

# **BACKGROUND PAPER No. 1 – DEFINING THE MEDICARE BASKET**

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## **The Legal Framework for Health Governance in Ontario**

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## **CONTENTS:**

### **Introduction**

1. *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, Chapter M.26
2. *Ministry of Health Appeal and Review Boards Act*, 1998 S.O. 1998, Chapter 18  
Schedule H
3. *Health Insurance Act*, R.S.O. 1990, Chapter H.6
4. *Regulated Health Professions Act*, 1991 R.S.O. 1991, Chapter 18
5. *Health Care Accessibility Act*, R.S.O. 1990, Chapter H.3
6. *Health Protection and Promotion Act*, R.S.O. 1990, Chapter H.7
7. *Public Hospitals Act*, R.S.O. 1990, Chapter P.40
8. *Independent Health Facilities Act*, R.S.O. 1990, Chapter I.3
9. *Long-Term Care Act*, 1994 S.O. 1994, Chapter 26
10. *Community Care Access Corporations Act*, 2001 S.O. 2001, Chapter 33
11. *Health Facilities Special Orders Act*, R.S.O. 1990, Chapter H.5
12. *Nursing Homes Act*, R.S.O. 1990, Chapter N.7  
*Charitable Institutions Act*, R.S.O. 1990, Chapter C.9  
*Homes for the Aged and Rest Homes Act*, R.S.O. 1990, Chapter H.13
13. *Private Hospitals Act*, R.S.O. 1990, Chapter P.24
14. *Mental Health Act*, R.S.O. 1990, Chapter M.7
15. *Community Psychiatric Hospitals Act*, R.S.O. 1990, Chapter C.21
16. *Health Care Consent Act*, 1996 S.O. 1996, Chapter 2 Schedule A  
*Substitute Decisions Act*, 1992 S.O. 1992, Chapter 30
17. *Ambulance Act*, R.S.O. 1990, Chapter A.19
18. *Healing Arts Radiation Protection Act*, R.S.O. 1990, Chapter H.2
19. *Laboratory and Specimen Collection Centre Licensing Act*, R.S.O. 1990, Chapter L.1
20. *Drug and Pharmacies Regulation Act*, R.S.O. 1990, Chapter H.4
21. *Bill 46, 2001 “Public Sector Accountability Act”*

### **Summary**

## Introduction

In this background paper we will examine the legal framework that currently governs health care services in Ontario (as of June 2003). The purpose of this overview is to identify the roles and responsibilities of various parties to the provision of health care and to describe and assess the accountability mechanisms set down in health care legislation. We will evaluate each piece of legislation and the role accorded to the relevant players therein.

The parties whose powers, duties and responsibilities this paper will analyse are: the Minister of Health, the Ministry of Health and Long Term Care (the Ministry), public hospital boards, community care access centres (CCACs), and physicians.

The Minister and Ministry of Health's role and responsibility are of central importance since they are the primary source of funding for health services and the primary resource allocation decision-makers. There is little distinction made in the legislation between the duties and functions of the Minister of Health and those of the Ministry. The first Act examined, the *Ministry of Health and Long Term Care Act*, makes it clear that the Ministry's power to undertake the provision of health services is delegated from the Minister. For this reason the duties and responsibilities of these two parties are amalgamated under one heading in the discussion that follows.<sup>1</sup>

Public hospital boards, CCACs and physicians each occupy a critical position in the health care system. Hospital Boards and CCACs are, to some extent, responsible for organizing access to services either through the direct provision of services, as with the hospital, or through funnelling patients to appropriate providers, as with CCACs. Physicians may be viewed as "gatekeepers" to

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<sup>1</sup> In certain instances the Minister works in concert with, or subject to the approval of, the Lieutenant-Governor-in-Council (the "LGC"). Where the LGC holds an express power, that situation will be described in the Minister/Ministry section of the analysis.

the entire health care system since it is through them that patients will initially access health care and through their direction and prescription that they will move on to utilize further elements of the system such as diagnostic or specialist services. The responsibility and accountability these parties have for the decisions they make will be examined. Where a relevant decision-maker is not mentioned, the reader should assume that the Act does not provide for any duties on the part of that decision-maker.

### ***1. Ministry of Health and Long-Term Care Act, R.S.O. 1990, Chapter M.26***

This Act sets up the overall bureaucratic structure for Ontario's health care system. It provides that the Minister shall preside over and have charge of the Ministry and all its functions,<sup>2</sup> and also allows the Minister to delegate that authority to specified people: Deputy Ministers, public servants, employees of the Ministry, and Officers and the Board members of agencies for which the Minister is responsible.<sup>3</sup> The Minister may delegate any power or duty accruing to him and may place any condition or limitation on the delegation that he deems suitable.

#### ***1.1 Minister of Health/Ministry of Health***

The Minister is responsible for the administration of this Act and is empowered to:<sup>4</sup>

- advise the government on health issues;
- oversee and promote the health of the people of Ontario;
- develop and maintain the services and facilities of the health care system;
- control the charges made by hospitals and health facilities;<sup>5</sup>

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<sup>2</sup> Section 3(1) of the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, C. M.26 (the "MHLTC Act").

<sup>3</sup> Section 3(3) of the MHLTC Act.

<sup>4</sup> Section 6 of the MHLTC Act.

<sup>5</sup> The MHLTC Act contains four provisions (in s. 6(1)) relating to the cost of services by allowing the Minister to:

- enter into agreements for the provision of health services and equipment and for the payment of remuneration for such health services on a basis other than fee for service.
- institute a system for payment of amounts payable under the *Health Insurance Act* in the form of payment by the Province of all or any part of the annual expenditures of hospitals and health facilities.

- make payments related to health care services.

In pursuit of these functions, the Minister shall inquire into what services and facilities are required to meet the health needs of the province and shall promote and assist in the development of adequate resources.<sup>6</sup> The Minister may conduct research and collect information related to health needs and may recommend programs and methods to the government. He or she also has the power, subject to approval by the LGC, to make regulations governing the standards for facilities providing care,<sup>7</sup> designating classes of facilities and requiring prescribed providers to submit information on their activities to the relevant District Health Council (DHC).

Section 7 allows the Minister to enter into agreements with municipalities, and other persons or corporations respecting the provision of hospitals, health facilities and services. Pursuant to s. 8 the Minister may set up district health councils; there are currently 16 geographically defined DHCs in Ontario, which advise the Minister on health matters, make recommendations on the allocation of resources to meet health needs, and develop plans to balance and integrate local health care systems. DHCs may also perform other duties as assigned by the Minister, but they may not undertake any planning activity without the Minister's approval.<sup>8</sup> Section 9 allows the Minister to set up advisory committees as he considers it necessary or desirable.

The Act has few requirements for accountability. However, s. 13 does require that the Minister make an annual report on the affairs of the Ministry to Cabinet; the report is then tabled in the Legislature.

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- govern the care, treatment and services and facilities provided by hospitals and health facilities and assess the revenues required to provide such care, treatment and services.
  - control charges made to all patients by hospitals and health facilities.

<sup>6</sup> Section 6.2 of the MHLTC Act.

<sup>7</sup> Subject to the approval of the LGC, the Minister may make regulations ... to prescribe and govern the standards for the facilities for providing care, treatment and services in hospitals and health facilities – s. 12(a) of the MHLTC Act.

<sup>8</sup> *Ministry of Health and Long-Term Care Act* R.R.O. 1990, Reg. 784 District Health Councils, per s.1, "Every district health council shall obtain the approval of the Minister before it initiates any planning of the health or hospital services needs of its district."

