Healthy patients, healthy communities

Response of the Ontario Public Service Employees Union to Bill 41,
An Act to amend various Acts in the interest of patient-centred care

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SEFPO Syndicat des employés de la fonction publique de l'Ontario

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"A health system that is public, accountable and transparent puts patients before profits. Bill 41 could be an opportunity for positive change within the health care system, but there is work yet to be done to strengthen the capacity of this legislation to truly put patients first."

– Warren (Smokey) Thomas
President, Ontario Public Service Employees Union

Introduction: from discussion paper to Bill 41

In December of 2015, Ontario's Minister of Health and Long-Term Care released the *Patients First* discussion paper, subtitled "a proposal to strengthen patient-centred health care in Ontario." The paper outlines a proposal to initiate an overhaul of Ontario's health care system.

Since the release of the minister's discussion paper and, subsequently, the introduction of Bill 41 – the legislation proposed to bring about this health system overhaul – several concerns and recommendations have been raised by labour unions, civil society organizations, health care workers and advocates, academics, and concerned citizens. The Ontario Public Service Employees Union (OPSEU) is honoured to be among this group and thankful for the opportunity to provide input. As a follow-up to its *Patients Before Profits* response paper released in February, OPSEU has prepared its recommendations in response to the proposed Bill 41 legislation that was introduced in October. If enacted, OPSEU's recommended amendments would strengthen Bill 41's capacity to put patients first by protecting and upholding public medicare and the principles of the Canada Health Act. OPSEU's recommendations fall into three categories: organizational and structural considerations, accountability structures, and engagement processes for health system restructuring.

Of major concern to OPSEU is that the proposed legislation does not address one of the fundamental flaws inherent in the current Community Care Access Centre (CCAC) structure and the proposed future Local Health Integration Network (LHIN) structure: the privatization embedded within the health care system. This includes, but is not limited to, the contracting-out of home care services to private, for-profit companies. This embedded privatization not only contradicts the minister's promise to protect our universal health care system; it is a major impediment to truly patient-centred care.

Organizational/structural considerations

Privatization is embedded in the system

In their current form, Community Care Access Centres (CCACs) do not adhere to the foundational principles of public medicare. In fact, the situation is quite the opposite. Ingrained within the structure of the CCACs is a system of contracting-out of home care services. The competitive bidding process has been a catalyst in driving down wages and benefits for those working in the home care sector. In a system marred by privatization, workers are increasingly faced with precarious work, where they are underpaid and unprotected. The movement of the CCACs to the LHINs will not create a public non-profit home care system. Bill 41 would see the continuation of the contracting-out of home care to for-profit companies, with all of the problems inherent in the structure as it already exists. Duplicate administration and the incentive for profit-taking will continue under this model.

According to Auditor General Bonnie Lysyk, in her 2015 report, there are 160 third-party providers currently contracted by the province's CCACs to provide home and community health care services. Many of these are for-profit. To make money, these companies suppress wages and force their workers to rush through treatments. This is contrary to the concept of "patients first." Precarious work and low wages mean high turnover in the home and community care sector, which can result in poor continuity in care. New hires don't have time to learn the nuances of each patient, but these nuances are critical to each patient's well-being. "Per-visit" wage schemes often mean that nurses are paid less than minimum wage (e.g., $17 for a visit that can take up to two hours), resulting in a dissatisfied and exploited workforce.

In her report, the Auditor General found that for every dollar spent by the CCAC, only 61 per cent is spent on the actual face-to-face treatment of patients. Much of the remaining 39 per cent goes to managerial salaries and profits of the for-profit companies. The exact amount however, is unknown because private sector service providers have no obligation to open their books to public scrutiny. They are accountable only to shareholders in making profit, and not to the patients they serve.

