Accountability in Health Care and Legal Approaches

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Health Care Accountability Papers – No|3

Health Network

May 2004
ACCOUNTABILITY IN HEALTH CARE AND LEGAL APPROACHES

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Contents

Foreword....................................................................................................................................iv

Introduction ...................................................................................................................................1

Judicial-based Mechanisms .........................................................................................................3

1. Charter and Human Rights Claims to Publicly Health Care Services .........................3
   Charter Cases ..................................................................................................................3
   Human Rights Cases .....................................................................................................4
   Discussion ..................................................................................................................6

2. Charter Challenges to Restrictions on Health Care Choices ........................................9
   Discussion ..................................................................................................................11

3. Legal Challenges or Complaints to Bodies Created by Statute ..................................12
   Discussion ..................................................................................................................15

4. Medical Malpractice Law ..............................................................................................16
   Fiduciary Law ............................................................................................................18
   Informed Consent .....................................................................................................19
   Discussion ..................................................................................................................19

Legislative Mechanisms .............................................................................................................21

1. Bills of Rights .....................................................................................................................21
   Discussion ...................................................................................................................25

2. Care Guarantees ................................................................................................................27
   Care Guarantee Proposals ..........................................................................................28
   International Experiences .........................................................................................30
   Discussion ..................................................................................................................31

Conclusion ...............................................................................................................................33

Appendix A ..................................................................................................................................35

Our Support ..................................................................................................................................37
Foreword

Canadians have been clamouring for more attention to the accountability of the health care system in many different ways. It was identified as a priority issue in a national consultation on research priorities in 2001, it was highlighted in all the major health system reviews prepared for the provinces and the federal government from 2001 to 2003, and citizens themselves issued a strong challenge in the Citizens’ Dialogue on the Future of Health Care prepared for the Romanow Commission in 2002. Yet accountability for health care is not an established focus in the Canadian research community, and there are relatively few source documents to start the process rolling.

CPRN decided to fill this gap with a series of seven papers designed to explore the concept of accountability and how it might apply to health care. Papers will explore the concept of accountability, map the statutory accountabilities written into provincial and federal legislation, assess four principal approaches to accountability under discussion today: citizen engagement, legal approaches, performance reporting, and citizen governance. The series will close with a synthesis paper to summarize our learnings and suggest next steps.

This paper by Nola Ries and Timothy Caulfield from the University of Alberta Health Law Institute, is the third to be published. Others will follow in coming weeks and months. The paper explores judicial and legislative tools to improve access to health services and thus to strengthen the accountability of service providers to patients. It describes legal challenges based on the charter, on human rights legislation, and on legally established complaints processes as well as legal principles or legislative mechanisms that establish the patients entitle to care. Drawing upon both Canadian and European experiences, the authors conclude that the evidence in favour of such mechanisms is still rather mixed.

I wish to thank Nola Ries and Timothy Caulfield for summarizing the state of our knowledge on legal approaches to accountability and for giving us a roadmap to some of the cases now before the courts. I also wish to thank the reviewers and funders for making this Accountability Series possible.

Judith Maxwell
May 2004
Introduction

Over 10 years ago, a national legal organization released a report on the role of law in the Canadian health care system. The title of that report, “What’s Law Got to Do with It?” expresses a question that remains highly relevant today as our health care system faces new challenges, especially funding pressures and calls for greater accountability. As health care funders and policy-makers, governments throughout Canada must address competing goals: maintaining universal, comprehensive, publicly insured health care; allocating resources to other important programs and services; and striving for fiscal sustainability. Within this context, there seems to be growing interest, both on the part of governments and individuals, in using legal mechanisms to define rights and obligations in regard to health care.

The goal of this paper is to identify and analyse five key legal mechanisms, discuss their use (or proposed use), and evaluate their effectiveness as a tool for promoting accountability in health care. Where a mechanism is not currently in use in Canada, we look to international experiences with the same or similar mechanisms to comment on its effectiveness.

The five legal mechanisms this paper addresses are:

1. legal challenges based on the *Canadian Charter of Rights and Freedoms* or human rights laws to seek access to services through the publicly funded health care system;
2. legal challenges based on the *Charter* in which individuals challenge restrictions on the ability to exercise choice in regard to health care;
3. legal challenges or complaints directed to bodies created by statute, such as health service review boards and Ombudsman offices, in which individuals challenge the reasonableness or fairness of government health care policies;
4. legal principles (for example, based on tort law, fiduciary law and informed consent principles) that establish an entitlement to a specific level or standard of care; and

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3 A recent Conference Board of Canada report states that “[s]ome provinces could spend in excess of 50 per cent of their budgets on health care by 2020…. To turn the situation around before the 2020 crunch, governments will have to make tough decisions. They need to balance their priorities in health and health care with other competing priorities. This challenge cuts to the heart of Medicare….” See Conference Board of Canada, *Understanding Health Care Cost Drivers and Escalators* (Ottawa: Conference Board of Canada, 2004) at i.

5. legislative or policy mechanisms such as patient bills of rights, care guarantees or other statements that set out rights and responsibilities in regard to health care.

We categorize the first four as judicial-based mechanisms because they involve claims before courts or other decision-makers and they give rise to the development and application of legal principles on a case-by-case basis (that is, development of the common law). We describe initiatives that fall into the last category as legislative because they involve the development of laws and policies by elected officials. However, we recognize these categories are not mutually exclusive and, in fact, will overlap because judges and other decision-makers interpret and apply laws established through legislative action.
Judicial-based Mechanisms

1. Charter and Human Rights Claims to Publicly Funded Health Care Services

Individuals or groups may use the Charter or human rights laws to argue the government has a legal obligation to fund specific health care services. Although the Charter does not specifically protect a right to health care, it protects rights to life, liberty and personal security (section 7) and equality rights (section 15), which encompass the right to equal benefit of government benefit programs without discrimination on grounds such as disability and age. Similarly, human rights laws across Canada protect the right to access public services, such as health care, without discrimination.7

To date, Canadian courts and human rights tribunals have considered only a few cases in which individuals challenge a government decision not to fund specific health care services. However, as courts and tribunals become increasingly willing to review government resource allocation decisions, litigants may be more inclined to use these types of mechanisms to seek public funding for health care services.

Charter Cases

The 1997 Supreme Court of Canada decision in Eldridge v. British Columbia8 was the Court’s first opportunity to consider a Charter claim for a specific service in the health care setting. In Eldridge, three deaf individuals challenged the decision of the Government of British Columbia not to fund sign language interpretation as an insured benefit under the B.C. Medical Services Plan. The claimants argued that without publicly

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5 Section 7 states: “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with principles of fundamental justice.”
6 Section 15(1) states: “Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.” It is important to note that Charter rights are not absolute and infringements of these rights may be justified under section 1 of the Charter, which states: “The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law that can be demonstrably justified in a free and democratic society.”
7 For example, section 1 of the Ontario Human Rights Code, R.S.O. 1990, c. H.19 states: “Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, same-sex partnership status, family status or disability.” Likewise, section 8(1) of the British Columbia Human Rights Code, R.S.B.C. 1996, c. 210, states:
   A person must not, without a bona fide and reasonable justification,
   (a) deny to a person or class of persons any accommodation, service or facility customarily available to the public, or
   (b) discriminate against a person or class of persons regarding any accommodation, service or facility customarily available to the public
   because of the race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex or sexual orientation of that person or class of persons.
funded interpreter services, they did not have equal access to the health care system as compared to non-deaf individuals. In a unanimous decision, the Supreme Court of Canada agreed with the claimants and held the government’s failure to fund sign language interpreters, when necessary for effective communication in the health care context, violated the claimants’ rights to equality under the Charter.

In 1999, the Nova Scotia Court of Appeal considered the case of *Cameron v. Nova Scotia*,
which involved an infertile couple who argued the Province of Nova Scotia discriminated against them by not funding fertility treatments, in-vitro fertilization (“IVF”) and intra-cytoplasmic sperm injection (“ICSI”), that could assist infertile persons in attempting to have a biologically related child. They argued fertile people have access to publicly funded health care services, such as prenatal and childbirth care, to assist them in having children, but the infertile are denied the chance of having a child because they are denied funding for IVF and ICSI. The majority of the appeal court ruled that the government’s funding decision discriminated against the couple because of their disability (infertility), but concluded the government’s action was justified because the therapy is costly and has low success rates.

The most recent case involving a claim for public funding for health care is *Auton v. British Columbia*. This case involves a claim by children with autism and their parents seeking government funding for a particular form of autism therapy referred to as early intensive behavioural intervention, which involves a therapist working one-on-one with an autistic child for up to several years at the cost of $45,000 - $60,000 annually. In 2002, the British Columbia Court of Appeal ruled the government discriminated against children with autism by refusing to fund the therapy and rejected the government’s arguments that the therapy is still quasi-experimental and too expensive to fund. The Supreme Court of Canada will hear an appeal of this case in May 2004 and the outcome of the case will likely set a crucial precedent for future cases in which individuals challenge government decisions to exclude funding for specific services.

**Human Rights Cases**

While *Charter* cases are adjudicated by courts, specialized human rights tribunals have been established by the federal and provincial governments to hear complaints about alleged violations of human rights laws. In some jurisdictions, individuals have launched complaints under human rights legislation to challenge government funding choices in health care and other contexts. For example, similar to the *Auton* litigation, human rights agencies in several provinces are currently dealing with complaints.