### *1.2 Public Hospital Boards*

Section 8.1(10) states that health care providers, who are prescribed by the regulations, must submit plans and other information as required by the Minister to the Minister and, if requested to do so, to the relevant DHC.<sup>9</sup> The providers may also be required by regulation to make these plans available to the public.

### *1.3 Community Care Access Centres*

Community Care Access Centres are “health facilities” as that term is defined under the regulations attached to the *Health Insurance Act*; that definition is incorporated into this Act. They may be required by the Minister, pursuant to s. 8.1(10), to submit planning information to the Minister or to the DHC, as requested.

## ***2. Ministry of Health Appeal and Review Boards Act, 1998 S.O. 1998, Chapter 18 Schedule H***

This Act restructured the number and role of various bodies adjudicating certain disputes in the health care system. For example, the Act consolidated a number of boards (the Health Services Appeal Board, the Health Facilities Appeal Board, the Health Protection Appeal Board, the Nursing Home Review Board and the Laboratory Review Board) into the Health Services Appeal and Review Board (HSARB). The former Health Professions Board and the Hospital Appeal Board were consolidated into the Health Professions Appeal and Review Board. Both boards must report to the Minister of Health on an annual basis.

The Health Professions Appeal and Review Board conducts hearings and reviews on matters arising out of:

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<sup>9</sup> This information relates to service provision and is used by the DHC to further their planning processes; it does not include budget information from the parties.

- The Regulated Health Professions Act
- The Drug and Pharmacies Regulation Act
- The Public Hospitals Act.

The Health Services Appeal and Review Board conducts hearings and reviews on matters arising out of:

- The Ambulance Act
- The Charitable Institutions Act
- The Healing Arts Radiation Protection Act
- The Health Care Accessibility Act
- The Health Facilities Special Orders Act
- The Health Insurance Act
- The Health Protection and Promotion Act
- The Homes for the Aged and Rest Homes Act
- The Immunization of School Pupils Act
- The Independent Health Facilities Act
- The Laboratory and Specimen Collection Centre Licensing Act
- The Long Term Care Act
- The Nursing Homes Act
- The Private Hospitals Act

Whether a board's decision can be appealed to the regular courts depends on the Act in question and we will deal with this issue further below. It should also be noted that the powers of the HSARB vary considerably depending on the Act in question. Generally, the HSARB has the power to accept, reverse or send back for further review, the decisions made by parties acting under the relevant legislation.

### **3. *Health Insurance Act*, R.S.O. 1990, Chapter H.6**

This Act sets out the framework for the provision of public health insurance in the province and deems the Minister of Health to be the “public authority”<sup>10</sup> for the purposes of the *Canada Health Act*.

#### **3.1 *Minister of Health/Ministry of Health***

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<sup>10</sup> *Health Insurance Act*, R.S.O. 1990, Chapter H.6, S. 2(1)

Section 2(1) vests the Minister with responsibility for the administration and operation of the Ontario Health Insurance Plan (OHIP). The Minister's duties allow that he may: 1) make arrangements to pay physicians and practitioners; 2) enter into agreements with other provinces who provide reciprocal coverage for citizens of Ontario when in those other provinces; 3) limit the health services provided outside Canada for which the plan will pay; 4) establish advisory committees; 5) authorize the collection of information necessary for purposes related to OHIP; and, (6) regulate the number and location of eligible physicians in the province. Section 9 requires the Minister to make an annual report to the LGC and to lay the report before the Legislature.

The LGC appoints a General Manager of OHIP whose role is defined as that of chief executive officer<sup>11</sup>. The General Manager is responsible for the day-to-day operation of OHIP from determining patient's eligibility for services to making payments to doctors for services rendered. The General Manager collects and reviews payment claims by physicians. If the claims are challenged on the basis that they are not medically or therapeutically necessary the matter may be referred to one of the advisory committees detailed below. Decisions of the General Manager may be appealed through the HSARB.

The *Health Insurance Act* authorizes the operation of three advisory committees: the Medical Review Committee (MRC), the Practitioner Review Committee (PRC) and the Medical Eligibility Committee (MEC).

The MRC is constituted as a committee of the College of Physicians and Surgeon of Ontario. The Minister of Health appoints physician members of the committee from among the nominees put

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<sup>11</sup> *Ibid*, s. 4(2)(a)



forward by the College and directly appoints all non-physician members. Section 5(2.1) establishes the ratio of physician to non-physician members at a minimum of 3:1. The MRC is responsible for auditing a specified number of doctor's accounts referred by the Minister<sup>12</sup> and reviewing the medical necessity of services provided upon referral by one physician to another when the provision of such a service is disputed by the General Manager of OHIP. As well, the committee may be required to review matters as referred to it by the Minister, to report and to make recommendations. The members of the MRC have the powers of an inspector as defined in s. 40(1).<sup>13</sup> The MRC does not deal with cases of suspected fraud by physicians; those matters are handled by a police investigation.

The Practitioner Review Committee shares similar functions to the MRC but oversees non-medical practitioners such as chiropractors, chiropractors, osteopaths, optometrists and dentists to the extent that their services are insurable. As with the MRC, the Colleges nominate practitioners from whom the Minister chooses appointees. The Minister nominates non-practitioner members. The ratio of non-practitioners to practitioners is set at not more than 2:1.

The Medical Eligibility Committee, composed entirely of physicians appointed by the Minister, reviews disputes arising out of a decision by the General Manager that an insured person is not entitled to an insured service in a hospital or health facility because such service is not "medically necessary." S. 19(2) requires the MEC to "consider the facts relevant to the disputed decision,

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<sup>12</sup> The website of the Ontario College of Physicians and Surgeons <[http://www.cpso.on.ca/Info\\_physicians/MRC/mrcqa.htm](http://www.cpso.on.ca/Info_physicians/MRC/mrcqa.htm)> (date accessed: June 17, 2003) explains, "The MRC process and its administration is paid for by the government on a cost recovery basis. We have a contract with them to conduct a specific number of audits per year (100). There is absolutely no requirement or inducement to make recommendations to recover funds unless the audit justifies such action."

<sup>13</sup> *Health Insurance Act*, s. 40(1) says an inspector has the power to "interview physicians, practitioners, other staff and employees of hospitals and health facilities on matters relating to the provision of insured services. They may question these persons on matters relevant to the inspection or review; they may enter and inspect premises where insured services are provided; they may inspect operations carried out on the premises; they may inspect and receive information from health records; they may inspect and make copies of books of account, documents, correspondence, payroll and employment records."

including any medical records and reports about the insured person and, when considered necessary by the Committee, interviewing the insured person and discussing the matter with the person and his or her physician.” The MEC, after consideration, will recommend that the General Manager either pay or refuse to pay for the service as claimed. Decisions made by all three committees can be appealed to the HSARB and may be appealed to the general courts.

### *3.2 Public Hospital Boards*

Section 40.2(4) requires operators and administrators of hospitals to co-operate fully with an inspector who is carrying out an inspection under the Act and to ensure that employees also co-operate fully. S. 40.2(7) allows the General Manager to suspend payments to a hospital that does not co-operate with an inspector.

### *3.3 Community Care Access Centres*

CCACs are not mentioned by name in the Act or the regulations, but regulation 13(1)(b) allows the Minister to designate “home care service” agencies as “health facilities” under the *Health Insurance Act*.

### *3.4 Physicians*

The *Health Insurance Act* defines physicians who are eligible to bill OHIP (s. 15), what services they may bill for, and requires them to keep accounts of the services provided and claims made (s. 17). Physicians’ claims on the plan are reviewed by the OHIP General Manager and, in cases of dispute, may be referred to the MRC or MEC for resolution. Pursuant to s. 19, physicians may request the MEC to review the General Manager’s decision regarding the medical necessity of a service. Physicians may appeal decisions of the MRC or MEC to the HSARB.