Recommendation #1: Amend Bill 41 to ensure that all new capacity in the health care system be created under the model of public, non-profit ownership only. This is in line with the Patients First *promise to "protect our universal public health care system."*

Recommendation #2: Eliminate the contracting-out (RFP) system and implement a fully public, not-for-profit home care system in Ontario. This would eliminate the duplication of administrative costs, remove the profit-seeking incentive that undermines the system and encourage improved working conditions, job security, worker satisfaction and greater workforce stability across the restructured LHINs/LHIN sub-regions. This would greatly benefit patients and ensure a more holistic approach to health care.

Bill 41 enables the LHINs to assume responsibility for the management and direct delivery of home and community care. This eliminates the structural barriers that have reinforced the contracting-out system. The workers should be brought in as direct service providers employed by the LHIN. The Ministry ought to explore the options for termination or non-renewal of all contracts with provider agencies. OPSEU's recommendation would support greater authority for the Minister of Health and Long-Term Care to develop and enforce provincial standards for service and delivery across all LHINs (based on a thorough consultation process). Currently, there are major discrepancies in standards and care levels between the numerous service provider agencies. This is because the current model puts profits first, not patients.

Bill 41 opens the door to user fees

Ontarians, like the majority of Canadians more broadly, are passionate supporters of public medicare. Ontarians believe that when they need care, they have access to it based on their need and not on their ability to pay. This goes for home care services as well. What they don't expect is to be forced to pay out-of-pocket fees. Currently, subsection 28(2) of the *Home Care and Community Services Act, 1994* establishes that where an agency provides or arranges the provision of homemaking or community support services, "the approved agency **shall not** require payment from the person for the service and shall not accept a payment made by or on behalf of the person for the service." Bill 41, section 40 proposes repealing subsection 28(2).

The new wording for subsection 28(2), as proposed by Bill 41, states that the approved agency "**may** require payment from the person for the service and **may** accept a payment made by or on behalf of the person for the service." Yet a LHIN that provides or arranges the provision of homemaking or community support services "**shall not** require payment."

Requiring any form of payment for needed health care services stands in stark contradiction to the principles of the *Canada Health Act*. The proposed language in subsection 28(2) will have major implications for Ontario's home care system and the patients it serves. Subsection 28(2) would open the door to increasing privatization as patients are forced to pay ever-expanding out-of-pocket fees. This would put patients last.

Recommendation #3: That Bill 41, section 40 (as it relates to rewording subsection 28(2) of the Home Care and Community Services Act, 1994) be removed from the legislation. Furthermore, OPSEU is calling for the LHIN to act as the provider agency. Subsection 28(3) would apply.

Private hospitals' mandates could expand

Despite their seemingly contradictory existence within a public health care system, private hospitals in Ontario are governed by the *Private Hospitals Act,* which applies to facilities that were licensed before October 29, 1973 and therefore grandfathered into the public health care system. The purpose is to govern facilities that existed pre-medicare, not to expand their capacity or mandate further.

Section 45(1) of the proposed legislation would add a power for the Minister of Health and Long-Term Care to issue operational or policy directives to private hospital licensees, where the minister considers it to be in the public interest to do so. This broadens the powers of the minister to intervene in the operations of Ontario's private hospitals. The proposed new section 14.1 of the *Private Hospitals Act* would be added with respect to the minister's power to revoke or transfer the license of the private hospital. While OPSEU refrains from questioning the ministry's motivations for broadening these powers, it is important to note that this amendment may open the door for the minister of the day to use this policy-directive power to order the existing private hospitals to broaden their services and provide them with more funding to do so, expanding the capacity of private hospitals and undermining the principles of public medicare.

Recommendation #4: Remove section 45 from Bill 41.

Bill 41's changes would negatively impact health care workers

Frontline workers are the backbone of the public health care system. They provide care to our loved ones and are the gatekeepers of the system. A healthy system that produces healthy patients depends on a healthy workforce. OPSEU's mandate is to ensure fair terms and working conditions for all workers.

Under the structure proposed by Bill 41, the Local Health Integration Networks (LHINs) would fall under the *Crown Employees Collective Bargaining Act (CECBA)*, a piece of legislation that significantly changes how the union negotiates on behalf of its members currently employed by the CCAC.

