting eventually made public.

Care coordination would gradually move from LHINs to these new OHTs (likely with associated job losses – surely opposed by the Ontario Nurses Association, which represents most of the affected workers). Legislation would allow for any approved agency to fund community care, which could include OHTs.

Leaked documents also suggested a broader role for OHTs offering a single point of clinical and fiscal responsibility for their geography or patient group, holding a performance oversight relationship with other HSPs. They would, according to those documents, be empowered to make operational funding decisions to meet local targets for improvement and volumes.

The government has spoken vaguely about group payments tied to outcomes, and leaked documents referenced a “blended payment” model, where multiple providers share a single payment linked to patient outcomes. Where a patient outcome exceeds expectations there would be a greater payout than if that patient failed to meet objectives. Such funding models are meant to incentivize care providers to work more closely together, giving them a shared stake in their patients’ journeys. Leaked documents noted that OHTs could retain any surplus and share risk for shortfalls, providing further incentives for operational efficiencies.

Government has stressed that patients would still be able to choose their preferred providers.

Digital First for Health
It’s at this level that the government’s new Digital First for Health strategy, detailed in leaked documents, would be adopted and implemented. Digital first thinking would be embedded in the business of care delivery. OHTs will be expected to offer patients virtual care and access to electronic heath records, and maintain better electronic sharing of patient information between providers.

Government also intends for consolidation and integration between point-of-care systems over time to reduce the need for transferring records between providers; leaked documents cited eReferral and eConsult, and suggest government and Ontario Health would reorganize digital delivery partners and programs.

What we don’t know
Many questions remain outstanding.

- We do not know the criteria or process for becoming an OHT; we believe the Ministry, at minimum, wants primary care, home care and hospital care at the table, but beyond that details are unclear.
- The pace for scale-up is also unknown. Indeed, it’s not clear what full provincial roll-out will mean: will all HSPs be expected to join OHTs? If not, will they be required to have some kind of funding or accountability relationship with their local OHT?
- It’s also not clear how government intends to integrate home and community care, which is highly fragmented and governed under different legislation, or primary care doctors, many of whom resisted similar moves in the past.
- How will blended funding work, particularly when typical health outcomes are in many cases difficult or impossible to quantify and measure against? And what incentive will there be for health providers who may see this as a risky income model?
- Will government force providers to join or become accountable to OHTs?
- What are the labour and pay equity implications of joining an OHT?
- What happens to providers that offer specialized services province-wide to a patient group that doesn’t fall within its own OHT? What happens to the patients they serve?
- Where do other integrated models like Community Health Links fit in?

Funding and accountability – including physician services
As set out in the Bill, funding to HSPs and OHTs would flow through Ontario Health much as it currently does through LHINs. But while currently the Minister can only assign rights and obligations under an agreement *with an HSP* to a LHIN, she would be able to assign rights and obligations under an agreement with *any* person or entity to Ontario Health. In particular, a prohibition against transferring responsibility for non-fee-for-service physician funding is removed.

Ontario Health can enter into Service Accountability Agreements (SAAs) with HSPs and other entities or persons for services that support care delivery. Under existing legislation physicians, podiatrists, dentists and optometrists are prohibited from being included under the definition of "health service provider" – that prohibition would be lifted. Finally, the Bill would remove a prohibition against the Minister devolving responsibilities to a LHIN (in this case, Ontario Health) related to fee-for-service and other physicians. All in all, the Bill seems to be positioning Ontario Health to have an accountability and possibly funding relationship with doctors.

Unlike LHSIA, the previous draft would have left the process for entering into an SAA to regulation. The Bill that was tabled on February 26th, on the other hand, lays out the process in legislation, and differs in important ways from LHSIA. In general, the agency would have more power to impose terms on HSPs more quickly. Ontario Health and a funded entity would have 90 days to negotiate terms of an SAA; at that point, the Agency could deliver a notice of offer to the HSP or other funded entity. There would then be another 60 days to negotiate, at which point the notice of offer would be deemed to be the SAA. The parties can agree in writing to a different process of negotiation, letting the Ministry know, but other notification requirements that currently exist would be removed by this Bill.

