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## Integrating Health Services in Ontario Through Mergers and Centralization

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A Provincial/Territorial Health Reform Analysis

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## Abstract

On 18 April 2019, the Legislative Assembly of Ontario passed *Bill 74, The People's Health Care Act*, which provided new authorities to the Ministry of Health and a newly created Ontario Health super agency to facilitate the integration of health care services across Ontario. This reform represents a shift away from the previous regionalized system of Local Health Integration Networks (LHINs). While centralization is intended to improve efficiency within the system and create a patient-centred model of care, it also equips the Ministry and Ontario Health with greater authority over health agencies. Ontario's reform represents another move towards centralization in a wave of regionalization reversal that has swept across the country. Implementation of this reform will take several years to roll out. An analysis of centralization reforms in other jurisdictions can provide insight into Ontario's decision to reform. Though this bill was presented as a modernization of Ontario's health system to meet people's needs, a common theme in stakeholders' opinions is the lack of consultation with the public.

*Le 18 avril 2019, l'Assemblée Législative de l'Ontario a mis voté le projet de loi 74, sur les soins de santé pour la population, conférant de nouveaux pouvoirs au Ministère de la Santé et à une toute nouvelle Agence Ontarienne de la Santé pour faciliter l'intégration des services de santé en Ontario. Cette réforme vient remplacer le précédent système régionalisé de réseaux locaux d'intégration des services de santé. Bien que la centralisation vise à améliorer l'efficacité au sein du système et à créer un modèle de soins axé sur le patient, elle confère également au Ministère et à Santé Ontario une plus grande autorité sur les organismes de santé. La réforme de l'Ontario représente un autre pas vers la centralisation suivant la vague d'inversion de la régionalisation partout au pays. La mise en œuvre de cette réforme se fera sur plusieurs années. Une analyse des réformes de centralisation dans d'autres juridictions peut donner une décision de l'Ontario de se réformer. Malgré le fait que ce projet de loi soit présenté comme une modernisation du système de santé de l'Ontario pour répondre aux besoins des citoyens, les parties prenantes partagent un thème commun dans leurs opinions: le manque de consultation du public.*

### Key Messages

- Centralization has the potential to pave the way for improved connectivity and efficiency within Ontario's health system.
- Bill 74 provides the Ministry with increased power over health agencies which raises the concern that local communities may be excluded from decision-making.
- To assess whether Bill 74 achieves its mandate, appropriate evaluation criteria need to be established.

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### Messages-clés

- *La centralisation peut rendre le système de santé de l'Ontario mieux interconnecté et plus efficace.*
- *La loi 74 permet au ministre plus de pouvoir sur les agences de santé. Ceci est inquiétant puisque les communautés locales pourraient être exclues prises de décisions.*
- *Afin d'évaluer si la loi 74, des critères d'évaluation appropriés doivent être mis en place.*

## 1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

On 18 April 2019, the Ontario Legislative Assembly passed *The People’s Health Care Act* (Bill 74). This reform centralizes the function of existing government health agencies (Cancer Care Ontario, Health Quality Ontario, eHealth Ontario, Trillium Gift of Life Network, Health Shared Services Ontario, HealthForce Ontario Marketing and Recruitment Agency), Local Health Integration Networks (LHINs) and other prescribed organizations into the new entity Ontario Health (“The Agency”). Bill 74 institutes broad changes in governance, through the replacement of the 14 LHIN boards of directors with a single Ontario Health board of directors.

While this reform has implications for how money flows to hospitals, some specialty care services, home and community care and other community services, it has no direct impact on OHIP-covered physician services and physician-prescribed services which comprise more than half of every dollar spent on health care in Ontario. Unlike other reforms of this type which focus on primary care, Bill 74 is centred on integration of care in hospitals and hence may lead to a decentralization of financial power and decision-making to large health science centres and hospitals.

## 2 HISTORY AND CONTEXT

Prior to the enactment of Bill 74, Ontario’s health system was organized by 14 Local Health Integration Networks (LHINs) in a three-tier system consisting of local health organizations, LHINs and the Ministry. LHINs were established in 2006 with the aim of integrating service delivery to facilitate greater coordination of care within a region. Ontario was the last province in Canada to implement a health reform regionalizing health care.

The failure of regionalized health authorities to achieve improved continuity of care and better integration has led to a reversal of the regionalization trend in recent years across the provinces, beginning with Alberta’s implementation of a province-wide integrated health system in 2008 (Marchildon 2016). Centralization has the potential to lower costs through economies of scale, for instance through centralization of human resources, information technology and finance (Allin *et al.* 2018).

## 3 GOALS OF THE REFORM

### 3.1 Stated

With the creation of the centralized agency, Ontario Health, Bill 74 seeks to:

- improve access to and connectivity of health services and provide better quality patient care,

- provide a central point of accountability and oversight for the health care system, and
- create a digitally enabled system with a single medical record to improve accessibility of patient health information to service providers (Bill 74).

Overall, the bill aims to create a sustainable system for providing high quality care to improve the health of the people of Ontario.

### **3.2 Implicit**

Bill 74 gives the Minister legislative authority to order integration of health service providers (HSPs) and integrated care delivery systems (ICDSs) within 30 days without any consultation, which may compromise self-governance of institutions if the interests of the Minister and Ontario Health are not aligned with those of the HSPs and ICDSs (Watts, Newell, Putyra 2019). Furthermore, given that the list of agencies in the bill includes the item “prescribed organizations,” the MOHLTC retains some flexibility in determining other organizations that can later be subject to integration decisions by the Agency (Ontario Hospital Association 2019).