Most of the accountability provisions in the Act speak to controlling fraud, both on the part of physicians and on the part of patients. The statute details accounting procedures and fee schedules for physicians and enumerates circumstances where practitioners have a duty to report information to OHIP, such as the suspected fraudulent use of a health card.

#### ***4. Regulated Health Professions Act, 1991 S.O. 1991, Chapter 18***

This Act defines certain health care services as “controlled acts” and limits the performance of them to specified registered health professionals. The Act defines the professions to which it applies and requires individuals who hold themselves out as members of one of these professions to be subjected to regulation and oversight by a College or Council. The Colleges are subsequently required to establish specified committees: i.e. membership, patient relations and quality assurance.

##### ***4.1 Minister of Health/Ministry of Health***

The Minister is empowered to administer the Act and has a duty to ensure that health professions are regulated in the public interest, that standards of practice are maintained, that people have access to health professions of their choice and that the professions treat the public with sensitivity and respect<sup>14</sup>. The Minister may require a College to do anything that, in the Minister’s opinion, is necessary to carry out the intent of the Act<sup>15</sup>.

The Act establishes a Health Profession Regulatory Advisory Council (HPRAC). The HPRAC is made up of members appointed by the LGC, on the Minister’s recommendation. Members may not be public servants, or present or past members of one of the professional Colleges. The HPRAC’s role is to advise the Minister on the necessity or desirability for certain professions to

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<sup>14</sup> *Regulated Health Professions Act*, 1991 S.O. 1991, C. 18, s. 3

<sup>15</sup> *Ibid*, s. 5(1)(d)

be brought into, or removed from, the scope of the *Regulated Health Professions Act*.

Additionally, the HPRAC is to monitor the patient relation programs of the professional Colleges and report on their effectiveness, and to advise the Minister on each College's quality assurance program. The Minister shall refer any matter arising within the scope of the foregoing duties to the Advisory Council upon the request of any person, unless the Minister considers the request frivolous, vexatious, or not made in good faith<sup>16</sup>. Section 14 reiterates the HPRAC's role is advisory only and "no failure to refer a matter or to comply with any other requirement relating to a referral renders anything invalid."

As noted above, disputes arising out of this Act are adjudicated by The Health Professions Appeal and Review Board (HPARB). The HPARB may appoint inspectors and receive expert evidence in resolving matters before it.

#### *4.2 Colleges*

The Act establishes a system of Councils or Colleges that each regulates a profession, for example, the College of Physicians and Surgeons. The Colleges have the power to define criteria for membership, to register members and to supervise members in the conduct of their profession. Each College is required to have programmes for patient-relations and quality assurance, and to report to the Minister on their effectiveness -- although neither the Act nor its regulations define what is meant by "effectiveness." The patient relations program is intended to enhance relations between members and patients, while the quality assurance program is to assure the quality of the practice of the profession and promote continuing competence among the members. Nothing in the Act defines "quality assurance" or specifies a level of achievement such a program would have to achieve -- there is no statutory benchmark. The Colleges are required to report annually to

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<sup>16</sup>*Ibid*, s. 12

the Minister. As well, the Advisory Council of each College is, within five years of the s. 6(2) coming into effect, to report on the effectiveness of their patient relations, quality assurance programs, and disciplinary procedures for professional sexual misconduct.<sup>17</sup>

## **5. Health Care Accessibility Act, *R.S.O. 1990, Chapter H.3***

The *Health Care Accessibility Act* ensures that patients can access care without having to make “out-of-pocket” payment for services. It prohibits physicians, optometrists and dentists from charging more or accepting more than the amount payable under the OHIP plan (the “OHIP Fee”) for rendering an “insured service”. The Act allows the OHIP plan to pay doctors, dentists and optometrists for specified insured services while prohibiting practitioners from getting the money from the patient in advance.<sup>18</sup>

### *5.1 Minister of Health/Ministry of Health*

The Act gives the Minister the power to enter into agreements with the Ontario Medical Association, the Ontario Dental Association and the Ontario Association of Optometrists to negotiate the schedule of OHIP Fees payable for insured services.

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<sup>17</sup> *Ibid*, s. 6. (1) “Each College and the Advisory Council shall report annually to the Minister on its activities and financial affairs”.

(2) The Advisory Council shall report to the Minister, within five years after this section comes into force, on the effectiveness of,

(a) each College's patient relations and quality assurance programs; and

(b) each College's complaints and discipline procedures with respect to professional misconduct of a sexual nature. 1991, c. 18, s. 6 (2).

<sup>18</sup> For example, the services of a dentist or optometrist will sometimes qualify as insured services under OHIP; dental surgeries for fractures or medically necessary jaw reconstruction are insured services when performed in a hospital and a vision exam is an insured service subject to the requirement that the patient is entitled to one exam every two years (people under 20 and over 65 are entitled to an annual exam).

## *5.2 Public Hospital Boards*

The Act prohibits any hospital from charging a patient for an “insured service” unless permitted to do so by the circumstances and conditions as prescribed in the regulations.<sup>19</sup>

## *5.3 Physicians*

Physicians are not permitted to charge more than the prescribed OHIP Fee for an insured service and may not insist on payment before the patient has received that money from OHIP. Where the charge for a service is disputed by the General Manager of OHIP, physicians and other practitioners covered by the Act, are entitled to have that decision reviewed by the HSARB.

## **6. *Health Protection and Promotion Act*, R.S.O. 1990, Chapter H.7**

This Act provides for the establishment of public health boards it sets up medical officers of health for each board, and describes their duties with regard to the protection and promotion of public health. In Ontario there are 37 Health Units which are geographic areas associated with one or more municipalities<sup>20</sup>. Each Health Unit is required to have a Board of Health.

### *6.1 Minister of Health/Ministry of Health*

The Minister has the power to designate Health Units within the province and may also investigate disease or direct others to investigate disease in the province<sup>21</sup>. Section 80(1) enables the Minister to appoint inspectors to investigate and either to receive their reports or direct those reports to other parties. The Minister appoints an employee of the ministry to be Chief Medical Officer of Health for the province<sup>22</sup>, may give directions to any Board of Health<sup>23</sup>, and may take

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<sup>19</sup> *Health Care Accessibility Act*, R.S.O. 1990, C. H.3, s. 2(3)

<sup>20</sup> *Health Protection and Promotion Act*, R.R.O. 1990, Reg. 553

<sup>21</sup> *Health Protection and Promotion Act*, R.S.O. 1990, C. H.7, s. 78

<sup>22</sup> *Ibid*, s. 81(1)

<sup>23</sup> *Ibid*, s. 83(1)

any actions he deems necessary if a Board fails to follow that direction<sup>24</sup>. Section 86(1) gives the Minister the broad power to take any actions appropriate to address a health hazard in the province.

### *6.2 Boards of Health*

The Boards of Health have authority over issues concerning sanitation, control of infectious diseases and health promotion efforts as required by regulation. Members of a Board of Health include both elected officials appointed by the municipality served by the Board and appointees of the LGC. Although the provincial government has established the various Boards of Health, it requires municipalities to cost-share the funding for the Boards' activities. Each Board must appoint a Medical Officer of Health for the Health Unit.

It is the Board's duty to superintend the provision of health programs and services, as required by this Act, and to ensure the regulations for community health protection and control of communicable diseases are followed.