Investigators and supervisors
Ontario Health and the Minister would have similar authority to LHINs to appoint an investigator to funded HSPs and OHTs with only small changes to the existing rules:

- Long-term care homes would continue to be exempted from investigations, and if an OHT with a long-term care home was investigated, the home would be exempt
- When questioning individuals, investigators would be empowered to determine what matters are relevant to their investigation, and the individual would have to cooperate
- Investigators would no longer be restricted from accessing personal health information
- Unlike the previous draft, under Bill 74 the Agency could not appoint an investigator to a hospital (or OHT including a hospital) – only Cabinet can, on the advice of the Minister; this aligns with the existing rule that only Cabinet can appoint a hospital supervisor

Currently the Minister can only appoint LHIN supervisors. Under the new rules, the ability to appoint a supervisor for an HSP would transfer from LHINs to the Minister (other than, as noted, for hospitals – that's Cabinet's purview – or LTC homes, which are exempt).

Rules governing a supervisor are otherwise unchanged. The Bill clarifies that a Minister would not need to give notice of a supervisor to an HSP or OHT if it is governed by a Board that lacks enough members to maintain quorum. And the new draft notes that a supervisor of an OHT has powers over each constituent entity (other than LTC homes or hospitals).

Minister's Integrations
The Minister would accrue significant powers to force integrations under this proposed legislation. The Minister would absorb all powers LHINs currently have to force service integrations, in addition to maintaining her current ability to force HSPs to cease operating, amalgamate, or transfer operations to another person or entity, and add a new authority to require an HSP or OHT to coordinate services or partner with another Agency funding recipient.

The Minister's authority would go beyond this. Where the Minister and LHINs were previously restricted to specified kinds of integrations, the Minister would now be empowered to do "anything to integrate the health system", with specific integrations included as examples. The Minister would no longer need to act on advice from a local agency (currently she can only force integration on the advice of a LHIN). And unlike the previous draft, the Minister could now force amalgamations with *any* Agency-funded persons or entities, not just HSPs and OHTs.

Many important restrictions in existing legislation remain, however – the Minister cannot:

+ Force a religious provider to do something contrary to its religion
+ Require transfer of property from a charity to a non-charity, or force a non-charity to receive charitable property and hold it for a charitable purpose
+ Issue certain kinds of orders to a Board of Management or municipality
+ Issue certain kinds of orders to a long-term care home (unless it is providing other health services, in which case an order cannot be issued to cease operating the home)
+ Issue an order for a non-profit to amalgamate with or transfer operations to a for-profit
+ Issue an order that is prohibited in regulations

Note that the leaked draft would have prevented the Minister from issuing *any* kind of order to a long-term care home, Board of Management or municipality. The tabled Bill, on the other hand, allows for some integrations – this is aligned with LHSIA and does not represent a change from the status quo.

Rules governing integration decisions, including public notice, appeals, and issuing a final decision all remain the same, except that the proposed legislation clarifies that HSPs which are corporations must comply with a decision notwithstanding requirements under other legislation for members, shareholders or directors to consent. The Bill also now (unlike the previous draft) upholds the Minister's ability to amend or revoke an integration decision.

Directives and standards
The Minister would retain the same authority to issue directives to Ontario Health that she currently has over LHINs. This new version of the Bill expands that authority beyond what was contemplated in the draft: the Minister would now issue directives to any Agency-funded person or entity (currently, LHINs can issue directives to HSPs only). Long-term care homes, hospitals and the University of Ottawa Heart Institute would no longer be exempted, but the Minister would still be prevented from directing a religious provider to do something contrary to their belief. However, in another change from the leaked draft, the Minister would no longer have the authority to issue standards; this was a new power introduced in 2016's *Patients First Act*.

The previous draft specified that the Minister's power to issue directives would enable her to force HSPs and OHTs to use the Agency's supply chain and procurement services. This section has been removed from the tabled Bill. However, the broad power to issue directives would likely still include this authority.

Planning and engagement
Ontario Health, HSPs and OHTs would still need to establish mechanisms for consultation as part of their operational planning. The language around these consultations has changed, however, now specifying that they must include "patients, families, caregivers, health sector employees and others" as laid out in regulation, but dropping reference to engaging "the community of diverse persons and entities." There are fewer requirements for Ontario Health to consult than currently exist for LHINs; for example, it is not required to have a health professionals advisory committee. On the other hand, the Bill expands on requirements in the previous version by, for example, enshrining the recently-established Minister's Patient and Family Advisory Council and requiring Ontario Health to consult it.