Under the *Labour Relations Act*, CCAC employees currently have the right to strike. OPSEU's members that are currently employed by the CCACs have fought long and hard for their collective agreements.

The restructuring proposed in Bill 41 will have a major impact on employees as a result of the transfer from the CCACs to the LHINs. As a result of the move from the LRA to CECBA, employees will be required to negotiate essential services agreements in the event of a strike or lockout; the way grievances and arbitrations are handled will change; and workers will lose the right to file classification grievances. The CCAC workforce is made up primarily of women, and the gains made through collective bargaining to date have been a positive factor in minimizing the wage gap and supporting women as professionals in the workforce.

It is estimated that approximately 30-60 employees are employed by each LHIN. Many of these are non-union positions. OPSEU wants to ensure that the working conditions and processes for collective bargaining remain as robust as they were with the CCAC as the employer.

Recommendation #5: That the LHIN be removed as a "Crown Agency" from Regulation 386/07 of the Crown Employees Collective Bargaining Act to uphold the current collective bargaining structure under the Ontario Labour Relations Act.

LHIN "sub-regions" could negatively impact care

While the creation of sub-regions could improve communication and planning and subsequently access to services, their creation alone does not improve LHIN accountability, especially with respect to the public in the sub-regions identified.

Section 13 of Bill 41 sets out that section 15 of the *Local Health System Integration Act, 2006* (LHSIA) will be amended to add subsection 2.1, which states "The integrated health service plan shall include strategic directions and plans for the geographic sub-regions of a local health system in order to achieve the purposes of this Act."

This is in addition to the existing subsection (3) which covers "restrictions" and states, "The integrated health service plan shall be consistent with a provincial strategic plan, the funding that the network received under section 17 and the requirements, if any, that the regulations made under this Act prescribe." Bill 41 does not require the LHIN to take local needs into consideration (although the expressed purpose of the sub-regions is to have more localized planning, service management and delivery of care). Subsection (3) of the *LHSIA* requires that

Integrated Health Service Plans (IHSPs) be consistent with the provincial strategic plan. While provincial strategic plans are important, IHSPs could be used as tools to override any and all plans developed locally in favour of provincial strategies.

It is worth noting that Integrated Health Service Plans (IHSPs) are not capacity plans, and they do not measure or try to meet population need across the continuum of care. IHSPs have varied widely from region to region and their goals have ranged from concrete to completely meaningless. LHINs, to date, have not had the power to implement many of the goals they set. Bill 41 does nothing to change this.

Under the existing LHIN structure there are wide discrepancies in the care levels provided from LHIN to LHIN, and there is legitimate concern that the sub-regions will be afflicted in much the same way under the new structure. Where provincial government strategies are not in line with specific services needed by the population in a sub-region, there is real concern about the "ghettoization" of sub-regions – namely that a community's needs will not be factored in meaningfully. Sub-regions will have to fall in line with the government's overall strategic direction whether it is best for patients in that sub-region or not. Resources are not guaranteed to flow based on an assessment of population need. Accountability flows upward, from the LHIN to the Minister and not downward, to the patient. This structural concern is not addressed in the new legislation: there is nothing that ensures everyone is entitled to receive the level of care they require.

The provincial government has identified some key issue areas requiring attention, including improved French language health planning and First Nations and Indigenous engagement. OPSEU is concerned that in areas with larger French and Indigenous populations, the appropriate services that have historically been underfunded (now being identified as focus areas) will be funded out of the general LHIN budget. Where need is higher, and where immediate investments are needed (just to get these targeted services up to where they ought to be already), these targeted services would consume large portions of the LHIN general budget and come at the cost of other needed services. There should not be competition for resources to provide needed services within any LHIN or LHIN sub-region. Any focus areas that the provincial government identifies (through meaningful public consultation) or ministry directives on provincial standards ought to come with their own targeted funding envelopes to ensure that each sub-region is able to provide the services to meet population need within that sub-region. Funding for such directives should not come out of the current budget year.

Recommendation #6: Amend Bill 41, section 13 to add a subsection under section 15 of the LHSIA that all IHSPs must include assessment, measurement and planning to meet population need in each sub-region.