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11 The federal Human Rights Commission has jurisdiction to deal with complaints made under the *Canadian Human Rights Act*, S.C., c. H-6, which covers federal government bodies and federally-regulated industries. Provincial human rights agencies have jurisdiction to hear complaints in accordance with human rights legislation in force within the relevant province.
regarding access to publicly funded autism therapy.\textsuperscript{12} For example, the Newfoundland and Labrador Supreme Court has recently upheld a Human Rights Board of Inquiry ruling that the Province violated provincial human rights legislation because some children were placed on a wait list to access intensive behavioural intervention therapy.\textsuperscript{13} The complaint in this case was brought on behalf of Brandon Sparkes, a boy who was diagnosed with autism in September 2000, placed on a wait list for therapy, and was not admitted to the program until November 2001 at age four, when much of the window of opportunity for intervention had already closed.\textsuperscript{14} Although Newfoundland and Labrador apparently had the shortest waitlist in Canada at the time,\textsuperscript{15} it was argued on behalf of the child that the government discriminated against him by failing to provide timely treatment.

The Court upheld the human rights tribunal decision that:

Brandon Sparkes was treated differently from children with other illnesses, such as cancer, by being denied effective and timely treatment. \ldots the Ministry had failed to show it could not have allocated adequate resources to provide treatment to Brandon and the small number of other autistic children who were waitlisted for early intervention treatment.\textsuperscript{16}

Although the Province argued this decision could seriously undermine the health care system if it implied all waiting lists were discriminatory, the Court emphasized the ruling was confined to wait lists for autism therapy, noting that autism is unlike other medical conditions because there is currently no way to determine which children may be more likely to benefit from therapy. Consequently, the priority setting process that is key to managing other waiting lists is inapplicable to the wait list for autism therapy.\textsuperscript{17}

In 2003, the British Columbia Human Rights Tribunal heard a case regarding government funding for certain aspects of gender-reassignment surgery.\textsuperscript{18} The complainant in this case was a female-to-male transsexual who wanted the provincial Ministry of Health to

\begin{footnotesize}
\textsuperscript{12} The Ontario Human Rights Tribunal will hear complaints later in 2004 that alleges the Ontario government discrimates against children over six who have autism by limiting funding for early intensive behavioural intervention therapy to children under age six. See e.g. “Autism-related complaints against province increase” \textit{The Globe and Mail} (3 March 2004) A7. The British Columbia Human Rights Tribunal is also dealing with a case regarding autism therapy for a teenager: see \textit{Cucek v. British Columbia}, [2003] BCHRT 44 (preliminary decision).
\textsuperscript{14} In distinction from \textit{Auton}, then, this case concerns delay in accessing care rather than the government’s refusal to fund the care. Yet, as the Autism Society of Newfoundland and Labrador argued, “[i]n the case of young autistic children treatment delayed is effectively treatment denied.” \textit{Ibid.} at para 20.
\textsuperscript{15} \textit{Ibid.} at para. 10.
\textsuperscript{16} \textit{Ibid.} at para. 12.
\textsuperscript{17} \textit{Ibid.}, paras. 47 – 51.
\textsuperscript{18} \textit{Waters v. British Columbia}, 2003 BCHRT 13. An application for judicial review of this case was filed in the B.C. Supreme Court on June 18, 2003.
\end{footnotesize}
cover the cost of phalloplasty surgery he underwent in the United States.\textsuperscript{19} The Human Rights Tribunal recognized that a provincial government may refuse to cover the cost of experimental or unsafe therapies; however, in this case, phalloplasty was not considered experimental at the time the complainant underwent the process. As a result, the Tribunal ordered the government to reimburse the complainant for some costs associated with receiving surgery in California.

\textit{Discussion}

These cases represent the use of \textit{Charter} challenges and human rights complaints to seek an expansion of health care services funded by provincial governments. Interestingly, this mechanism may have dual effects in regard to accountability, one beneficial and one perhaps not so.

These types of cases may have the effect of enhancing accountability in health care by requiring governments, as health care funders, to justify in a public forum their resource allocation choices. For example, if cost concerns underlie a government decision not to fund a particular service, then the government will have to provide evidence to substantiate its concern. The Supreme Court of Canada has emphasized that governments cannot defend their choices with arbitrary assumptions. The Court has noted that “[i]t is all too easy to cite increased cost as a reason for refusing to accord … equal treatment. … I do not assert that cost is always irrelevant…. I do assert, however, that impressionistic evidence of increased expense will not generally suffice.”\textsuperscript{20}

Governments tend to focus on the immediate cost impacts of funding a new service, as well as the financial liability they may face by setting a precedent for other funding requests. Individuals who seek to expand health care coverage often emphasize the wider cost savings that may result from funding a service, as well as psychological and social costs incurred when some groups are excluded from accessing an important benefit program like Medicare. In \textit{Eldridge}, for example, the government focused on the expense of a medical sign language interpretation program, and was particularly concerned with the possible long-term financial impact of requests for language interpretation services by other groups.\textsuperscript{21} However, the Supreme Court criticized the government for its lack of evidence to substantiate this speculative concern.\textsuperscript{22}

Looking at the issue through a different cost lens, the claimants focused on the broader medical, social and psychological costs that could result from a failure to ensure deaf patients can communicate effectively with their health care practitioners. These include the risk of misdiagnosis, failure to follow a prescribed treatment, and feelings of fear,

\textsuperscript{19} This procedure involves surgical construction of a penis. The evidence before the Tribunal in this case was that the provincial government would fund vaginoplasty surgery for male-to-female transsexuals but would not pay for phalloplasty for female-to-male transsexuals on the basis that this surgery is experimental.


\textsuperscript{21} \textit{Eldridge}, B.C.S.C., \textit{supra} note 8 at para. 22.

\textsuperscript{22} \textit{Eldridge}, S.C.C., \textit{ibid.} at paras. 92 & 94.
anxiety and exclusion that deaf patients may experience when they are unable to communicate effectively regarding their health care needs.23

Similarly, in Auton, the claimants and the government viewed the question of cost and benefits from very different perspectives. While the government argued it could not afford the cost of funding autism therapy, the parents argued the government could not afford not to fund it. Without appropriate therapy, the parents argued, many children with autism are likely to “drain” public resources for their entire life by requiring state-funded income and housing assistance as adults. Justice Allan of the B.C. Supreme Court accepted this reasoning, stating that “it is apparent that the costs incurred in paying for effective treatment of autism may well be more than offset by the savings achieved by assisting autistic children to develop their educational and societal potential rather than dooming them to a life of isolation and institutionalization.”24 This view is echoed in the Sparkes decision, where the Court observed that “…the short-term funding required to develop challenged children, with this disorder, into productive adults, is far less than the funding needed to support them if they do not receive treatment and have long-term needs as a result.”25

Governments also often emphasize the broader tradeoffs or opportunity costs that are involved in choosing to fund one service over another. In Auton, Justice Allan noted that “[t]he Crown makes the irrefragable statement that its health care resources are limited and argues that the effect of funding treatment for autistic children would direct resources away from other children with special needs.”26 On appeal, the government argued further that

a decision in favour of the petitioners will impel the necessarily complex administrative choices required to be made in the course of balancing the myriad and competing demands for health care, into the courts for decision on the allocation of scarce resources on a case by case basis, rather than on a comprehensive and systematic basis.27

This statement highlights the potential adverse impact these cases may have on accountability in health care. In a democracy, citizens elect representatives to govern on their behalf. Policy choices and resource allocation decisions ought to be made by elected legislators who, arguably, are in the best position to balance competing priorities and apportion limited funds. As courts grant remedies in Charter or human rights cases that have the effect of directing how government must spend money on health care,

23 Ibid. at paras. 56, 57 & 69.
24 Auton, B.C.S.C., supra note 10 at para. 147. However, after considering an economic cost-benefit analysis of the autism therapy tendered into evidence by the claimants, the trial judge opined (at para. 145) that “it is not possible to estimate accurately either the additional immediate costs of a treatment programme or the inevitable savings in the long run.”
25 Supra note 13 at para.12.
26 Auton, B.C.S.C., supra note 10 at para. 145.
27 Auton, B.C.C.A., ibid. at para. 56.
governments may contemplate reducing overall benefit levels.\textsuperscript{28} Paradoxically, then, advancing rights claims before courts or quasi-judicial tribunals to obtain access to particular services may actually dilute the scope of the system and the services it provides.

Health policy commentators Christopher Manfredi and Antonia Maioni argue that “rights discourse narrows the range of feasible policy alternatives,”\textsuperscript{29} particularly in the health care policy context. This concern echoes the government’s argument in the \textit{Auton} case that a ruling in favour of the claimants would “constitutionalize” certain health care treatments and, consequently, restrict the policy options that might otherwise be considered.\textsuperscript{30} Advancing rights claims under the \textit{Charter} “narrow[s] the scope of policy discussion by equating legally enforceable rights with a single, ‘correct’ policy choice.”\textsuperscript{31}

Because the nature of rights-based litigation requires courts to identify “winners and losers”\textsuperscript{32} in each particular case, the outcome of the case may constrain subsequent policy-making. In the result,

...rights-based claims allow stakeholders in the system to redistribute significant public resources through a process outside the ordinary arena of political conflict where alternative views about resource allocation must be considered. Rights-based claims present courts with a choice between an allegedly rights-deficient allocation and a new, constitutionally mandated policy regime consistent with a claimant’s own interests.\textsuperscript{33}

The “ordinary arena of political conflict” is not wholly dysfunctional in that public pressure for health policy change can and does occur and elected decision-makers recognize the importance Canadians place on health care. The policy changes taking shape as a result of the recommendations of the Romanow Commission,\textsuperscript{34} as well as

\textsuperscript{28} In \textit{Just Words: Constitutional Rights and Social Wrongs} (Toronto: University of Toronto Press, 1997), Joel Bakan notes that the aftermath of the Supreme Court of Canada decisions in \textit{Tetrault-Gadoury v. Canada (Employment and Immigration)}, \textit{[1991] 2 S.C.R. 22} and \textit{Schacter v. Canada}, \textit{[1992] 2 S.C.R. 679}, provide an example of governments restricting benefits levels to address a successful \textit{Charter} claim. These cases required the federal government to extend unemployment insurance benefits to certain groups who had previously been ineligible. However, Bakan notes (at 59) that, to comply with the Court’s ruling, the federal government “raised revenue for these extensions by increasing the number of weeks that a person must work before being eligible for UI benefits, reducing the number of weeks a person can receive benefits, and stiffen[ed] penalties for workers who quit without just cause or refused to take suitable jobs or are fired for misconduct.”