### *6.3 Medical Officer of Health*

Every Medical Officer of Health (MOH) must be a physician and the Minister must approve each appointment. A MOH is responsible for directing staff in the relevant Health Unit, for implementing required programs and for reporting to the Board of Health. Her authority is limited to the geographic area defined as the "Health Unit". Under s. 10(1) the MOH has a duty to inspect the Health Unit to prevent, eliminate and decrease health hazards. Section 14(1) gives her the power to write orders directing action to be taken to effect these ends. The MOH can also require

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<sup>24</sup> *Ibid*, s.84(1)

persons to take, or refrain from, actions to prevent the transmission of communicable diseases<sup>25</sup>.

Pursuant to s. 67(3), the MOH is responsible to the Board of Health for the management of public health programs and services under this Act.

#### 6.4 Public Hospital Boards

Hospital administrators must report incidents of communicable disease to the MOH.<sup>26</sup>

#### 6.5 Physicians

Under s. 26 a physician has a duty to report listed communicable diseases to the MOH for the Health Unit, and under s. 34(1), a physician must also report when patients with communicable diseases refuse or neglect treatment of the condition. In such instances the MOH may apply for a court order for the examination, treatment, or hospital confinement of the patient<sup>27</sup>. The *Health Care Consent Act* does not apply in these instances<sup>28</sup>.

### 7.0 *Public Hospitals Act*, R.S.O. 1990, Chapter P.40

This Act regulates the establishment of public hospitals.

#### 7.1 *Minister of Health/Ministry of Health*

The LGC may appoint investigators and hospital supervisors, as they are required, who are enabled (by s. 8) to investigate the management, administration or quality of care provided by a hospital or any other matter related to the hospital, when the LGC believes it will be in the public interest to do so. Similarly, under s. 9, hospital supervisors may be appointed when the LGC

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<sup>25</sup> *Ibid*, s. 22

<sup>26</sup> *Ibid*, s. 27(1) contains this requirement and reportable diseases are listed in *Health Protection and Promotion Act* Ontario Regulation 559/91.

<sup>27</sup> *Ibid*, s.5(1-3)

<sup>28</sup> see Section 16 of this paper, below.



believes it is in the public interest to make such an appointment. Hospital supervisors have all the powers of a hospital board.

The Minister is responsible for administering the *Public Hospitals Act*<sup>29</sup>. This includes, under s. 4, the authority to approve the incorporation of new public hospitals and the amalgamation of existing ones, as well as the authority to approve expansion and improvement of hospital facilities. The Minister is responsible for payments to hospitals<sup>30</sup> and oversees their operating plans and budgets. The Minister has the power to close hospitals and to specify what services they may or may not provide and at what volume<sup>31</sup>. Section 6(10) requires that the Minister have regard to DHC reports when making decisions about services and volumes. When making a decision in the public interest under this Act<sup>32</sup>, the Minister, or the LGC, *may* consider:

- (a) the quality of the management and administration of the hospital;
- (b) the proper management of the health care system in general;
- (c) the availability of financial resources for the management of the health care system and for the delivery of health care services;
- (d) the accessibility to health services in the community where the hospital is located; and
- (e) the quality of the care and treatment of patients.

Section 32 grants the Minister the power to make regulations on any matter covered by the Act.

## 7.2 Public Hospital Boards

Public Hospitals in Ontario are incorporated under the *Corporations Act*<sup>33</sup>. The Minister, under the powers detailed above, may direct hospitals to provide specified services or to cease providing them. Hospital boards have some discretion in determining the health priorities of the

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<sup>29</sup> *Public Hospitals Act*, R.S.O. 1990, C. P.40, s. 3

<sup>30</sup> *Ibid*, s. 5

<sup>31</sup> *Ibid*, s. 6

<sup>32</sup> *Ibid*, s.9

<sup>33</sup> *Corporations Act* R.S.O. 1990, Chapter C.38

community they serve and allocating their budget to meet those priorities. This discretion in allocating resources arises, in part, out of the method used to fund hospitals, with some funding being targeted to specific programs and the remainder left to the administrator's judgment. In addition, public hospitals are not 100% funded by the province, but may also receive funds from charitable institutions and may use those monies at their own discretion or within the parameters defined by the donor.

The articles of incorporation of a public hospital will specify the purpose for which the hospital is established, for example if it is a children's hospital or a drug rehabilitation hospital. Section 7 allows that every hospital is empowered to carry on the undertaking for which it was incorporated. Hospital boards must adopt by-laws, as prescribed by the regulations,<sup>34</sup> and those by-laws shall provide for the management and administration of the hospital by specifying procedures for the election or appointment of the board, its officers, committees and administrator.<sup>35</sup> The hospital board shall monitor the activities of the hospital to ensure compliance with the Act, regulations and hospital by-laws. The administrator is responsible to report to the board all actions taken to comply with the Act, regulations and by-laws.

The by-laws also define the duties and functions of medical staff and require the establishment of a medical advisory committee (MAC). The MAC defines criteria for the granting of hospital privileges to doctors, limits or suspends those privileges and oversees the quality of care offered by physicians at the hospital. The MAC is required to report in writing on the practice of medicine in the hospital to each regularly scheduled board meeting. In addition to the MAC, the regulations require each hospital board to establish a fiscal advisory committee to make

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<sup>34</sup> *Ibid*, s.12

<sup>35</sup> *Public Hospitals Act* R.R.O. 1990, Reg. 965

recommendations to the board on matters relating to the operation, use and staffing of the hospital.

Under this structure physicians are accountable to the MAC for the care they provide in the hospital and the MAC is responsible to report their findings to the Board. The Board reports to the Minister when required and to the DHC if directed to do so. Decisions of the MAC may be appealed to the Health Professions Appeal and Review Board.

### **8. *Independent Health Facilities Act*, R.S.O. 1990, Chapter I.3**

The *Independent Health Facilities Act* concerns the licensing, funding and quality of services of facilities providing medical procedures traditionally performed in public hospitals. These facilities function in a manner similar to hospital outpatient clinics. The Act licenses surgical centres that perform procedures such as cataract surgery and abortions, and facilities offering diagnostic services such as x-rays and ultrasound.

#### **8.1 *Minister of Health/Ministry of Health***

The Minister of Health is responsible for appointing an employee of the Ministry to be the Director of Independent Health Facilities. The Minister has the power to designate services or classes of services to be provided by independent health facilities (IHF) as well as the power to designate facilities or classes of facilities as IHFs. The Minister is required under s. 41 to report annually to the LGC on the implementation of the Act.

The Director of Independent Health Facilities is responsible for licensing and assuring the quality of IHFs. The quality and the standards of an IHF or of the service or services to be provided therein are designated in the regulations or by the College that oversees the profession providing the service in question. The Director's powers are primarily geared towards licensing IHFs

including granting new licences, limiting existing licences and approving the relocation and transfer of already licensed facilities. IHF corporations must report changes in ownership to the Ministry<sup>36</sup>.

The Director may require an inspection or assessment of a licensed facility. The procedure for inspections and assessments is similar: the Director notifies the Registrar of the relevant College with oversight of the service that he requires an inspection of the facility. The Registrar appoints an inspector or assessor and makes a report back to the Director on his findings.

### *8.2 Licensees*

Licensees are required to appoint a quality advisor<sup>37</sup>, who must be a health professional associated with the IHF and who ordinarily provides insured services there<sup>38</sup>. If all services provided by the facility are provided by physicians, then the quality advisor must be a physician. The licensee may only act as quality advisor, if otherwise properly qualified, when there is no other qualified professional who will consent to be the quality advisor. The licensee must also appoint an advisory committee to advise the quality advisor. The advisory committee, defined by r. 2(2), is to be made up of health professionals who ordinarily provide the services at the IHF. Regulation 4(1) requires the licensee to ensure the health facility adheres to “generally accepted professional standards.” If the quality advisor determines the IHF does not meet this standard, he must report this failure to the Director of Independent Health Facilities.