Recommendation #7: Ensure that all focus areas identified by the Ministry of Health and Long-Term Care and ministry directives (for example: French language services, First Nations and Indigenous services, mental health services) are funded through targeted funding envelopes. The Ministry must establish a mechanism for setting benchmarks for the levels of care provided, and ensure that these benchmarks are based on a rigorous analysis of population need. There needs to be a clear accountability structure in place to ensure that LHIN spending is 100 per cent in line with the funding they receive from the ministry and that targeted funding envelopes are fully honoured. There ought to be legislated repercussions for failure to do so, and all of this information should be publicly-accessible.

LHIN accountability

LHINs should be accountable on performance measures

Under the current legislation, LHINs are prohibited from providing any health service directly. LHINs are required to forge "Accountability Agreements" with health service providers. The Accountability Agreements set out performance measures and funding levels and the LHINs are supposed to oversee these. But, in reality, there is no real accountability or enforcement for many of the performance measures set out in these Accountability Agreements (which are fundamentally a funding mechanism).

Recommendation #9: Where Accountability Agreements are required (for example, with hospitals), they must include assessments of population need in their determination of performance measures/funding levels AND stipulate clear consequences for failing to achieve these performance goals.

Since OPSEU is calling for the LHIN to act as the new home care provider agency with the capacity to hire its own staff as health service providers, there would be no need to negotiate Accountability Agreements with contracted-out providers (please see recommendation 2). Please also see recommendation 12 which outlines the need for LHIN boards of directors to be democratically-elected and recommendations 15 & 16 which call for mandatory public consultation processes and formalized relationships with key stakeholders.

LHINs should be accountable for meeting population need

The primary function of the *LHSIA* has been to give the LHINs and the Minister of Health and Long-Term Care powers to overrule local boards of directors, to order them to provide certain services or levels of service and to force restructuring. There is no end date for these extraordinary powers.

If care is meant to put "patients first," the primary function of the LHIN would have to be focused on planning to provide services that meet population need. Rather than the requirement to find opportunities to integrate as a priority, they ought to be required to measure, plan and meet population need (and allocate appropriate resources to accomplish this).

Recommendation #10: Include an amendment to repeal LHINs' endless restructuring powers.

Recommendation #11: Include an amendment that allocation of resources (human and financial) be based on assessment, measurement and planning to meet population need.

LHINs should be accountable to the public

Plainly put, the LHINs are not accountable to the public. The LHINs are appointed by Cabinet, as are their board chairs and vice-chairs. They are not accountable to local communities. There is virtually nothing in the LHINs legislation that enables anyone locally to influence LHIN decisions. As previously stated, the LHINs answer upwards – to the Ministry of Health and Long-Term Care. What is very distressing about Bill 41 is that the "enhanced oversight and accountability" that has been outlined by the ministry are actually tools for the enhanced power for the minister and the LHIN, not enhanced accountability.

The LHIN will now be able to issue directives, investigate and supervise health service providers. The minister can also issue directives, investigate or supervise LHINs and has enhanced power to issue directives to public and private hospitals. But there is absolutely no mention of improved accountability to the public, the users of the health care system. As mentioned, the LHINs are appointed by Cabinet. They have always done the bidding of the ministry and have worked to integrate and cut services endlessly, which has not been in the public interest. Giving them more power does not make them more accountable; it makes them an even greater risk to the public good. The ministry itself has asserted that the LHIN will now be "well-placed to be in the lead for the integration of care at the regional and sub-regional level." But

this exacerbates what has fundamentally been the problem with the LHINs all along: an eternal mandate to force through integrations.

The new, "Integrated Clinical Care Council" which will make recommendations to the Minister on clinical standards in priority areas on the other hand will have absolutely no power. They are able to make recommendations, but that's all. They have no authority when it comes to enforcement.

Recommendation #12: Amend Bill 41 to establish democratically-elected LHIN boards of directors that are accountable to their communities and representative of the diversity of their communities. Patient-centred change is simply not possible within the current structure.