\textsuperscript{30} \textit{Auton}, B.C.S.C., \textit{supra} note 10 at para. 149.

\textsuperscript{31} Manfredi & Maioni, \textit{supra} note 29 at 218.

\textsuperscript{32} In this context, we borrow the phrase “winners and losers” from Gerard F. Anderson, “The Courts and Health Policy: Strengths and Limitations” (1992) 11 Health Affairs 95 at 98.

\textsuperscript{33} Manfredi & Maioni, \textit{supra} note 29 at 222.

Senator Kirby’s health care committee, demonstrate governments are influenced to expand health care benefits in response to public pressure. The federal and provincial governments have agreed to develop a national home care program and a catastrophic drug program. Various provinces are also taking steps to reduce waiting lists to ensure more timely access to surgical and diagnostic services, another issue that figured prominently in both the Romanow and Kirby reports.

Yet, the problem remains that the needs of some groups may not be addressed by government health care initiatives. The fact that a person with HIV may soon receive financial assistance to cover the cost of expensive drug cocktails (as part of a catastrophic drug program), or that a person who takes time off work to care for a dying family member at home may be eligible for employment insurance benefits (as part of a home care program), does not address the need of a child with autism. So, it seems inevitable that certain groups may feel they have little recourse but to challenge government health care funding decisions through *Charter* or human rights litigation.

2. *Charter* Challenges to Restrictions on Health Care Choices

Cases like *Eldridge*, *Cameron* and *Auton* involve *Charter* claims seeking to expand the scope of publicly funded health care services. In contrast, litigants may also use the *Charter* to challenge government actions that have the effect of restricting freedom to make decisions about one’s health and medical treatment. Typically, these cases have involved challenges to criminal laws regulating or prohibiting certain forms of conduct.

*R. v. Morgentaler*, involved a *Charter* challenge to provisions of the Canadian Criminal Code that criminalized abortion unless certain requirements were met. Specifically, the impugned provision required a woman seeking an abortion to appear before a three-member therapeutic abortion committee, obtain a certificate authorizing the abortion and, finally, find a physician other than one on the committee to perform the abortion. Because of this process, many women faced significant delays in obtaining abortion services, particularly in areas outside large urban centres. The majority of the Supreme Court of Canada found that this criminal scheme was an unjustifiable violation of the *Charter*. One judge stated that the *Charter* right to “security of the person must include a

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37 Issues related to wait lists and care guarantees are discussed in further detail in subsequent section of this paper. See also infra note 94 and accompanying text.
39 [1988] 1 S.C.R. 30 [*Morgentaler*].
40 Dickson C.J., Lamer, Beetz, Estey and Wilson JJ. all found an unjustifiable s. 7 violation. McIntyre and La Forest JJ. dissented and found no breach of s. 7.
right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction.\footnote{Supra note 39 at 81.}

Rodriguez v. British Columbia\footnote{[1993] 3 S.C.R. 519 [Rodriguez].} also involved a Charter challenge in the health care context. Sue Rodriguez challenged the constitutionality of the Criminal Code prohibition against assisted suicide. Ms. Rodriguez had amyotrophic lateral sclerosis (commonly known as Lou Gehrig’s disease), a fatal disease that progressively impairs basic physical capacities, such as breathing, swallowing, moving and speaking, but leaves the mind intact. Ms. Rodriguez understood the inevitable path of her disease and wanted to have the ability to end her life when her suffering became intolerable. However, when that time came, she would physically be unable to commit suicide without assistance and wanted a physician to help her to die, but any physician who aided her risked criminal sanction. Ms. Rodriguez argued this law deprived her of the right to live the last of her life in dignity and the right to be free from state interference in making fundamental decisions about her life or, more precisely, about her death.

In a narrow majority, the Supreme Court of Canada dismissed Ms. Rodriguez’s claim.\footnote{Sopinka, La Forest, Gonthier, Iacobucci and Major JJ. constituted the majority. Lamer C.J., L’Heureux-Dubé, Cory, and McLachin JJ. dissented.} The Court acknowledged Ms. Rodriguez’s suffering but concluded that the state’s interest in protecting vulnerable individuals and safeguarding human life justified the prohibition on assisted suicide.\footnote{Supra note 42 at 595-608.} The dissenting judges would have found that the prohibition was unconstitutional because it was arbitrary and showed lack of respect for individual choice.

The more recent Ontario case of R. v. Parker\footnote{(2000) 49 O.R. (3d) 481 (C.A.) [Parker].} involved a challenge to provisions of the federal Controlled Drugs and Substances Act (formerly the Narcotic Control Act) prohibiting possession of marijuana. Mr. Parker suffered from a severe form of epilepsy and grew marijuana for his own use to control his seizures. Upon being charged with possession of marijuana, an offence punishable by imprisonment, Mr. Parker argued the offence provisions violated his rights under the Charter because he faced criminal sanction for using marijuana to meet a medical need. The Ontario Court of Appeal agreed Mr. Parker’s rights to liberty and security of the person were violated by the untenable choice between safeguarding his health and risking imprisonment. The Court emphasized that “[d]eprivation by means of a criminal sanction of access to medication reasonably required for the treatment of a medical condition that threatens life or health also constitutes a deprivation of security of the person.”\footnote{Ibid. at para. 97.}

Québec’s health care and hospital insurance legislation prevents patients from purchasing private insurance to pay for health care services covered through the public system and from paying privately for hospital-type services. The hip replacement patient argued he would have purchased the surgery privately had he not been prohibited from doing so, and asserted the Québec law violated his Charter rights.

In a month-long trial that involved testimony from numerous expert witnesses, the claimants asked the Québec Court, in effect, for a ruling that would permit the creation of a second tier of private health care insurance and delivery in Canada. In response, the governments of Canada and Québec called experts in health economics and policy to describe the possible adverse effect such a ruling could have on the accessibility and cost of health care. Justice Piché ultimately ruled the prohibition against private insurance violated the patient’s Charter rights. She stated that the right to obtain health care is a fundamental right and observed that “[i]f access to the health care system is not possible, it is illusory to think rights to life and security are respected.”48 However, Justice Piché went on to conclude that the Charter violation was justified in the interests of sustaining a system of health care that is equally available to all individuals regardless of ability to pay. She cited extensive evidence led during the trial describing the likelihood that a second tier of private health care would increase waiting times for services and drive up total health costs. Ultimately, she stated the government was justified in adopting a legislative scheme that benefited the overall population even if such a scheme limited the freedom of some individuals.

The Supreme Court of Canada will hear an appeal in the Chaoulli case in June 2004. To date, a number of provincial governments and other organizations have received permission from the Supreme Court of Canada to intervene in the case and present arguments before the Court. The Canadian Medical Association and the Canadian Orthopaedic Association have been granted intervener status and will argue that “timely access to medically necessary care is a fundamental health care issue and that governments should turn their minds to the ‘care guarantee’ concept as an option for resolving the excessive waiting time conundrum.”49 Ten Senators, including Michael Kirby, who led the 2002 Senate inquiry into Canada's health care system, will also reportedly promote care guarantees as interveners in the Chaoulli case.50

**Discussion**

These cases all involve Charter challenges against regulatory regimes imposed by the state that have the effect of restricting individual choices regarding their own body and health. These cases are, therefore, distinguishable from cases like Auton because the claimants are not asking the courts to order the government to provide funding for

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48 C.S.Q. decision, ibid. at para. 223 (translated by authors).
49 An online article on the Canadian Medical Association website reports this statement from an affidavit filed by CMA President-Elect, Albert Schumacher. See Patrick Sullivan, “Medicare case before Supreme Court rouses strong passions” (12 February 2004); online: <http://www.cma.ca/cma/common/displayPage.do?pageId=/staticContent/pregenerated(Articles/L2/HTML/2004/0212/18898_medicarePassionsRouses.htm>.
specific health care services. However, like Auton, these challenges require the government to present evidence to defend its policy choices and, in this sense, may enhance accountability. However, these cases raise similar concerns about judicial decisions that may have serious policy ramifications for the health care system. For example, if the Supreme Court rules the legislative regime at issue in Chaoulli is unconstitutional then, arguably, the Court will have opened the door for increased privatization within the Canadian health care system, an outcome many Canadians may criticize.

3. Legal Challenges or Complaints to Bodies Created by Statute

Certain agencies established by statute may have authority to make or review decisions regarding funding or provision of health care services. In several Canadian provinces, administrative bodies have been created and empowered by statute to review certain decisions regarding the provision of health care services. For example, in British Columbia, the Medical Services Commission has authority to determine insured benefits under the provincial health plan. In Ontario, the Health Services Review and Appeal Board may hear appeals of decisions regarding health insurance benefits made by the General Manager of the Ontario Health Insurance Plan (“OHIP”). The Québec Régie de l’assurance-maladie is responsible for administering and implementing the provincial health insurance plan and may control eligibility for insured services.

An interesting case from Ontario illustrates the use of an appeal to the Health Services Review Board to obtain public funding for an otherwise uninsured service. This situation involved Fiona Webster, a woman with a strong family history of breast cancer who asked OHIP to cover the cost of a genetic test to determine if she carried the BRCA 1/2 genes that predispose some women to breast cancer. Although limited testing services were available to women in Ontario who enrolled in research projects, Ms. Webster wanted funding for testing through Myriad Genetics Inc., a U.S. company that holds a patent on the BRCA 1/2 genes. OHIP took the position that the test was experimental...

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51 However, we note these cases implicitly require some state involvement to realize the rights the claimants asserted. For example, Morgentaler involved access to abortion services that are covered under public health insurance. Ms. Rodriguez’s claim to assisted suicide generally would involve the participation of a state-paid physician. Finally, Parker would likely involve some government regulation of marijuana prescribed for medicinal use.