### *8.3 Physicians*

Under the Act, the College of Physicians and Surgeons is responsible for monitoring the quality of care received at IHFs. The Act grants the College the authority to conduct inspections of

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<sup>36</sup> *Independent Health Facilities Act*, R.S.O. 1990, C.- 1.3, s. 13-15

<sup>37</sup> *Independent Health Facilities Act* Ontario Regulations 57/92

<sup>38</sup> *Ibid*, reg. 1(1)

licensed independent health facilities and to assess the quality of services delivered. The College is responsible for developing standards of practice and administering the quality assurance and assessment program. When the College undertakes an inspection or assessment of facilities through an inspector, the report of the inspector is submitted by them to the Director of Independent Health Facilities.

## **9. *Long-Term Care Act*, 1994 S.O. 1994, Chapter 26**

The *Long Term Care Act* governs the provisions of services to patients in the community.

### *9.1 Minister of Health/Ministry of Health*

The Minister has the power to approve agencies as providers of services under this Act and to determine the level of funding they will receive from the Ministry. In exercising these functions the Minister may impose certain terms and conditions. The Minister approves the annual budgets of agencies under this Act. Section 5 of the Act allows that the Minister may approve an agency where the Minister is satisfied the agency is financially capable of providing the service for which it is approved and that the agency will uphold the “bill of rights”<sup>39</sup> contained in s. 3 of the Act. Under s. 50, there are provisions that allow the Minister to take over an approved agency if it is not running according to guidelines.

### *9.2 Community Care Access Centres*

Pursuant to this Act and s. 3(1) of the *Community Care Access Corporations Act*, CCACs may be approved by the Minister as “multi-service agencies.”<sup>40</sup> To that extent they are responsible under the Act for providing services in keeping with the bill of rights. The bill of rights entitles patients

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<sup>39</sup> See below s. 9.2 of this paper for a description of these “rights”.

<sup>40</sup> S. 3(1) of the *Community Care Access Corporations Act* states “The Minister may, by regulation, deem a community care access corporation to be an approved agency under the Long-Term Care Act, 1994 and may, in the regulation, specify the professional services, personal support services or homemaking services that the corporation is approved to provide under that Act.” See also the next section of this paper.

to respectful treatment from service providers and allows that person to participate in the formulation of a “service plan” with the agency<sup>41</sup>. The bill of rights also requires CCACs to notify clients of their legal rights and of the mechanism for making a complaint about the quality of service they have received. The CCAC is also required to review disputes arising under this framework.

The CCAC, or any other multi-service agency, must review all complaints from persons using their services within sixty days. The types of complaints fall under two headings: complaints about the quantity of service; and complaints about the quality of service. Complaints about quantity have to do with denial of service by the agency, disagreement over the amount of service a person may receive and termination of service. Such complaints, after review by the agency, may be appealed to the HSARB whose decision is then final. Complaints about quality of service or infringement of the rights provided in the bill of rights must be reviewed by the agency within sixty days but are not eligible for appeal to the HSARB.

Section 23 requires the approved agency to provide the service required in a reasonable time, that it maintain a waiting list for services, and that it inform patients when they are placed on the waiting list<sup>42</sup>. The agency is responsible for ensuring that a quality management system is in place to monitor, evaluate and improve the quality of services provided by the agency but, as noted above, there is no clear accountability for failure to perform.

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<sup>41</sup> *Long-Term Care Act*, 1994 S.O. 1994, C. 26, s. 5. “A person applying for a community service has the right to participate in the service provider's assessment of his or her requirements and a person who is determined under this Act to be eligible for a community service has the right to participate in the service provider's development of the person's plan of service, the service provider's review of the person's requirements and the service provider's evaluation and revision of the person's plan of service.”

<sup>42</sup> *Ibid*, Ss. 23(1-3)

The agency is also responsible for developing and implementing a plan for preventing and addressing physical, mental and financial abuse of persons who receive community services.

It is of note that the “Bill of Rights” contained in the context of long term care and community care does not apply more broadly to, for example, hospital and physician services.

#### **10. *Community Care Access Corporations Act*, 2001 S.O. 2001, Chapter 33**

The Act sets up the framework for community care access centres. It establishes 43 centres throughout the province, which provide access to community-based services like nursing, physiotherapy, occupational therapy, social work, personal support and homemaking. CCACs are statutory corporations that must comply with Ministry directives and guidelines.<sup>43</sup>

CCACs have the following corporate objects:

- to provide, directly or indirectly, health and related social services and supplies and equipment for the care of persons;
- to provide, directly or indirectly, goods and services to assist relatives, friends and others in the provision of care for such persons;
- to manage the placement of persons into long-term care facilities;
- to provide information to the public about community-based services, long-term care facilities and related health and social services, and
- to co-operate with other organizations that have similar objects.

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<sup>43</sup> *Community Care Access Corporations Act*, 2001 S.O. 2001, C. 33, S. 11 of the Act states: “(1) The Minister may issue directions on matters relating to the exercise of a community care access corporation's rights and powers and the performance of its duties under this Act.  
(2) Each community care access corporation shall comply with all directions issued by the Minister.”

### *10. 1 Minister of Health/Ministry of Health*

The Minister has the power to create CCAC corporations and can appoint a supervisor of a CCAC if it is in the public interest to do so. The Minister may require that any aspect of the CCAC's affairs be audited. Section 14(4) says the Minister may do any of the following things for the purpose of making decisions under the Act:

- require a CCAC to give the Minister information, documents or records that are in the custody or control of the corporation;
- require the CCAC to create a new document or record by compiling existing information;
- require the CCAC to update information previously given to the Minister, and
- impose a deadline for doing one of the acts described in the three foregoing sections.

The Minister may delegate his powers under this Act<sup>44</sup>. Section 21 requires the Minister to undertake a comprehensive review of this Act five years after it comes into force.

### *10. 2 Public Hospital Board*

Although the inter-relationship between Public Hospital Boards and CCACs is obviously critical, Public Hospital Boards have no duties or responsibilities under the CCAC legislation.

### *10.3 Community Care Access Centre*

CCAC Executive Directors and Board members are appointed by the LGC. The affairs of the CCAC are under the management and control of its board of directors<sup>45</sup>. The Executive Director functions as the chief executive officer of the CCAC and is responsible for management and administration of its affairs, subject to the supervision and direction of the board of directors<sup>46</sup>.

The Board may make by-laws and pass resolutions to regulate its proceedings as a board and for

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<sup>44</sup> *Ibid*, s. 19(1)

<sup>45</sup> *Ibid*, s. 8(1)

<sup>46</sup> *Ibid*, s. 10(3)



the conduct and management of the CCAC<sup>47</sup>. The Board may appoint officers and prescribe their duties; it may also delegate any of its own powers and duties as it considers appropriate<sup>48</sup>. Each CCAC is required to make an annual report<sup>49</sup> and to provide other information or reports on their operations and affairs as required by the Minister<sup>50</sup>

Each CCAC is required to establish a Community Advisory Council, the composition and duties of which are determined by the board of the CCAC and by any regulations attached to the Act. Where there is no regulation governing their duties<sup>51</sup>, the Board of the CCAC may determine the duties of the Advisory Council<sup>52</sup>.

Some of the accountability issues under this heading are dealt with in the preceding section on the *Long Term Care Act* via its applicability to multi-service providers.