## **4 FACTORS THAT INFLUENCED HOW AND WHY**

### **4.1 The issue came onto the government’s agenda**

An issue is brought to the governmental agenda, according to Kingdon (2014), only when the three streams of problems, policies and politics converge—that is, when problems are linked to policies within an appropriate political climate.

Bill 74 responds to the Minister of Health’s recognition of problems of access to health services, long patient waiting times and fragmentation of HSPs in Ontario (Elliot 2019). This recognition comes after a 2015 report from the Auditor General of Ontario which suggested that LHINs fell short of their mandate to contain health care costs and to increase the efficiency and effectiveness of health care (Lee 2018). On the fifteen indicators set out to measure LHIN performance over time, the Auditor General reported that performance had improved on only six indicators, while it remained the same or deteriorated since 2010 on nine indicators (Auditor General of Ontario 2015).

The introduction of this bill can also be viewed as part of a political wave of health reform from regionalization to centralization that has been sweeping across the country in the past decade (Marchildon 2016).

### **4.2 The final decision was made**

The decision to pass Bill 74 can be framed in the context of the incumbent Progressive Conservative (PC) majority government’s motivation to reformulate a regionalized system that was implemented during a Liberal majority government. Furthermore, the prospects

for this reform have been shaped by the PC’s 2011 election promise to eliminate LHINs, which was based on the argument that LHINs use up resources needed on the frontline.

According to opinion editorials from the Ontario Health Coalition (2019), the final decision was made with minimal public consultation. While most bills typically draw no more than a few hundred requests to present at a public hearing, Bill 74 received over 1,400 despite the one-day sign-up window provided by the Ford administration (Crawley 2019).

Following the introduction of the bill, concerns were raised regarding the risk of eliminating local decision-making and neglecting the diversified needs of Indigenous and Franco-phone communities across Ontario (Fraser 2019). In response to these concerns, Schedule 2 of the bill amended the *Ministry of Health and Long-Term Care Act*, which requires a French language health services advisory council and, at minimum, one Indigenous health council to advise the Minister of Health.

## 5 HOW THE REFORM WAS ACHIEVED

### 5.1 Implementation Plan

According to the Ontario Hospital Association, the implementation period of the bill will likely span several years. This timeline will be considerably delayed as the province prioritizes its response to COVID-19.

On 8 March 2019, twelve members of Ontario Health’s board of directors were appointed by the Lieutenant Governor in Council. The board may comprise up to 15 members who will hold office for three years. Members may be reappointed for another term, with the maximum term being six years (OHA 2019). This board will oversee the transfer of agencies into Ontario Health and ensure continuity in patient care during the process. To ease the transition of LHIN functions to Ontario Health, oversight of the 14 LHINs was reorganized into five regional clusters in the interim period. The LHIN CEO positions accordingly were reduced from 14 to five during the transitional period.

## 6 EVALUATION

The “core bargain” of Ontario’s health care system—which refers to medical care provided in hospitals and by physicians that is fully paid for by Ontario’s publicly funded health system—has contributed to an accumulation of resources and power in physician groups such as the Ontario Medical Association (OMA) and Ontario Hospital Association (OHA). Since this reform largely leaves OHIP-covered physician services untouched, the existing power and resource dynamics remain.

As of publication of this article, the implementation phase has not yet been completed and hence a formal evaluation is not possible. An analysis of other provinces’ decisions to shift from a regionalized to a centralized system may provide some insight into the potential

effectiveness of Ontario’s reform. Though several provinces have implemented centralized health services, there has been limited evaluation of these decisions and hence little to no empirical evidence demonstrating whether centralization or regionalization is more effective (Allin *et al.* 2018). In Nova Scotia, the consolidation of nine District Health Authorities into a single Nova Scotia Health Authority in 2015 had not yielded expected cost savings (Fierlbeck 2019). In Alberta, the provincial auditor noted that centralization reform has reduced administrative costs, however an evaluation of whether the reform’s objectives have been achieved in the 12 years since it was implemented has yet to be completed (Allin *et al.* 2018).

Evaluation criteria that focus on performance metrics used by the Auditor General to assess LHIN performance (such as patient wait times, ER visits, and MRI scans), in addition to financial metrics, may offer an effective form of assessing Ontario Health successes and failures.

## 7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1 summarizes the strengths, weakness, opportunities and threats of the reform from the various stakeholder perspectives explored in this paper. Stakeholders are indicated in parentheses in the table.

Table 1: SWOT Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>• Increased accountability due to consolidation of the boards (minister).</li> <li>• Potential to increase connectivity and communication among health care providers, and access to care (ministry, users, providers).</li> <li>• Expansion of digital tools such as virtual consultations and accessible health records (ministry).</li> </ul>	<ul style="list-style-type: none"> <li>• A single board overseeing health care service delivery in a diverse province (providers, users, community).</li> <li>• Closed-door Agency meetings decrease transparency and limit public involvement in political decision-making (users, providers, community).</li> <li>• Minimal public consultation in the passing of the bill (providers, community).</li> <li>• No right to appeal restricts local involvement in decision-making (providers).</li> <li>• No formal evaluation system established (providers).</li> </ul>

## OPPORTUNITIES

## THREATS

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| <ul style="list-style-type: none"> <li>● Potential to lower health care costs by removing an extra layer of bureaucracy and overlap in infrastructure and administration (ministry).</li> <li>● Improved integration and efficiency of digital health tools (users).</li> </ul> | <ul style="list-style-type: none"> <li>● Elimination of local decision-making and involvement (users, providers, community).</li> <li>● Changes to financial and delivery arrangements have the potential to cause disruptions in patient care (users, providers).</li> </ul> |
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