52 The Medical Services Commission is composed of nine members: three government representatives; three representatives from the British Columbia Medical Association (“BCMA”); and three public members jointly nominated by the BCMA and the government: Medicare Protection Act, R.S.B.C. 1996, c. 286, section 3(1).

53 Ibid. Section 5 sets out the powers and duties of the Medical Services Commission and stipulates it must act in accordance with the principles of the Canada Health Act.


and refused to offer funding, although it would cover the cost of surgery to remove Ms. Webster’s breast tissue (a prophylactic bilateral mastectomy) with the goal of reducing her cancer risk. Ms. Webster wanted to know if she actually was genetically predisposed to breast cancer before undergoing surgery and argued it was nonsensical for the government to spend close to $20,000 to remove her breasts and not spend approximately $4000 on a genetic test to determine if the surgery was necessary.

Ultimately, Ms. Webster appealed OHIP’s decision to the Ontario Health Services Appeal and Review Board, which granted Ms. Webster’s request for funding for the BRCA 1/2 test performed by Myriad Genetics. The Globe and Mail newspaper described the case as “precedent-setting” and noted “[t]he decision is expected to have implications for women throughout Canada and for provincial governments, which must confront the fact that costly new genetic tests for a wide range of diseases are popping up every month.” However, while Ms. Webster’s case attracted national media attention, we hear little of other similar cases, perhaps suggesting that few individuals are aware of, or follow through with appeals to, bodies such as the Health Services Review Board.

Ombudsman offices in provinces throughout Canada may also play a role in ensuring that public bodies exercise their powers fairly. Typically, Ombudsmen have jurisdiction to investigate “matters of administration,” which the Supreme Court of Canada has described as encompassing “everything done by governmental authorities in the implementation of government policy.” While the Ombudsman provides citizens with an avenue of complaint for “cases of bureaucratic maladministration,” the Ombudsman’s power is generally limited to making recommendations.

In some instances, Ombudsmen may be called upon to investigate concerns regarding administration of health care programs. For example, in 2001, the Ontario Ombudsman issued a report regarding a government funding program instituted to help defray travel

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57 A recent study indicates that BRCA-positive women can reduce their cancer risk by up to 90% through prophylactic mastectomy. See Timothy R. Rebbeck et al. “Bilateral Prophylactic Mastectomy Reduces Breast Cancer Risk in BRCA1 and BRCA2 Mutation Carriers: The PROSE Study Group” (forthcoming) J. Clinical Oncology.

58 Carolyn Abraham, “Tenacious woman scores medical victory” supra note 56.

59 For example, the British Columbia Ombudsman Act, R.S.B.C. 1996, c. 340, s. 10, provides: “The Ombudsman, with respect to a matter of administration, on a complaint or on the Ombudsman's own initiative, may investigate (a) a decision or recommendation made, (b) an act done or omitted, or (c) a procedure used by an authority that aggrieves or may aggrieve a person. See also, Alberta Ombudsman Act, R.S.A. 2000, c. O-8, s. 12, Ontario Ombudsman Act, R.S.O. 1990, c. O-6, s. 14 and Nova Scotia Ombudsman Act, R.S.N.S. 1989, c. 327, s. 11.


61 Ibid. at 461.

62 The Supreme Court of Canada has observed that “[t]he Ombudsman’s powers, far from being formidable, are in reality quite limited. The Ombudsman may only investigate, recommend and publicize. His recommendations are binding on no one; he has no power to overrule the decisions of government officials. Nor can he bring a punitive action for official malfeasance. Clearly, he cannot impede the functioning of those with whom he deals.” Ibid. at 473-4.
costs for patients with breast and prostate cancer who require radiation treatment.\textsuperscript{63}
Cancer patients in northern Ontario complained to the Ombudsman that this funding program treated them unfairly because it covered more expenses for patients who reside in southern Ontario. After investigating, the Ombudsman concluded that the government program treats patients unfairly based on their place of residence and recommended that equal travel funding should be available.

The British Columbia Ombudsman has also played a monitoring role within the health care system, particularly in regard to investigating complaints about self-governing health professions. Since 1993, the BC Ombudsman has had jurisdiction to investigate complaints about health professions colleges\textsuperscript{64} and, in a 2003 report, the Ombudsman criticized some colleges for failing to take appropriate steps to safeguard the public from incompetent or unethical health practitioners, as well as those who act outside their lawful scope of practice.\textsuperscript{65} The Ombudsman also chastised some colleges for failing to treat their members fairly and praised proposed legislative reforms that would give the provincial government more authority to superintend colleges.\textsuperscript{66} While noting the important role of Ombudsmen in providing a public complaint mechanism, the BC Ombudsman advised that budgetary reductions have required him to stop investigating complaints against health profession colleges. In his words:

\begin{quote}
\ldots the absence of sufficient resources for my Office to continue investigating complaints against the colleges means that those aggrieved by college decisions, whether members of the public or of the professions, no longer have the opportunity for review by a body that is independent of government. A major avenue of accountability has been closed.\textsuperscript{67}
\end{quote}

Other public officials, such as coroners, may also provide an accountability mechanism in some limited circumstances. In catastrophic situations where individuals have died while receiving health care, a coroner’s inquest may make recommendations to avoid harm in future cases.\textsuperscript{68} In January 2004, the Ontario Coroner’s Office released its findings in an inquiry into a woman’s death following chiropractic treatment and recommended

\begin{footnotes}
\item[64] Other Ombudsmen in Canada have similar powers. For example, in 2003, Alberta’s \textit{Health Professions Act} was amended to give the Alberta Ombudsman authority to investigate complaints against health professional bodies. See \textit{Health Professions Act}, R.S.A. 2000, c. H-7, s. 127. See also \textit{Ombudsman Amendment Act}, S.A. 2003, c. 30.
\item[65] Ombudsman of British Columbia, \textit{Acting in the Public Interest? Self-Governance in the Health Professions: The Ombudsman’s Perspective} (Special Report No. 24 to the Legislative Assembly of British Columbia, May 2003) online: <http://www.ombud.gov.bc.ca/publications/reports/Public_Reports/Special%20Reort%20No.%2024.pdf.>
\item[67] \textit{Supra} note 65 at 4.
\end{footnotes}
additional study to examine links between strokes and neck manipulation. 69 The March 2004 revelation that two patients in a Calgary hospital were killed by accidental administration of a lethal drug has spurred calls for a public inquiry. 70 In February 2004, the Ontario coroner released findings in regard to a similar death and recommended changes to medication protocols to avoid fatal errors. 71 While discussion of all public officials who may have some role in investigating health care practices is beyond the scope of this paper, these recent events demonstrate the availability of other potential accountability mechanisms. Cases involving patient death will often lead to legal action against health facilities and professionals involved in the patient’s care, so these cases are relevant to the discussion of medical malpractice litigation discussed in the next section.

Finally, in some situations, individuals may go to court to seek judicial review of decisions of administrative bodies in regard to health care services. The case of Stein v. Québec 72 involves judicial review of a decision to deny funding for health care services obtained outside Canada. Barry Stein had been diagnosed with colon cancer that had spread to his liver. His physicians advised that the liver metastases should be removed as soon as possible however surgery was rescheduled several times and Mr. Stein ultimately sought surgery in New York to avoid further delay and because a recommended surgical procedure was considered experimental in Canada. He sought reimbursement from the Québec Régie de l’Assurance maladie for the treatment he underwent in the United States but this request was denied. Mr. Stein then appealed to the Tribunal Administratif du Québec, which upheld the Régie’s decision. On review, the Québec Superior Court ruled the Tribunal’s decision was “irrational, unreasonable and contrary to the purposes of the Health Insurance Act” 73 and it ordered the Régie to accept the reimbursement claim.

Discussion

A minority of Canadian provinces have an administrative body with jurisdiction to review decisions regarding health insurance benefits and the mandate of such bodies is circumscribed by legislation. For example, if an Ontario patient obtains treatment in another jurisdiction to avoid a lengthy wait list at home, OHIP will only cover the cost of the treatment if it is “generally accepted” as appropriate for the patient’s medical condition and necessary “to avoid a delay that would result in death or medically significant irreversible tissue damage.” 74 This statutory language establishes a very high hurdle for a patient to surmount and limits the grounds on which an OHIP official can approve coverage for services. Moreover, many patients may simply be unaware of the

73 Ibid. at para. 32.
74 Health Insurance Act Regulations, R.R.O. 1990/552, s. 28.4(1)(b).
existence of such administrative bodies, reducing the likelihood they will have a major impact on health system decision-making.

The Office of the Ombudsman provides another potential mechanism for investigation of unfairness in health system administration. However, without jurisdiction to make orders, Ombudsmen must rely on the power of public attention to persuade officials to change their practices. As the situation in British Columbia highlights, the current climate of budget cutbacks may hinder Ombudsmen in providing an effective avenue of accountability.

Lastly, if a patient goes to court to seek judicial review of an administrative body’s decision, the court cannot simply substitute its own view of the matter and is generally confined to considering whether the decision is reasonable, supported by some evidence, and made in accordance with relevant legislation. Only in egregious cases such as Mr. Stein’s is a court likely to interfere with the decision of a specialized health care administrative body.