## **11. *Health Facilities Special Orders Act*, R.S.O. 1990, Chapter H.5**

### *11.1 Minister of Health/Ministry of Health*

This Act applies to ambulance services, nursing homes, private hospitals and laboratories. It allows the Minister to suspend operations at a facility when he has reason to believe the facility is not being operated in keeping with the standards prescribed for it by statute and regulation. The suspension may apply to a service provided by the facility or to the entire facility itself. The Minister is required to give notice to the facility of his intention to suspend any part or all of its operations. The facility licensee may then make an explanation to the Minister regarding the matter that gave rise to the suspension. The notice requirement may be dispensed with in

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<sup>47</sup> *Ibid*, s. 8(2)

<sup>48</sup> *Ibid*, s. 8(3) and 8(4)

<sup>49</sup> *Ibid*, s. 13(1)

<sup>50</sup> *Ibid*, s. 13(3)

<sup>51</sup> The only regulation that applies to this Act is Ontario Reg. 33/02 which designates and names the 43 CCACs.

<sup>52</sup> *Ibid*, s. 9(3)

emergency situations. Under this Act the Minister may take control of the facility and appoint a supervisor. The decisions of the Minister under this Act are subject to appeal to the HSARB and, subsequently, the Divisional Court.

## **12. *Nursing Homes Act*, R.S.O. 1990, Chapter N.7**

### ***Charitable Institutions Act*, R.S.O. 1990, Chapter C.9**

### ***Homes for the Aged and Rest Homes Act*, R.S.O. 1990, Chapter H.13**

We address these three Acts together because they are, in most respects, identical pieces of legislation. The only notable difference is in the type of ownership of the facility; in all other ways their roles and responsibilities are quite similar. Nursing homes are privately owned or municipally owned entities; charitable institutions are run by charities; and homes for the aged are licensed by the Ministry and may be privately or publicly owned.

#### *12.1 Minister of Health/Ministry of Health*

Under the *Nursing Homes Act* and the *Homes for the Aged*, the Minister has the power to appoint a Director to oversee administration of the Acts. The Minister, or Director, has the power to approve facilities and to licence them where required. The Acts also allow the Minister to conclude service agreements with the facilities that will offer the facilities funding. The Minister has the power to appoint inspectors to inspect the facilities.

#### *12.2 Licensees*

The Acts require each facility to set up a quality management system designed to monitor, evaluate and improve the quality of the “accommodation, care, services, programs and goods provided to the residents”. Under the Acts, public inspectors may inquire into any aspect of the

home's operation and look at the "records" of the facility. Each of the Acts defines a "record" so as to exclude any matter related to quality management issues.<sup>53</sup>

Each Act allows for a resident's "bill of rights", including the right to have a resident's council represent them to the corporation operating the home and to the Ministry. The rights enumerated are directed toward assuring residents of the right to be treated with respect, to be consulted in matters concerning their care, and rights to information. Of particular interest are numbered rights 2, 6 and 12.<sup>54</sup>

2. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

6. Every resident has the right,

i. to be informed of his or her medical condition, treatment and proposed course of treatment,

ii. to give or refuse consent to treatment, including medication, in accordance with the law and to be informed of the consequences of giving or refusing consent,

iii. to have the opportunity to participate fully in making any decision and obtaining an independent medical opinion concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a nursing home, and

iv. to have his or her medical records kept confidential in accordance with the law.

12. Every resident has the right to exercise the rights of a citizen and to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the residents' council, nursing home staff, government officials or any other person inside or outside the nursing home, without fear of restraint, interference, coercion, discrimination or reprisal.

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<sup>53</sup> From the *Nursing Homes Act*, for example, the definition of "record" in s. 24. (1) "In this section, "record" includes a book of account, bank book, voucher, invoice, receipt, contract, payroll record, record of staff hours worked, medical record, drug record, correspondence and any other document, regardless of whether the record is on paper or is in electronic, photographic or other form, but does not include that part of a record that deals with quality management activities or quality improvement activities."

<sup>54</sup> From sections 2, 6, 12 of each Act.

Each of the Acts deems the “bill of rights” a contract that the management of the facility has entered into with each resident and accordingly management is required to respect and promote those rights. This would seem to move questions of accountability for quality of care, for instance, into the realm of private law. Decisions relating to access to the facility, such as whether one is accepted into it or not, may be appealed to the HSARB but there is no clear framework for accountability for other sorts of decisions<sup>55</sup>.

### *12.2 Physicians*

Doctors have a duty to report suspected abuse of residents to the Administrator of the facility.

## **13. *Private Hospitals Act*, R.S.O. 1990, Chapter P.24**

The Act allows for the licensing of private hospitals in Ontario. The terms of the licence will set out the classification of the hospital, the procedures it is licensed to perform and how many patients it may house.

### *13.1 Minister of Health/Ministry of Health*

The Minister has the power to enforce and administer the Act, which is directed at controlling the use of the term “hospital” by restricting its use to licensed facilities. It also describes the Minister’s powers in relation to the licensing, renewal and revoking of licences for private hospital facilities. The Minister’s licensing decisions are subject to appeal to the HSARB and, subsequently, to the Divisional Court. In addition, under s. 15(5), the Minister may take control of a private hospital or appoint a supervisor, for a period of six months, after refusing to renew or revoking the facility’s licence. The Minister has the capacity to approve the proposed

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<sup>55</sup>For instance, decisions relating to quality which are specifically excluded from the record.

superintendent of a private hospital and can also appoint inspectors to inspect private hospital facilities<sup>56</sup>.

### *13. 2 Private Hospital Licensees*

The Act allows that every private hospital is empowered to carry on its purpose as defined in its Articles of Incorporation. It requires licensees to appoint a superintendent who must be a legally qualified medical practitioner, a registered nurse, or a person whose qualifications are acceptable to the Minister. The licensee is responsible for maintaining a registry of patients and for observing the terms of the licence granted.

The Act provides that a private hospital's licence may be revoked by the Minister, if in the Minister's opinion:

- (i) the premises of the private hospital are unclean, unsanitary or without proper fire protection,
- (ii) the standard of patient care provided in the private hospital is inadequate,
- (iii) the private hospital is managed or conducted in a manner contrary to this Act or the regulations, or
- (iv) the private hospital is managed or conducted in such a manner that the revocation of the licence is required in the public interest<sup>57</sup>.

There is no statutory standard which holds a licensee accountable for the quality of care at the facility. Implicitly, such accountability would flow through the physicians whose provision of services is being overseen by the College of Physicians and Surgeons in their capacity under the *Regulated Health Professions Act*.

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<sup>56</sup> *Private Hospitals Act*, R.S.O. 1990, C. P.24, s. 19(2)

<sup>57</sup> *Ibid*, s. 12 (1)(c)

#### ***14. Mental Health Act, R.S.O. 1990, Chapter M.7***

The Mental Health Act treats mental health as a distinct subset of health care. The Act addresses a physician's duties in assessing a patient's mental health and determining their suitability for admission under the classificatory headings of informal, voluntary and involuntary patients. The *Mental Health Act* describes conditions under which a person may be admitted to a community psychiatric hospital as an informal or involuntary patient. An "informal patient" is a person who is a patient in a psychiatric facility, having been admitted with the consent of another person under section 24 of the *Health Care Consent Act*. An "involuntary patient" is a person who is detained in a psychiatric facility under a certificate of involuntary admission or a certificate of renewal.

The kind of decision-making the Act contemplates includes whether or not a patient will be admitted to hospital, whether they will be admitted against their will, whether they will be subject to a community treatment order and what the community treatment plan shall consist of. The Act also details when, how and to whom clinical records of a patient may be released. As this is an area where the health care system has the capacity to detain a patient in less than extraordinary circumstances, many of the issues addressed in the statute have to do with procedures to justify detention. Disputes under this Act are not heard by the HSARB but by the Consent and Capacity Board.