Recommendation #13: Amend Bill 41 to enshrine the right to access publicly-funded home care for all Ontarians (a fully public home care system based on the principles of the Canada Health Act*). If this legislation is truly about putting patients first, they ought to have the rights to ensure it.*

Recommendation #14: Close wide loopholes that have allowed LHINs to hold closed, in-camera board meetings (contrary to the requirement for meetings to be publicly accessible). There needs to be clear rules that govern when and for what reasons meetings can be held in-camera and what information must be made publicly available. The public must have clear rights to access information. There must be clear consequences for LHINs that refuse to release information that ought to be in the public domain.

Engagement processes

The LHINs must engage with communities and the workforce

Under Section 16 of the *Local Health System Integration Act, 2006*, there is much discussion around "engagement" with the community on an ongoing basis. As per section 16(3), this "may include holding community meetings or focus group meetings or establishing advisory committees."

It is important to note that engagement is very different than public consultation. When the LHINs "engage" with the community, there is no legislated structure by which the public input collected is incorporated into the decisions of the LHIN. "Engagement" could easily be (and has often been) used to keep up appearances. Improving LHIN accountability and responsiveness to

local needs depends on increased transparency and meaningful consultation with the community and workforce.

The same applies to all of the stakeholder groups identified by the Ministry of Health and Long-Term Care where more formalized linkages are to be formed for health system planning. These stakeholder groups include boards of health, French-language health planning entities, First Nations and Indigenous communities and a Patient and Family Advisory Council. There is nothing in the legislation that structurally formalizes these relationships or ensures that the input collected is used in a meaningful way by the LHIN (the requirement for consultation is not mandated into the IHSPs outlined in the amended section 15, subsection 2.1 of the *LHSIA*). There is also no mention of who will be included under these broad terms. Who will be chosen to sit on the Patient and Family Advisory Council and how will they be chosen? What French language health planning entities will be sought out?

Even more troubling is Bill 41 Section 14(2) which addresses Subsection 16(5) of the *Local Health System Integration Act, 2006.* With respect to a health professionals' advisory committee, the wording has been changed from "Each local health integration network **shall** establish a health professionals' advisory committee" to "Each local health integration network **may** establish a health professionals' advisory committee." Bill 41 removes all requirements for the restructured LHINs to establish a health professionals' advisory committee, and therefore engage with health professionals. This shows a flagrant lack of willingness to ensure the voices of workers are included in the LHIN decision-making process, especially considering that the current model of "engagement" is already so flawed and undemocratic.

Recommendation #15: Amend Bill 41 to require public consultation to ensure democracy in LHIN processes, establish a mechanism by which this consultation is factored in to LHIN decision-making and enshrine a system for redress for complaints.

Recommendation #16: Bill 41 must structurally formalize the relationship between the LHIN and key stakeholders (for example, the relationship between the LHINs and boards of health). There needs to be an open and transparent consultation process and the stakeholders need to be empowered within that structure. The health professionals' advisory committee must be included as key stakeholder.

Recommendation #17: Despite being more formalized in Bill 41, the relationship between Public Health Units (medical officers of health) and the LHINs needs to be clarified. Bill 41 must ensure that the Public Health Units remain autonomous from the LHINs. Under Bill 41, Section 39(1), Section 67 of the Health Protection and Promotion Act is amended by adding subsection (5)

*which states that "the medical officer of health of a board of health **shall engage** on issues relating to local health system planning, funding and service delivery." While "engagement" may positively improve planning, it is important to emphasize that boards of health must remain autonomous to ensure their funding is protected (a portion of which is provided by the municipality) and to uphold their governance structure, which includes elected representatives from municipal councils and is much more democratic than that of the LHINs.*

Recommendation #18: Reinstate the word "shall" in Subsection 16(5) of the LHSIA. Clarify the powers/authority designated to all advisory committees outlined in the legislation. There needs to be an enforced requirement for consultation with the workforce, public and other stakeholders.