4. Medical Malpractice Law

The medical malpractice system provides another source of public accountability. Indeed, medical malpractice law has helped establish duties owed by health care providers to patients, including the duty to provide a reasonable standard of care. One of the primary goals of medical malpractice law is to act as a deterrent to poor practice and to help establish and maintain a given standard of conduct.\textsuperscript{75} Though there is little empirical evidence on point, one well-known Canadian report on the medical malpractice system concluded that “the threat of tort litigation against health care providers for negligence contributes in a positive way to improving the quality of health care provided and reducing the frequency of avoidable health care injuries.”\textsuperscript{76}

What is the legal standard of care? Physicians have a legal duty to “exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner” in the same circumstances.\textsuperscript{77} To a large degree, the standard of care has continued to evolve, becoming increasingly onerous as our knowledge about the causes of disease increases and new technologies emerge.\textsuperscript{78} In fact, there are very few examples of cases, at least in the health care context, where a Canadian court has allowed an erosion of the standard of care in order to satisfy a broader social goal. To some degree, this is because medical malpractice law compels health care providers to focus on the needs of the

\textsuperscript{75} Lewis Klar, \textit{Tort Law} (Toronto: Carswell, 1996).


\textsuperscript{78} Ellen Picard and Gerald Robertson, \textit{Legal Liability of Doctors and Hospitals in Canada} (Toronto: Carswell, 1996).
individual. This reality is well illustrated by the British Columbia Supreme Court decision in *Law Estate v. Simice.* In this case, the court considered the impact of cost containment pressure on an emergency physician’s clinical decision. A patient came to the emergency room with a headache and later died of an aneurism. It was suggested that one reason for not providing a timely CT scan was that the provincial health insurance scheme imposed constraints on the use of such diagnostic tools. The court did not accept cost containment pressure as an excuse for substandard care:

> [I]f it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the Medicare system overall, the former must take precedence in a case such as this. The severity of the harm that may occur to the patient who is permitted to go undiagnosed is far greater than the financial harm that will occur to the Medicare system if one more CT procedure only shows the patient is not suffering from a serious medical condition.

Though there have been surprisingly few similar cases, the *Simice* case highlights the potential of medical malpractice law to serve as an accountability mechanism in the context of a changing health care system.

Ongoing lawsuits in Canada regarding the spread of infectious diseases in health care settings are another example of the use of legal mechanisms to enforce specific standards of care. The 2003 outbreak of severe acute respiratory syndrome (“SARS”) focused attention on hospital infection control measures and, in late January 2004, an Ontario law firm filed a class action lawsuit on behalf of patients who contracted SARS in hospitals during the second wave of the outbreak in Toronto. This claim alleges that public health officials failed to maintain sufficiently rigorous infection control precautions. Throughout 2003, a number of Canadian hospitals notified patients that improper sterilization of equipment may have exposed them to HIV, hepatitis and other diseases. In response, many patients have filed legal actions alleging hospitals failed to meet an acceptable standard of care. For example, in November 2003, Sunnybrook and Women’s College Health Sciences Centre in Toronto disclosed that biopsy and ultrasound equipment were not properly disinfected, placing over 800 patients at risk of infection.

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A class action lawsuit filed against the hospital alleges it was negligent in failing to meet adequate sterilization standards. Following these revelations, the Ontario government ordered a province-wide audit of hospital infection control practices and the final report was released in January 2004.

This type of litigation clearly creates a strong incentive for health care facilities and providers to ensure their practices meet, or even exceed, currently accepted standards. As the lawyer for patients suing the Sunnybrook Hospital has commented, this litigation “has two obvious potential benefits: provision of adequate compensation for the victims and forcing the hospitals to protect the public from the threat of similar infections.” Interestingly, these legal claims have an impact simply by being filed; they draw significant media attention and health officials spring to action to review existing practices to assure worried citizens that any lapses will not recur. So, even if the plaintiffs never succeed at the end of the day, the litigation may still have spurred reforms in health care practice.

**Fiduciary Law**

In Canada, physicians are considered to be in a “fiduciary relationship” with their patients. Fiduciary obligations flow from the relationship of trust between physician and patient and the implicit or explicit understanding that physicians will focus, almost exclusively, on the best interests of the patient. As noted in the Supreme Court of Canada decision in *McInerney v. MacDonald*, “[c]ertain duties do arise from the special relationship of trust and confidence between doctor and patient,” including an obligation to treat the patient with the utmost good faith and loyalty.

From an accountability perspective it is important to note that fiduciary law compels physicians to focus on the needs of the patient and to disclose any actual or potential conflicts of interest that might compromise that obligation. For example, fiduciary law heightens the obligation of physicians to tell patients about any factors that may

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2004, Grand River Hospital in Kitchener revealed that approximately 100 women who underwent gynecologic tests may have been exposed to human papilloma virus, which is associated with an increased risk of cervical cancer. See Lee Greenberg, “Improperly sterilized equipment sparks trace for patients: Ninth scare in Ontario” *National Post* (14 January 2004) A5. Class action litigation is also underway in Newfoundland on behalf of about 300 women who underwent procedures at a gynecology clinic. See Ches Crosbie Barristers Press Release “Class Action Lawsuit Filed Against Hospital for Injuries Caused by Failure of Sterilization” (25 November 2003) online: http://www.chescrosbie.com/content/labcity_isb_press.pdf.

84 See Roy Elliott Kim O’Connor LLP Press Release, “Patients exposed to poor hospital sanitation procedures initiate Class Action lawsuit against Sunnybrook and Women’s College Health Sciences Centre” (1 December 2003) online: http://www.reko.ca/sunnybrook_pr1.pdf.


87 *Supra* note 84.


compromise patient care or influence clinical decision-making, including information about cost containment pressures.

**Informed Consent**

The doctrine of "informed consent" is well established in Canadian law. It imposes a legal duty on physicians to provide their patients with "material information" concerning proposed treatment, including the potential risks involved in the treatment, so as to enable the patient to make an informed choice. "Material information" is defined in terms of what a reasonable person in the patient's position would want to know. Failure to provide this information constitutes negligence on the part of the physician.  


92 Timothy Caulfield, "Medical Malpractice, the Common Law, and Health-Care Reform" in G. Marchildon, T. McIntosh and P. Forest, eds. *The Fiscal Sustainability of Health Care in Canada* (University of Toronto Press, 2004) 81.

In this era of health care reform, the legal responsibility to disclose information to patients provides an interesting accountability mechanism. For example, it compels health care providers to tell patients about alternatives.  

Some authors have suggested this may include information about resource allocation policies that impact patient care and alternatives available in the private sphere.  

**Discussion**

Legal principles and precedents developed through medical malpractice and other legal claims may enhance accountability in health care by offering a means for enforcing compliance with acceptable standards of care. These principles also establish patient rights, such as the right to make informed choices about health care, and provider obligations, such as the fiduciary duty to act always in the patient’s best interests. Lawsuits may also serve as a catalyst for public awareness and efforts to address health care concerns.
Legislative Mechanisms

A number of initiatives are underway in various jurisdictions throughout Canada to enhance quality, accessibility and accountability in health care. These include the creation of organizations to oversee various aspects of the health care system, the development of wait list registries, issuing health care “report cards”, and proposing patient bills of rights and care guarantees. The following discussion focuses on the latter two as they are often have the force of law, while the others are policy initiatives that do not necessarily involve legal consequences.

1. Bills of Rights

Some Canadian provinces have proposed legislation that would enumerate rights and responsibilities of various stakeholders in the health care system. For example, New Brunswick has introduced a Health Charter of Rights and Responsibilities Act, which has received second reading in the provincial legislature. The preamble to this Bill reiterates the five key principles set out in the Canada Health Act (public administration, comprehensiveness, universality, portability, and accessibility) and adds that effectiveness, efficiency and accountability are further important aspects of the health care system. The Bill confers certain rights on residents of New Brunswick, including


94 See e.g.: British Columbia Ministry of Health Services Surgical Waitlist Registry (http://www.healthservices.gov.bc.ca/waitlist); Alberta Wait List Registry (http://www.healthhint.gov.ab.ca/AWR/WaitListPublicHome.htm); Saskatchewan Surgical Care Network (http://www.sasksurgery.ca/wait-list-info.html); Manitoba Health Services Wait Time Information Website (http://www.gov.mb.ca/health/waitlist/index.html); Québec Ministry of Health and Social Services wait list information: http://www.mssss.gouv.qc.ca/sujets/listedattente/index.html.


96 For a copy of this proposed legislation, known as Bill 60, see: http://www.gnb.ca/legis/bill/pdf/54/5/Bill-60.pdf.
rights to timely and safe access, information needed to make informed decisions, and a complaint mechanism.97

Ontario has also introduced draft legislation, The Commitment to the Future of Medicare Act.98 As with the New Brunswick legislation, this Bill confirms commitment to the principles of the Canada Health Act and states that “[t]he people of Ontario and their Government … [b]elieve in public accountability to demonstrate that the health system is governed and managed in a way that promotes efficient delivery of high quality health services to all Ontarians.”99

This Bill allows for the creation of accountability agreements between the Minister of Health and health resource providers that specify “performance goals and objectives respecting roles and responsibilities, service quality, accessibility of services, related health human resources, shared and collective responsibilities for health system outcomes, consumer and population health status, value for money, consistency and other prescribed matters.”100 The Bill empowers the Minister to recognize the accomplishment of health service providers who meet or exceed the terms of their accountability agreement (though the nature of this recognition is not specified)101 and also impose penalties on those who do not. Consequences may include “reduction, variation or discontinuance of funding”.102 These provisions clearly represent a “carrot and stick” approach to improving accountability in the health system and are already causing some discord between the province and health facilities.

While Ontario recently announced additional hospital funding of $385 million, this increase is subject to hospitals entering accountability agreements with the government.103 The Ontario Hospital Association has advised its members to refuse to tie

97 Section 3(1) of the Bill provides:
   Every resident of New Brunswick has the following rights:
   (a) a right of timely access to health care services,
   (b) a right to receive relevant health care information,
   (c) a right to take informed health care decisions,
   (d) a right to safe, comfortable and considerate attention, and
   (e) a right to the investigation of complaints.