##### ***14.1 Minister of Health/Ministry of Health***

The Minister may appoint advisory officers to assist Medical Officers of Health, Boards of Health and Hospitals in matters pertaining to mental health<sup>58</sup>. Advisory officers are empowered to visit and inspect psychiatric hospitals, to interview patients, to examine facilities and to inquire into

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<sup>58</sup> *Mental Health Act*, R.S.O. 1990, C.- M.7, s. 9

the adequacy of staff in the facility. Advisory officers are empowered to inquire into “any other matter” relevant to the maintenance of standards of patient care.

Section 33.9(1) requires the Minister to establish a review process to look into the incidence, effectiveness and evaluation of outcomes of community treatment orders<sup>59</sup>. This review must be made available to the public.

#### *14.2 Public Hospital Boards*

Section 8 authorizes psychiatric hospitals to carry on their undertaking while S. 14 enjoins hospitals from detaining informal or voluntary patients. Otherwise, the roles and responsibilities here are like those of any public hospital.

#### *14.3 Physicians*

A physician’s duties under this Act are directed at the kinds of issues that arise in the treatment of mental illness and have to do with psychological assessments and applications for involuntary admission. They have no special duty or accountability outside of those that arise from the particular circumstances of the kind of care offered.

### **15. *Community Psychiatric Hospitals Act*, R.S.O. 1990, Chapter C.21**

The *Community Psychiatric Hospitals Act* establishes the framework for community psychiatric facilities by both including them under the *Public Hospitals Act*, in part, and by allowing specific provisions applicable only to them by virtue of the care they provide. These provisions are of two kinds: specific requirements directed to the keeping of medical records for patients with mental illness and structures to deal with involuntary admissions and issues of consent to care.

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<sup>59</sup> The first review must be conducted within three years of the section coming into effect and every five years thereafter.

### *15.1 Minister of Health/ Ministry of Health*

The hospitals are established by the LGC, who also appoints a board of governors. The Minister is responsible for the administration of the Act and the Ministry is responsible for 100% of the funding of psychiatric hospitals, unlike public hospitals who may also receive funds from charitable organizations.

### *15.2 Public hospital board*

The board of governors of the psychiatric hospital is responsible for appointing a superintendent or chief officer of the hospital. The superintendent is responsible to the board to see that the hospital complies with the Act, the regulations and their own by-laws. The superintendent reports to the Ministry as required and is the appointed liaison between the Ministry, its inspectors and the hospital. The board operates much like any other hospital board under the *Public Hospitals Act* in terms of fiscal accountability. They are required to present an annual report and affix an annual audit to the report. It is not clear what level of responsibility the board bears in terms of being accountable for decision-making because regulation 5 states that the Ministry will deal with the superintendent in all matters relating to the hospital.<sup>60</sup>

### *15.3 Physicians*

The Act and regulations make physicians responsible for assessing and admitting patients. The patient or physician applies to the superintendent for admission of a patient to the hospital. The

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<sup>60</sup> *Community Psychiatric Hospitals Act* R.R.O. 1990, Reg. 91, r. 5 “The superintendent is the officer representing the hospital with whom the Minister, an inspector and other officers of the Ministry shall deal with respect to hospital matters.”



physician has a duty to keep medical records and to make a provisional diagnosis within 72 hours of admission.

**16. *Health Care Consent Act*, 1996 S.O. 1996, Chapter 2 Schedule A**

***Substitute Decisions Act*, 1992 S.O. 1992, Chapter 30**

The *Mental Health Act*, the *Health Care Consent Act*, and the *Substitute Decisions Act* are all overseen by the Consent and Capacity Board, rather than the HSARB. The kind of determinations made under these Acts is of an inherently personal, as opposed to systemic, nature.

Accountability for decisions made in this realm is through the courts because the questions relate to personal rights.

**17. *Ambulance Act*, R.S.O. 1990, Chapter A.19**

This Act governs the provision of ambulance services throughout the province.

**17.1 *Minister of Health/Ministry of Health***

The Minister of Health is responsible for administering the Act and may establish an advisory council to make recommendations to him on the provision of emergency services. A Ministry of Health employee is appointed Director of Emergency Services and oversees the provision of ambulance services. Section 4(1) requires the Minister to ensure the existence of a balanced and integrated system of ambulance services throughout the province; to establish communication services for the dispatch of emergency care and to establish standards for the operation of ambulance services.

Section 4(2) grants the Minister the power to establish training centres for the training of ambulance and communication personnel. It also allows the Minister to require hospitals to

maintain ambulance services and to designate hospitals as “base hospitals” and make them responsible for monitoring the quality of care provided by ambulance services in their region.

### ***18. Healing Arts Radiation Protection Act, R.S.O. 1990, Chapter H.2***

This Act is directed at the safety of the installation of x-ray machines. It describes persons who may be licensed to install the machines and persons who may be allowed to prescribe their use. The Act is of the nature of a health and safety regulation and does not concern matters that give rise to the kind of accountability issues being reviewed by this paper.

### ***19. Laboratory and Specimen Collection Centre Licensing Act, R.S.O. 1990, Chapter L.1***

This Act licences laboratories to perform specified tests and to collect specimens.

#### ***19.1 Minister of Health/Ministry of Health***

The Minister has the power to designate, licence and monitor the performance of laboratories. The Act requires the Minister to appoint an employee of the Ministry to be Director of Laboratory and Specimen Collection Centre Licensing. The Director exercises the Minister’s power to grant licences and to inspect premises to ensure limiting terms in the licence are followed. The Minister or Director may deny a licence where they believe it is not in the public interest to issue one. Such a denial may be appealed to the HSARB and, subsequently, the Divisional Court.

The Minister has the power to enter into agreements for the evaluation of laboratories and tests licensed under this Act. Pursuant to section 20 the Minister may establish a committee to assist him by recommending standards and procedures of laboratory evaluations.

## **20. *Drug and Pharmacies Regulation Act*, R.S.O. 1990, Chapter H.4**

This Act controls the sale of drugs in the province by requiring them to be sold only through registered pharmacists and licensed pharmacies.

### *20.1 Minister of Health/Ministry of Health*

The Minister has the power to administer the Act but the power of enforcement is largely given to the Ontario College of Pharmacists. The procedures the College follows in enforcing the provisions of the Act are the same as the procedures followed by other Colleges under the *Regulated Health Professions Act*.

## **21. Bill 46 “*Public Sector Accountability Act*”**

Bill 46, the *Public Sector Accountability Act*, is draft legislation proposed to address the issue of accountability in public sector organizations. The stated purpose of the Bill is to improve program effectiveness and accountability to the public, to improve the service delivery, decision-making, and fiscal responsibility of public sector organizations. The proposed Act defines public sector organizations very broadly and, in its current form<sup>61</sup>, would apply to public hospitals, community psychiatric hospitals, private hospitals, public health boards and CCACs<sup>62</sup>.

### *21.1 Minister/ Ministry of Health*

Most of the Ministerial powers enumerated in the Act attach to the Minister of Finance. Though there are requirements to report to the Minister of Health, any failure to report or failure to achieve objectives leads to sanctions imposed by the Minister of Finance.

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<sup>61</sup> Bill 46, “*Public Sector Accountability Act*” 2d. Sess., 37<sup>th</sup> Parl., Ontario, 2001 (first reading 9 May 2001) cl. 3(2) of the proposed Act would allow regulations to exempt parties from the provisions prescribed.

<sup>62</sup> *Ibid*, cl. 2 prescribes the parties to whom the legislation will apply.