Recommendation #19: All relevant sectors of the health care system need to be included in the consultation processes. For example, hospital discharge has major implications for the home care system. Representatives from all sectors need to be at the table, including on a mandatory health professionals' advisory committee.

The public must have notice of changes

Central to improved LHIN accountability and transparency is the need for open communications and opportunities for public feedback. Under section 27 of the *Local Health System Integration Act, 2006,* if a LHIN plans to refuse a request from health services providers to integrate, it has to publicly release a draft decision and consider submissions it receives in response to that draft decision. But if the LHIN intends to **allow** the integration, there is no requirement for it to make a public decision or accept submissions. The only stipulation is that the health service providers would have to wait 60 days to receive the go-ahead.

Section 23(2) of Bill 41 opens the door wide by eliminating the 60-day requirement if the LHIN tells the provider that it "does not intend to issue a decision ordering them not to proceed with the integration." OPSEU's main concern is that this is not a parallel process. Where the LHIN plans to "not oppose" an integration, it is even more important that they release a public decision, accept submissions from the public, and allow public access to the notice and board minutes as this decision will result in major changes to the status quo and how health care is delivered locally. The fact that the LHINs are required to accept submissions when the status quo will remain, but not when major changes are afoot is backward and nonsensical. But even more troubling is that under the proposed legislation, there is no mandatory 60 day waiting period. A LHIN can decide immediately that it will not issue a refusal and the health service providers can move ahead right away with the integration, speeding up the process and

removing the ability for the public to express disapproval/criticism. As mentioned previously, the LHINs have a mandate to restructure through integration in perpetuity. Section 23(2) gives even more power to the LHIN to usher through integrations by choosing to "not decide" and allowing the health service providers to move ahead. This does not resonate with the minister's promise to improve accountability and transparency (which would demand improved capacity for public feedback and consultation for all proposed integrations).

Recommendation #20: Remove Section 23(2) from the legislation which amends subsection 27(3) of the LHSIA, 2006. This section states that the health service provider "may proceed with the integration at any time if the network notifies the provider that the network does not intend to give notice of a proposed decision." All integration decisions, or purposeful "non-decisions" should undergo the same notice period of 90 days (as per Bill 41, section 23(1)), in which public consultations ought to be undertaken, submissions accepted, and board notices and minutes made accessible to the public.

Conclusion

The road to health system restructuring is a long and winding one. While we applaud the minister's stated goal of a more patient-centred health system, we have several concerns and recommendations to strengthen Bill 41's capacity to actually put patients first.

OPSEU is calling for the creation of a fully public, not-for-profit home care system and an end to contracting out. The profit incentive should never be factored in to health care delivery, and patients should have the right to access quality public health care based on their need, not their ability to pay. The issue of embedded privatization needs to be addressed and efforts made to limit the powers of private sector health providers, not expand them. The health care workforce, which is the backbone of the health care system, ought to have fair terms and working conditions. Collective agreements that have been achieved through meaningful negotiations should be protected. Good working conditions for health care workers are the foundation of quality treatment for patients.

There is much work to be done to improve LHIN accountability, and to ensure that the LHINs are a force for positive patient-centred health system planning and service delivery rather than a source of endless restructuring that actually harms the health of communities. LHIN boards must be democratically-elected to ensure true accountability to the public; performance measures developed in health system planning must be based on population-need assessments at the local level while adhering to provincial standards for levels of care; information must be publicly accessible; meaningful consultation processes must include patients, their families and

frontlines health care workers; relationships with stakeholder groups must be formalized; and the process for future planning (especially with regard to the integration of services) must allow ample opportunities for meaningful input and feedback.

About the Ontario Public Service Employees Union

The Ontario Public Service Employees Union (OPSEU) is a trade union representing 130,000 Ontarians working in every corner of Ontario and most areas of the provincial public sector, including the municipal sector. In health care, OPSEU represents approximately 40,000 frontline workers in these areas: ambulance services; long-term care; mental health care; hospital professional services; hospital support services; community health care; and Canadian Blood Services and diagnostics.