99 Ibid., Preamble.

100 Ibid., s. 19.

101 Ibid., s. 25. Measures for recognizing this accomplishment will be prescribed by regulation: see section 32(1)(e).

102 Ibid., s. 32(1)(d).

103 In his February 24, 2004 announcement, the Health Minister declared: “What's needed is a transformation to a new framework of accountability and sustainability. Not another short-term fix, but a true ‘transformation.’” See Minister George Smitherman, “Transforming Health Care in Ontario” (Speech presented to the Economic Club of Toronto, 24 February 2004) online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/english/media/speeches/archives/sp_04/sp_022404.html>.
future funding to performance agreements until legal advice is sought. In a news release, the Association argued “[t]he central problem with Bill 8 is that is gives Queen’s Park the power to impose anything it likes on any individual hospital. … Bill 8 shuts communities out of local hospital decision-making by eliminating the responsibilities of local hospital boards.” At this point, it is difficult to assess the implications of this Bill and its capacity to enhance accountability. As with most incentive tools, performance agreements can be implemented well or poorly and their palatability and success will vary accordingly.

The Ontario Bill would also establish a Health Quality Council to monitor and report on the status of the Ontario health care system and introduce measures to prevent two-tier care, such as prohibiting extra-billing and preferential access to insured services based on ability to pay. In British Columbia, Bill 92, the Medicare Protection Amendment Act 2003, would prevent patient billing for publicly insured service, however, these amendments have not been proclaimed in force.

The Province of Québec has introduced legislation that would create a Health and Welfare Commissioner who would be “responsible for assessing the results achieved by the health and social services system … and for providing the Government and the public with the necessary background for a general understanding of the major issues in the health and social services arena.” In November 2003, the Québec Commission des

104 Ontario Hospital Association, Member Update “Government Funding Announcement, Performance Agreement Sign Back” (25 February 2004) online: <http://www.oha.com/oha/MEDIA.NSF/>
105 Ontario Hospital Association, Media Release “Ontario Hospitals Call For Greater Accountability: Legislation Undermines Local Hospital Boards and Weakens Accountability” (23 February 2004) online: <http://www.oha.com/oha/MEDIA.NSF/>
106 A common criticism of performance agreements is that they inappropriately attempt to exert a “command and control” relationship between governments and health service providers. A recent Policy Options commentary on accountability in health care notes that “[a]cross the country, public servants – few of whom have any practical operating experience in complex service delivery organizations – are being assigned the task of drafting or redrafting “performance agreements” that in many cases seek to “micromanage” and “control” health care agencies and institutions in a belief that a centralized approach will make health care provider organizations “more accountable.” Bruce Harber & Ted Ball, “From the Blame Game to Accountability in Health Care” (November 2003) Policy Options 49. The proliferation of “performance targets” as a means of enhancing accountability in the British National Health Service (NHS) during the late 1990s has been criticized. “Central management of the NHS created and reinforced a command-and-control system. … Overall, the bombardment by targets and the nagging by ministers produced a climate of apprehension and sullen resentment in the NHS.” Rudolf Klein, “Britain’s National Health Service Revisited” (2004) 350 N. Engl. J. Med. 937 at 393. Klein also cites the British Secretary of State as acknowledging that “a plethora of service targets, inspection regimes, and national standards’… became counterproductive.” Ibid.
107 Supra note 98, s. 4.
108 Ibid., Part II.
110 Bill 38, An Act respecting the Health and Welfare Commissioner, was tabled in the Québec National Assembly on December 18, 2003. See http://www.assnat.qc.ca/eng/37legislature1/Projets-loi/Publics/03-a038.htm.
111 Ibid., section 2. Section 10 provides additional detail:
droits de la personne et des droits de la jeunesse issued recommendations for amending the Québec Charter of Human Rights and Freedoms,\textsuperscript{112} the provincial human rights law. The Québec Charter establishes certain economic and social rights and states that “[e]very person in need has a right, for himself and his family, to measures of financial assistance and to social measures provided for by law, susceptible of ensuring such person an acceptable standard of living.”\textsuperscript{113} This provision has been interpreted in a somewhat limited manner\textsuperscript{114} and the Commission des droits de la personne recommends that the Charter “recognize the right of every person to benefit from the programs, goods, services, facilities and conditions that will allow that person to enjoy the highest state of physical and mental health of which the person is capable.”\textsuperscript{115}

A Québec court has recently agreed to hear a class action on behalf of an estimated 10,000 women in the province who allege they were denied timely access to radiation therapy following surgery for breast cancer.\textsuperscript{116} The Act respecting Health Services and Social Services\textsuperscript{117} provides that “[e]very person is entitled to receive, with continuity and in a personalized and safe manner, health services and social services which are scientifically, humanly and socially appropriate.”\textsuperscript{118} The statute further states that “[e]very person whose life or bodily integrity is endangered is entitled to receive the care required by his condition. Every institution shall, where requested, ensure that such care is provided.”\textsuperscript{119} The class action claimants contend that wait lists to receive cancer radiation treatment violate these rights, hospitals have an obligation to provide treatment

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\textsuperscript{112} Charter of Human Rights and Freedoms, RSQ, c. C-12.

\textsuperscript{113} Ibid., Article 45.


\textsuperscript{117} R.S.Q. c. S-4.2.

\textsuperscript{118} Ibid., s. 5.

\textsuperscript{119} Ibid., s. 7.
in a timely manner, and the provincial government must provide adequate funding to hospitals to prevent unacceptably long waits.

However, rights established by the legislation are limited by the stipulation that “[t]he right to health services and social services … shall be exercised within the framework of the legislative and regulatory provisions relating to the organizational and operational structure of the institution and within the limits of the human, material and financial resources at its disposal.” While the Québec court has agreed to hear the case as a class action, this ruling is not based on a determination that the claim is likely to succeed. In fact, “[i]t is important to bear in mind that the judge hearing a motion … for authorization to institute a class action is not called upon to decide that the action is well-founded or that it will succeed.” When this claim proceeds to trial, the court will have to resolve key questions regarding legal obligations to ensure access to health care, what constitutes timely access in the context of the case before it, and what factors may justifiably limit the right to treatment. So, although the government of Québec enacted a law that establishes certain health care entitlements, the scope of that law must be determined by courts as individual cases are litigated.

Discussion

Recommendations from the Romanow Report may have provided an impetus for legislative initiatives to establish patient rights. The Report notes:

During its hearings, the Commission heard suggestions that some sort of “Covenant” or “Patient Bill of Rights” was necessary and should set out clear legal rights and obligations, similar to those set out in the *Canadian Charter of Rights and Freedoms*. The value of a Covenant lies, however, in the fact that it reflects the consensus of Canadians as affirmed by their governments, not in the establishment of new rights that would be subject to legal interpretation and ultimately decided by the courts rather than by Canadians themselves.

This statement reveals that Romanow is not a proponent of enacting new laws whose scope and meaning may ultimately be defined in adversarial legal proceedings. Rather, he advocates the development of a “Health Covenant” that serves more as a guiding statement of key values and principles to provide a foundation for the health care system. The Health Covenant proposed by Romanow expresses a number of fundamental

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121 *Supra* note 116 at para. 9, which cites Justice Rothman’s ruling in *Comité d’environnement de La Baie Inc. v. Société d’électrolyse et de chimie Alcan Limitée*, [1990] R.J.Q. 655 (C.A.) (QL). When considering whether to certify a proceeding as a class action, a judge must consider specific factors to determine, in essence, if a class action is a fair and efficient means to hear the litigation. See *Code of Civil Procedure*, R.S.Q., c. C-25, s. 1003.
122 *Supra* note 34 at 49.
principles and itemizes responsibilities of individuals, health care providers and governments.

How will these legislative initiatives impact accountability in health care? First, these laws may have symbolic value, demonstrating that legislators take seriously public concerns regarding our health care system. Second, the establishment of bodies to monitor and report publicly on quality, safety and other issues, may enhance accountability.

On the other hand, the effectiveness of these initiatives may be constrained by a number of factors. A key challenge is the enforceability of principles set out in these laws. While the language contained in proposed bills or charters of rights may imply a solid entrenchment of legal rights to health care, this is likely not the case. For example, New Brunswick’s proposed Health Care Charter contains provisions clearly intended to limit the scope of the law: “Nothing in this Act (a) limits the authority of the government of New Brunswick to determine what health care services shall form part of the New Brunswick health care system, nor when, where or to what extent those services will be provided [or] (b) requires the provision of any health care service that does not form part of the New Brunswick health care system….” As another example, Québec’s Act respecting Health Services and Social Services explicitly states that the legal entitlements it confers must be interpreted within the limits of existing financial and other resources.

Moreover, in some respects, the proposed statutes discussed above simply codify principles that courts have already ruled are part of Canadian law. For example, patient bills of rights may include a right to make informed health care decisions and a right to access information. As discussed earlier in the section on informed consent and fiduciary law, patients already have these rights. Even though these rights may be confirmed in a general sense in bills of rights, the content of the right in specific situations would still be determined on a case-by-case basis.

A final limiting factor is the tendency of courts to interpret rights to benefits like health care and social assistance in a relatively narrow manner. The Supreme Court of Canada recently grappled with the issue of whether the Canadian Charter of Rights and Freedoms and Québec’s human rights legislation includes a right to a minimum level of welfare benefits. The majority of the Court ruled the Charter does not require the

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123 These are: mutual responsibility; public resource; patient-centred care; equity; a universal, accessible and portable system; a respectful and ethical system; transparency and accountability; public input; and quality, efficiency and effectiveness.  Ibid. at 50.
124 Individuals are responsible for maintaining their own health and using the health system wisely and are entitled to, among other things, “timely, high quality care…based on health needs, not ability to pay.” Health care providers have a number of responsibilities, including an obligation to use limited health resources prudently, while being entitled to “a meaningful role in making decisions related to the operation of the system.” Finally, government responsibilities include ensuring adequate funding for the system.
125 Of course, the capacity of such organizations to carry out their role effectively depends on receiving adequate resources to do so.
126 Supra note 96 at section 2(2).
127 See Gosselin v. Québec, supra note 114.
government to provide benefit programs to ensure people enjoy a minimum quality of life. Further, although the Québec Charter of Human Rights and Freedoms protects a right to “measures of financial assistance and to social measures ... [to ensure] an acceptable standard of living”, the Supreme Court found this provision did not authorize judges to review the adequacy of government benefit programs. Courts often acknowledge that legislators, not judges, are best suited to making complex social policy choices and hesitate to impose obligations on governments unless the law clearly supports such a ruling.