If, in the opinion of the Minister of Finance, the organization repeatedly fails to achieve the objectives set out in its business plan, or if the organization fails to achieve one or more significant objectives in the business plan, he may require a review of the organization's financial management business and operating practices<sup>63</sup>. The Act permits the Minister of Finance to order a review of the organization's financial management, business practices, and operating practices, either by the organization or by the Ministry. The Minister may order a review when he believes such review is in the "public interest"<sup>64</sup>. The Minister of Finance may make recommendations directly to public sector organizations upon the findings of the review, or to another Minister of the Crown recommending the exercise of a power that the other minister may have under another Act<sup>65</sup>. The Minister of Finance may compel the organization to adopt recommendations made under the review<sup>66</sup>. Section 9(9) allows the Minister to require organizations to pay for the cost of these reviews.

The Minister may make regulations prescribing or exempting parties from the Act<sup>67</sup>, and may also make regulations defining different classes of organizations and may impose different conditions or restrictions on those classes<sup>68</sup>.

The Act gives the Minister broad discretion to require reviews of organizations and to withhold funds from them for failure to achieve objectives.

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<sup>63</sup> *Ibid.*, cl. 9(1)

<sup>64</sup> *Ibid.*, cls. 9(2) and 9(3)

<sup>65</sup> *Ibid.*, cl. 9(4)

<sup>66</sup> *Ibid.*, cl. 11(1-3)

<sup>67</sup> *Ibid.*, cl. 19

<sup>68</sup> *Ibid.*, cl. 19(4)

## *21.2 Public Sector Organizations*

As noted above, this legislation will affect public hospitals, CCACs, public health boards, community psychiatric hospitals and private hospitals; we will refer to the prescribed entities as “public sector organizations”.

Bill 46 requires every public sector organization submit a detailed business plan to the Ministry of Finance and any other Ministry from which the organization receives funding. The business plan must set out the governance and management structures of the organization; its purposes; major activities for the year; goals and objectives associated with those activities; actions that will be taken to meet those goals and objectives; the human, financial, technological and other resources needed to meet goals and objectives; performance measures to be used in assessing whether the goals are achieved; forces outside of the organization’s control which might affect achievement of goals and objectives; methods to establish future goals; the budget for the year; and a description of measures that the organization will take to improve its services and its efficiency and the measures it will take to identify alternative methods of delivering its services, including provision of those services by the private sector<sup>69</sup>. The business plan must be approved by the governing body of the organization<sup>70</sup>.

Public sector organizations are required to plan for a “balanced budget”<sup>71</sup> and the failure to achieve a balanced budget will mean the organizations, in the two years following the deficit, must plan for sufficient surplus to cover the initial deficit.

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<sup>69</sup> *Ibid.*, cl. 4(2)

<sup>70</sup> *Ibid.*, cl. 4(4)

<sup>71</sup> *Ibid.*, cl. 5(1); cl. 5(3) defines a balanced budget as a budget in which anticipated expenditures do not exceed anticipated revenues.

Public sector organizations must submit an annual report to the Minister of Finance, and to any other Ministry from which they receive funding. Annual reports must also be made available to the public upon request. The annual report must include the year's business plan; a description of the extent to which the organization's goals and objectives were achieved; an explanation for why the goals were not achieved, if they were not; a statement assuring that the organizations systems and practices have effectively protected its assets and managed its resources efficiently; a financial statement, and a business plan for the following year<sup>72</sup>. The annual report must be approved by the governing body of the organization<sup>73</sup>.

Failure to comply with any of the requirements imposed by this Act could result in the withholding of government funding from the organization<sup>74</sup>.

## **Summary**

Accountability involves evaluating how well or poorly an organization's actions have served to achieve its goals. It is being held responsible for an outcome. This survey of health legislation has demonstrated two significant accountability gaps: 1) the goals, or desired outcomes, of the system and of any given player within the system are ill-defined; and 2) there is no accountability mechanism for a wide array of decisions made within the system.

The lack of defined of statutory benchmarks against which to measure outcomes is a shortcoming of many of the Acts. A number of the Acts require quality advisors and quality assurance committees but none defines "quality" or provides a legal standard against which the achievement of quality care may be measured. The *Health Insurance Act* and the *Regulated Health Professions Act* leave the definition of quality to the Colleges that oversee the professions providing services.

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<sup>72</sup> *Ibid*, cl. 6(3)

<sup>73</sup> *Ibid*, cl. 6(5)

<sup>74</sup> *Ibid*, cl. 11

In the *Independent Health Facilities Act*, it is left to the very physicians and practitioners who are providing the service to oversee themselves with no more definitive statutory guide than “generally acceptable practice”.

The absence of statutory benchmarks is exacerbated in some instances by the legislation’s purposive exclusion of “quality issues” from the review process that otherwise applies. The Acts relating to long-term care institutions and Community Care Access Centres, for example, each exclude this aspect of decision-making from review by inspectors or the HSARB.

The Acts surveyed allow for three kinds of accountability:

- Political accountability;
- Fiscal accountability; and
- Legal review

Political accountability comes into play at the extreme ends of the system. It applies both when the Minister fulfills the requirement under several of the Acts to table an annual report before the legislature and, on the community level, when statutory bodies such as DHCs or CCACs consult with community advisory groups. At the Minister’s level such accountability may be inappropriately calibrated to the myriad decisions and decision-making processes it encompasses. At the community level, while there is consultation, there is no real accountability in the mechanism because there is no responsibility. In every case community input is structured as advisory only. The *Regulated Health Professions Act*, in structuring the Health Professions Regulatory Advisory Committee and defining the scope of their activity, clearly states that a failure on the part of the Minister to refer a relevant matter to the HPRAC is of no consequence.<sup>75</sup>

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<sup>75</sup> See Section 4.1 above.

Fiscal accountability occurs at the systemic level and also at the level of individual programs and facilities. The Ministry is subject to an annual audit that forms part of the annual report the Minister makes to the Legislature. Individual programs and facilities are also held to account for their use of Ministry funds through an annual reporting mechanism. This kind of accountability is geared to determining whether monies were properly spent within the terms of a funding agreement and not whether the money was most appropriately allocated in the first place.

Many decisions made under the Acts may be appealed to a review panel (such as the HSARB) and, in some situations, to the courts. The kind of decision that this process reviews is most often a decision about access to a service or a dispute about the amount of a service to which a person is entitled. The HSARB is limited to deciding the issues before it on a case-by-case basis. It can order that the government provide a particular service for a particular person but it cannot order that the government provide access to the service for all persons. Accountability for such systemic decisions remains elusive.

Bill 46 addresses some accountability concerns but, for the most part, focuses on issues of financial accountability. The provisions relating to accountability for achieving goals and objectives are ill-suited to the health care context inasmuch as they ignore the reality that these services are provided on the basis of need, and that need often arises unpredictably<sup>76</sup>. The most potentially significant of the provisions for health care providers is the requirement that an organization must consider “contracting out” services to the private sector and that the failure to do so could result in the Minister of Finance withholding some or all of the organization’s funding. As well, the Ontario Hospital Association, after the Bill’s first reading, was sharply critical of the balanced budget requirement. The Minister of Health responded to this criticism by

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<sup>76</sup> The additional cost of providing health care during the recent outbreak of SARS in Toronto, for example.



announcing that public hospitals would be exempted from the provision until multi-year funding arrangements were implemented<sup>77</sup>. Given that Ontario is anticipating an election in the near future, this issue will have to wait until the new government is formed for resolution.

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<sup>77</sup> A. Belaiche, “Health Industry Communiqué, November 16, 2001”, online: Miller Thomson <[http://www.millerthomson.com/pdf/comm\\_public\\_sector.pdf](http://www.millerthomson.com/pdf/comm_public_sector.pdf)> (date accessed: June 27 2003)