The Bill drops the requirement, in current legislation and the previous draft, for the Minister to engage stakeholders and develop a provincial strategic plan.

Another significant change relates to consultation – under LHSIA, the government must hold public consultations, with rules laid out in legislation, before changing any regulations under the Act. This would be entirely removed under the new legislation.

Other Changes
The Bill would give Cabinet additional regulation-making authority. This includes the ability to:

- Make rules around requirements to become an OHT
- Set out rules for the transfer of agencies to Ontario Health and the OHTs and govern other matters related to transition
- Create rules for the terms and conditions of an SAA and the process for making one
- Prescribe the process for Ontario Health consultations
- Regulate other matter Cabinet considers necessary or desirable for carrying out the Act – significantly broadened latitude (though not unheard of; similar provisions exist under other legislation, including the *Excellent Care for All Act*)

The Bill's final schedule makes technical amendments to a range of existing laws, changing or removing references made obsolete should the legislation pass. It makes a few other changes:

- The *Employment Standards Act* exempts temporary home care workers at LHIN-funded service providers from rules governing temp agencies – this would be removed.
- The *Lung Health Act* would be repealed without replacement. This would remove the requirement that government establish a Lung Health Advisory Council and Action Plan.
- Health sector organizations would not be required to provide annual quality improvement plans to Ontario Health as they currently must to HQO and (on request) LHINs.
- As noted above, any approved agency could provide funding to purchase community services. This is a reversion to legislation that enabled CCACs to organize care, although in this case it is presumably intended to apply to OHTs. Note the requirement that an approved agency (including community support service agencies) be non-profit remains in effect.
- Removes some outdated sections of the *Public Hospitals Act* and *Private Hospitals Act* related to the Harris-era Health Services Restructuring Commission.
- Clarifies that the Agency may set compliance standards for organ and tissue donation (a power implied but not explicit in existing legislation for the Trillium Gift of Life Network), and that those standards be available for public inspection.

Reaction
Unlike reaction to the leaked documents – where the NDP was able to frame the issue and the government was constrained in its response – media coverage of the Minister's announcement has generally been positive. In the weeks since the first documents were leaked the NDP's insistence that this Bill opens the door to privatized, for-profit healthcare has been called into question. The Minister insists this is not the government's plan, and emphasized during her announcement that publicly-funded services will remain free and universal, with no line skipping.

Nevertheless, the NDP continues to make the case that this would hand the health system to private interests. Liberals in the House have taken a more cautious approach, praising some of the Bill's ideas but criticizing it as taking away local decision-making.

Media and other stakeholders have had time now to examine the government's plans. There is a feeling that if the government is able to achieve its goals with the Ontario Health Teams, it will lead to a real improvement for patients – but successful implementation will be a challenge and it's not clear what the government's full plan is. There has been stronger criticism of the move to amalgamate so many agencies into one, noting negative experiences in other provinces.

What's next
The Bill passed First Reading with the NDP, Liberals and Green Party voting against. It will now be debated at Second Reading, after which it will be sent to committee, where stakeholders will have an opportunity to provide input and MPPs a chance to offer amendments. Typically we would expect only small changes at this point – technical amendments, or fixes to prevent unintended consequences. It then returns to the House for Third Reading, after which it is voted on a final time before being sent to the Lieutenant Governor for Royal Assent. Cabinet would then determine dates for which different provisions come into effect.

As noted, the Ministry plans to issue an Expression of Interest for Ontario Health Teams in March 2019, with early adopters coming online in the summer. This would require the Bill's passage and at least partial enactment; we have heard that the government wishes to rush Bill 74 through the House by mid-March, with its first provisions coming into effect July 1, 2019. This would give a relatively small window for developing initial regulations in late spring, although additional regs could follow as implementation rolls out.

The government has stressed at several points that implementation will be a multi-year process. Agencies will be consolidated and LHINs dissolved in phases. OHTs will come online in a continuous process, with some LHIN responsibilities transferred to them as they reach maturity. Leaked documents indicate government hopes to report back to Cabinet with more detailed plans for LHIN dissolution in the fall of 2019, and another report-back in early 2020 on future phases of work, including a full provincial implementation plan for Ontario Health Teams.

H+K will continue to monitor closely and keep its health care clients informed and up-to-date.