2. Care Guarantees

Patients, health care providers and politicians all express growing concern regarding the impact of waiting times on access to health care services, especially surgeries and diagnostic tests. In March 2004 alone, two compelling situations involving wait lists captured significant media attention. First, in early March, the Saskatchewan Health Quality Council and the Minister of Health announced they would investigate the circumstances of a man who waited seven months for a biopsy to diagnose prostate cancer. By the time he received his diagnosis, the cancer had spread and the patient is now waiting for surgery after three cancellations. As discussed earlier, a Québec court has recently certified a class action lawsuit on behalf of thousands of breast cancer patients who had to wait for radiation therapy.

In its report, the Romanow Commission noted that

Canadians want and expect to have access to health care services when and where they need them. ... Providing timely access to quality health care services is a serious challenge in every province and territory. Consistently, the Commission heard concerns from Canadians about waiting for diagnostic tests, waiting for surgeries or waiting to see specialists.

In its submission to the Romanow Commission, the Canadian Medical Association suggested a need for care guarantees to ensure patients are able to obtain health care services within

128 The two dissenting judges were of the opposite opinion. Justice Arbour emphasized that “[f]ew would dispute that an advanced modern welfare state like Canada has a positive moral obligation to protect the life, liberty and security of its citizens.” Ibid. at para. 308. While she acknowledged debate over whether this “moral obligation translates into a legal one”, she concluded the Charter encompasses a right to state assistance to meet “basic needs of subsistence.” (at paras. 308, 311)

129 Supra note 112, Article 45.

130 Chief Justice McLachlin stated this provision “requires only that the government be able to point to measures of the appropriate kind, without having to defend the wisdom of its enactments. This interpretation is also consistent with the respective institutional competence of courts and legislatures when it comes to enacting and fine-tuning basic social policy.” Supra note 114 at para. 93.


132 Supra note 34 at 137. The Romanow Report also identified three priority areas where delays in obtaining access must be addressed (at 139-140): access to advanced diagnostic technologies (such as MRIs and CT scanners); access to specialists; and access to some surgical procedures (such as hip and knee replacements).
acceptable time limits. The Kirby Report also argued strongly in favour of implementing care guarantees and pointed out that barriers to care within the publicly funded health care system create incentives for an expanded role for private health care. As the Report notes:

...lack of timely access to needed care can seriously contribute to the deterioration of a person’s health and well-being. Given this fact, it is likely that increasing pressures will be exerted on governments, hospitals and physicians to ensure that medically necessary care is provided, within the publicly funded system, in a timely manner. It is also very likely that, failing substantial improvement, Canadians will exert pressure on government to make it legally possible for individuals to obtain timely care in a parallel private hospital and doctor system.133

In general, some studies demonstrate that waiting for care can adversely impact patients, both physically (for example, their condition deteriorates while they wait or delays result in worse post-treatment outcomes) and psychologically (stress and anxiety is exacerbated while patients wait for needed care).134 In its 2003 report on health care in Canada, the Canadian Institute for Health Information cites the following data collected in a Statistics Canada survey:

Overall, one in five patients aged 15 and older who received specialized services in 2001 reported that waiting for care had a negative impact on their lives. People identified pain (37%); poorer health (31%); trouble doing everyday tasks (24%); worry, anxiety and stress (59%); and loss of work (4%) or income (8%) as the most common ways that waiting affected their lives.135

**Care Guarantee Proposals**

As mentioned above, the Kirby Report strongly advocated the development of care guarantees and made the following recommendations:

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133 *Supra* note 35 at Chapter Five.
134 For a review of various studies assessing the impact of waiting lists on patients, see Terence Sullivan *et al.*, *First Do No Harm: Making Sense of Canadian Health Reform* (Vancouver: UBC Press, 2002), Chapter 4 “Canaries in the Mine: Waiting for Care” at 56. This review found evidence that quality of life suffered for patients waiting for the following procedures: hip and knee replacements; other orthopaedic procedures; prostate treatments; and cardiac procedures. However, in another review, S.E.D Shortt notes that evidence is lacking in some other areas. For example, one study demonstrated that only 10% of people awaiting cataract surgery experienced possibly irreversible vision loss. Additionally, negative impacts were not noted in relation to waits for tonsil surgery, urological surgery or breast cancer treatment. See S.E.D. Shortt, *Waiting for Medical Services in Ontario: Clarifying the Issues in a Period of Health Reform*, A Discussion Paper for the Atkinson Charitable Foundation (February 2000), online: <http://www.utoronto.ca/hpme/dhr/pdf/Shortt.pdf>.
· establish a “maximum needs-based waiting time” for all major procedures/treatments, based on clinical, evidence-based criteria;
· if a patient waits longer than the maximum waiting time, government (as the health care insurer) will pay for the patient to undergo treatment in another jurisdiction (either another Canadian province or outside the country);
· maximum waiting times should apply nationally.136

A March 2003 editorial in the B.C. Medical Journal argued in favour of establishing a “Canadian Health Charter” that would provide the following guarantees:

1. Patients awaiting elective consultation with a specialist will receive a consultation within 2 weeks. ...

2. Patients with acute injuries or illness (e.g., fractures, vascular, cardiac, abdominal, neurological, etc.) requiring emergency assessment in an acute care hospital shall receive investigations and treatment without delay. No such patient shall wait more than 4 hours for urgent tests or 8 hours for interventional treatment. ...

3. Patients with subacute illnesses that are determined by the referring or admitting physician to be urgent shall receive investigation and treatment within 1 month of referral.

4. Patients with non-emergency illnesses or injuries, who are in pain or disabled, will receive all investigations and treatments within 1 month of referral.

5. Patients with non-urgent or chronic illnesses or injuries, who are restricted but not suffering significant pain or disability, will receive all investigations and treatments within 3 months of referral.137

In its submission to the Romanow Commission, the Canadian Medical Association also advocated for a Canadian Health Charter, an “instrument that sets out the rights and responsibilities of all parties in health care, including patients, providers and governments.”138 Among other things, the proposed Health Charter would establish a patient right to timely and quality care, with recourse to other options if the public system fails to provide care within an acceptable time frame.

The Romanow Commission addressed the care guarantee option but took a less enthusiastic view than the Kirby Report, noting that:

136 Supra note 35 at Chapter Six.

Accountability in Health Care and Legal Approaches 29
The advantage of care guarantees is the certainty and reassurance they provide to patients. They also require health care authorities, providers and hospitals to take steps to ensure that the guarantees can be met. On the other hand, care guarantees should be approached with some degree of caution.

Currently, reliable methods are not available to determine what the appropriate guarantee should be and what the likelihood is that the health care system would be able to meet the time limits set in a guarantee. ...

The other major concern is with the difference between life-saving and elective procedures. ... provincial and territorial health care systems [should not be] handcuffed into care guarantees for elective or non-life-saving services that could, in practice, mean they would have to reallocate resources away from life-saving surgery or treatment in order to meet the care guarantees for other services.139

Various jurisdictions have implemented or are considering developing care guarantees to address some of the problems posed by lengthy waiting lists. Internationally, Britain, Spain, Sweden and Italy have used legislation to establish maximum waiting times for certain health care services.140 As care guarantees have not yet been implemented in Canada, the following discussion provides an overview of lessons learned from several international experiences.

**International Experiences**

Lessons from international experiences with care guarantees may inform the policy discussion in Canada. For example, in the early 1990s, Sweden introduced a “Maximum Waiting Time Guarantee” to address lengthy waiting lists for certain procedures that met the following criteria: (1) waiting for care causes a problem; (2) a well established treatment exists; (3) results are measurable; and (4) high clinical benefit is expected.141 Twelve procedures, including hip and knee replacement, cardiac surgery and cataract removal, were covered by the guarantee, but only in urgent and emergent cases where

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139 *Supra* note 34 at 144.
specific criteria were met. According to the care guarantee, if eligible patients did not receive care within three months at their own hospital, the government would cover the cost of the patient obtaining the service at another public or private hospital. In the first year of the guarantee, additional funding grants were provided to hospitals to help ensure care guarantees would be met. The guarantee was later expanded to address access to primary and specialist care.

Similarly, the United Kingdom introduced a “Patient Charter” in 1992 to establish national standards for appropriate waiting times.\textsuperscript{142} The Charter was amended in 1995 to provide for access to hospital-based services within 18 months and access to cardiac services within 12 months. Patients were also assured that their surgery would not be cancelled the day before their scheduled operation or after they were already admitted to hospital.

In general, criticisms of care guarantees are based on concerns that the success of decreasing waiting times for some patients (by reallocating resources to specific patients and procedures) comes at the expense of other patients waiting for care that is not covered by guarantees. For example, a Western Canada Waiting List Project report comments that:

> In both the United Kingdom and Sweden, evidence suggests that these policies had an effect in reducing lists and waits, but only in the short-term. They were also associated with paradoxical but perhaps predictable effects. For example, implementation of the UK Patient Charter did clear backlogged patients, but at the same time caused waits among other patients to increase.\textsuperscript{143}

The Canadian Medical Association concurs that “it is probably fair to say that international experience with charters and specific waiting time guarantees has been mixed”\textsuperscript{144} but goes on to make the important point that “there is no doubt that these have helped to bring about a patient-centered focus and a service standards orientation in those systems that have experimented with them.”\textsuperscript{145}

\textbf{Discussion}

In Canada, Prime Minister Paul Martin has expressed interest in care guarantees and they have figured in election promises during recent campaigns in Ontario and Québec. In 2001, the Alberta Premier’s Advisory Council on Health, chaired by Don Mazankowski, recommended 90-day guarantees for access to certain services.\textsuperscript{146} Although the Alberta government established a health reform team to implement this and other

\textsuperscript{142} National Health Service. \textit{The Patient’s Charter} (U.K. Department of Health, 1995).

\textsuperscript{143} \textit{Supra} note 140 at 4.

\textsuperscript{144} \textit{Supra} note 138 at 5.

\textsuperscript{145} \textit{Ibid}.

recommendations, by May 2003, a commitment to service guarantees was replaced with a more ambiguous reference to developing “access standards.”

International experiences suggest care guarantees are one option that may remedy problems posed by waiting lists, including diminished public confidence in the health care system. While such initiatives have helped reduce patient backlogs in places like the United Kingdom and Sweden, some suggest care guarantees are not a panacea to waiting lists problems. A 2002 analysis concludes:

Efforts at reducing waiting times and lists often occur simultaneously with other reforms and changes in the level of health-care funding. We cannot conclusively determine whether reductions in the growth of waiting times and lists are simply a short-term blip.... However, it is apparent that a patients’ bill of rights can be part of a package of initiatives designed to reduce waiting times by a government determined to tackle growing waiting times in the public system.

As this statement indicates, efforts to establish some form of care guarantee or patient charter, within the context of other reforms, may enhance efforts to manage waiting lists and respond to public concern regarding delays in accessing both primary and specialist health care services.

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148 Flood & Epps, supra note 140 at 29 [emphasis added].


Conclusion

In Canada, various legal mechanisms currently exist or are proposed that may be used to establish or shape rights in regard to health care. As discussed throughout, these mechanisms may have both beneficial and unfavourable impacts on accountability and it is difficult to reach a conclusion that, in general, use of legal mechanisms is good or bad.

Legal challenges based on the *Canadian Charter of Rights and Freedoms* and human rights laws typically seek to compel governments to provide public funding for specific services. *Charter* challenges may also contest the constitutional validity of legislative regimes that constrain choice in regard to health care. Medical malpractice litigation involves assessment of whether impugned practices meet currently accepted standards of care and legal obligations. These mechanisms may enhance accountability by bringing public attention to policy decisions and practices that otherwise would remain unknown to the majority of Canadians. Litigation before courts and other quasi-judicial decision-makers, or complaints to bodies such as Ombudsmen, require governments and other health authorities to explain and justify their choices in an open forum. Even if individuals claimants who bring legal action do not succeed, the publicity generated by such claims may spur health reform initiatives.

At the same time, though, some of these mechanisms may undermine accountability by pushing complex policy decisions into courtrooms where attention will necessarily focus on the circumstances of individual litigants, perhaps to the exclusion of broader consideration of competing demands on public resources. In addition, successful claims may accord greater status to certain therapies by enshrining public funding for them as a fundamental human or constitutional right. As a result, governments may be compelled to reallocate funds to those specific services and reduce financial support for other programs or services that have not been the subject of litigation. This situation is paralleled by the concern that enacting care guarantees for specific services will cause a reallocation of resources to the “protected” services, resulting in longer delays for access to services not covered by the guarantee.

To the extent a generalized conclusion can be reached, lawsuits likely do not offer the best approach to *systematic* health system reform. While individuals seem increasingly willing to pursue legal action in the health care context, the reality is that litigation is an expensive and time-consuming process that may be extremely draining, especially for individuals who are themselves ill or responsible for the care of others. Consequently, this mechanism is realistically only available to those who have financial and other

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149 Ongoing autism litigation in Ontario reveals the complexities and frustration that often attend legal action. Although the litigation process has been underway for many months and the plaintiffs seeking public funding for autism therapy have already closed their case, government lawyers recently advised that numerous, additional documents potentially relevant to the lawsuit have been located. In *Wynberg v. Ontario*, [2004] O.J. No. 1066 (S.C.J.) (QL), Justice Kiteley commented that “the staggering volume [of non-disclosure] has created a crisis” in the conduct of the litigation (at para. 40) and ordered the Crown to provide interim funding for autism therapy for children involved in the case.
resources to fight out a legal battle. While administrative bodies, such as health service review boards or Ombudsman offices, may offer complaint resolution mechanisms that are intended to be less costly and complex than litigation, individuals may be unaware these bodies exist and the agencies themselves may have limited jurisdiction or resources.

The development of legislative mechanisms such as bills of rights and care guarantees are proffered as means for defining entitlements in the health care context. These mechanisms may articulate relatively general statements regarding access to timely and safe care, for example, or they may establish explicit rights to public funding for enumerated services within specified time periods.

From the perspective of individuals who want unambiguous and enforceable standards, legislative mechanisms that do little more than express “guiding principles” are unlikely to offer the recourse they seek. It is perhaps unsurprising that governments may choose to enact somewhat vague assurances or constrain the scope of rights by stipulating that they must be interpreted in light of financial resources. This leaves wiggle room. Just as governments often resist judicial intrusion into public policy-making, they may also hesitate to bind themselves too strictly to specific standards.

However, as the experience of several international jurisdictions demonstrates, some governments may be inclined to establish care guarantees that are specific and enforceable. In addition to the concern that this approach may detract resources away from other areas, a further complicating factor is the lack of consensus about what guarantees are appropriate. Ideally, care guarantees would rest on a solid evidence base demonstrating that delays in accessing care are likely to have adverse health outcomes. Yet, this evidence may not be currently available. For example, the Québec breast cancer patients who are engaged in a class action regarding wait lists for radiation therapy argue they ought to have received treatment within eight weeks of surgery. However, while medical literature suggests that delays in commencing radiation therapy may increase health risks, there is no agreement about the specific number of weeks post-surgery in which radiation therapy should take place.150

The state of our public health care system is a source of almost constant concern in Canada and there appears to be growing interest publicly and politically in using legal mechanisms to define rights in regard to health care. In this paper, we have identified and discussed a number of key mechanisms, as well as current examples of their use, that bear on accountability in health care. Many of these mechanisms are relatively novel in Canada, including care guarantee proposals and the use of constitutional claims to establish rights to publicly funded health care or challenge restrictions on private care. Without doubt, it will be worthwhile to pay attention to legislative, judicial and public use of and response to these mechanisms and engage in ongoing evaluation of their overall impacts on health care in this country.

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150 See evidence summarized in Cilinger v. Centre hospitalier de Chicoutimi, supra note 116 at paras. 60 – 71.
Appendix A – Papers in the CPRN Health Care Accountability Series

*Rhetoric, Fallacy or Dream? Examining the Accountability of Canadian Health Care to Citizens*, by Cathy Fooks and Lisa Maslove

A recent scan of research literature indicates that general definitions of public accountability do exist – that is, being accountable publicly for actions. However, notions of accountability to citizens within health care are not well developed. Furthermore, the Canadian focus to date has been largely on the public release of comparative health indicators and the establishment of citizen governance structures at the regional level. Little attention has been given to other potential accountability mechanisms such as legal avenues or citizen engagement approaches for policy development. This first project will review concepts summarizing research on current definitions of accountability to citizens.

*Mapping Legal Accountabilities*, by Susan Zimmerman

Responsibility for designing, delivering, funding and evaluating health care in Canada is confusing. Before assessing potential improvements, mapping out current responsibilities and accountabilities is required and will be the focus of this second project. We will pose a series of who does what questions for various aspects of Canadian health care examining where decisions are made within the current legislative, regulatory and health policy environments. It will include an examination of the responsibility of governments, regional health authorities, the regulatory bodies, non-profit and for-profit health care providers (individuals and organizations), professional associations, educational institutions, patient organizations, and corporations. An accountability matrix will be created for the federal and provincial/territorial level health care responsibilities.

*Engaging Citizens: One Route to Health Care Accountability*, by Julia Abelson and François-Pierre Gauvin

An engagement approach focuses on new ways to engage citizens in decision making about policy and system issues, going beyond traditional public consultation and focus group methodologies. This paper will assess the possibilities for increasing the use of engagement approaches in Canadian health care.

*The Effectiveness of Performance Reporting as a Citizen Accountability Mechanism*, by Kathleen Morris and Jennifer Zelmer

Canada has begun work in this area with a common federal/provincial/territorial reporting framework being established in 2001 and further refined in 2003. Accreditation of
institutions and individual providers is another approach that is closely tied to performance measurement. This paper will review the evidence on the effectiveness of these reporting processes for citizen accountability and will describe the scope and nature of current performance reporting exercises.

**Accountability in Health Care and Legal Approaches, by Nola Ries and Tim Caulfield**

Proposals such as a service guarantee outlining items such as minimum wait times for procedures, or a Patient Charter of Rights, are being proposed in the Canadian health policy community. They are in the development stage at present with one province proposing specific language (New Brunswick), one province committed to a service guarantee 90 days after diagnosis (Alberta), and one province committed to a process to establish clinically appropriate wait times (Ontario). As well, Canadians are heading to court to assert specific entitlements to specific health care services. This paper will review the effectiveness of these proposals as citizen accountability mechanisms.

**The Effectiveness of Governance Approaches as a Citizen Accountability Mechanism, by Steven Lewis**

Regional health authorities with citizen governors are in operation in all provinces except Ontario and a number of provinces are establishing provincial-level organizations such as quality councils. A national level health council has also been established as a citizen accountability mechanism. This paper will review the evidence on the roles of citizens as governors in health care.

**Policy Synthesis and Action Plan**

Once the six papers are completed, CPRN will host a national solutions symposium to bring together researchers, policy makers, stakeholders and citizen representatives to review and comment on early findings. As well, the round table will test specific proposals to strengthen accountability mechanisms. From there, CPRN will develop a final report summarizing the information gathered throughout the project and make specific recommendations about next steps for Canada’s health care system.
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