

Law & Governance

Legal Focus on Healthcare and Insurance

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The Evolution of Health System Governance in Canada and Ontario

*Including cautionary reflections on the introduction of
Local Health Integration Networks in Ontario*

Steve Elson

In general terms, governance refers to the responsibilities of a Board of Directors or trustees to ensure that an organization lives up to its legal responsibilities as a corporation and any other legislation that applies. This includes its financial or fiduciary role, its legal accountabilities and its stewardship or oversight role to ensure that the best interests and objects of the organization are being upheld.

The failure of corporate boards to live up to these requirements as evidenced by Enron and related scandals have led to charges that corporate governors were 'asleep at the wheel'; that they were chosen more for who they were than what they did or the skills they had; and, that they failed to live up to what was required of them legally and in some cases morally.

In the aftermath of these events and a new awareness that governance is something worth paying attention to, steps have been taken to advocate for, and promote 'Good Governance'^{1 2 3}. This has occurred within the private sector but has also taken hold in the public sector.

Guidelines, workshops, conferences and courses now focus on what it now means to be an active and responsible board and board member. Terms of reference, role descriptions and board member evaluations are now expected.^{4 5}

These changes, albeit somewhat reactive in nature, reflect an evolution in the nature of governance. Rather than being largely silent and unknown adjuncts to the CEO or senior management team, Boards are now expected to have an independent voice and to challenge management as appropriate. Failure to do so has been shown to have disastrous results.

All of this has taken place within the traditional context of organizational or corporate governance. As such, it provides an interesting backdrop to the subject of health system governance.

In general, health system governance in Canada has evolved to focus on two parties. One is the governance mandate given to regional health authorities (RHAs)

to govern the broad range of health services that fall under their corporate umbrella.⁶ The other is the governance mandate given to provincial governments and more specifically ministries of health. The scope of responsibility of RHAs is geographically narrower than the provincial governments and it also carries a narrower service scope. For example, physician services in all provinces are paid and negotiated provincially, not regionally. The legal parameters that define the authority of RHAs are set by the provincial governments.

An important characteristic of RHAs is that in general they have been given a mandate to manage the delivery of healthcare services and to also improve the health status of the population for which they are responsible. This broad population health mandate has had a significant impact on governance, priority setting as well as strategic priorities set by the RHAs.

In general terms the RHAs, as legal corporations, have a very significant operational mandate in that they are directly responsible for the integration and delivery of all the health services that fall under their mandate. The governors of the RHAs in turn are responsible, like the governors of a single service organization for practicing 'good' governance. Although RHAs govern a system of health services, their primary mandate is to manage the system of services and use the resources made available to them to address client, patient and population health needs as best they can. More recently this expectation has been codified in several provinces through the development of formal accountability and performance agreements between the RHAs and the provincial government.

At the same time, broad health system planning, design and resource allocation decisions as well as some specific program allocations have continued to rest in the hands of the provincial governments. As an example, Canada Health Infoway, an agency of the federal government⁷, is currently working with provincial governments across Canada to stimulate the development of a Pan-Canadian Electronic Health Record. Key strategic decisions about whether and how much to invest in this initiative and how it will be designed and implemented are being made at the provincial, not at the regional level. The regions will be the focus of implementation. Key system-wide (and provincial) strategic decisions like this involve senior ministry of health officials and their political counterparts.

This demonstrates that there is a 'sharing' of system governance and management responsibilities between RHAs and provincial governments with a somewhat undefined demarcation between the two parties. Circumstances and political sensitivities can push both governance and management accountabilities in different directions. The lack of territorial definition

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or fluidity should not be seen as a problem since it is characteristic of a complex system – the health system being a primary example.

In Ontario, in contrast to other provinces, has no history of sharing system governance. The closest Ontario has come has been the sharing of its health system planning mandate with District Health Councils, which have been disbanded in light of the creation of Local Health Integration Networks (LHINs).⁸

System governance in Ontario has been highly concentrated within the senior levels of the Ministry of Health and Long-Term Care (MOHLTC) and their political masters. In light of this situation, the ability of individual organizations and sectors of the health system to influence the Ministry's senior management and political leadership has been a hallmark of informal 'power sharing'. For example, the Ontario Medical Association, the Ontario Hospital Association and the large academic teaching hospitals in particular have been highly effective in being able to influence government policy and resource allocation decisions. While there is an informal 'pecking order' and a continual jockeying for influence, these large powerful groups are consistently influential; the influence of others is less consistent.

In evolutionary terms, little has happened in Ontario to change this dynamic. However, with the introduction of LHINs there is an expressed intent on the part of the Ontario government to share system governance and management with these newly created entities. The Ontario government has stated that it is interested in moving away from its traditional system management role and taking on a more strategic and central governance role. This is very much in keeping with what the other provinces have done, with one important and significant difference. They have chosen not to dissolve the governance role of the thousands of organizations currently delivering and governing largely single and special purpose health service organizations throughout Ontario. They have introduced Local Health Integration Networks without dismantling the traditional power or governance structures either within or outside the MOHLTC. Through LHINs system governance at the regional level has been introduced and will, to some degree, be positioned as a go-between or middle ground between health service organizations and the MOHLTC. Not a particularly comfortable spot from a governance perspective, given the centralized history of healthcare governance in Ontario.

The other tension that is inherent in the governance role of the LHINs, as currently outlined, is that unlike RHAs they will not have direct control over the delivery of health services. However, they are expected to be accountable for system coordination and management. In this circumstance, the legislative framework and powers given to the LHINs will be critical to their success. For example, if they are given the power to allocate and reallocate resources and some measure of autonomy from the MOHLTC apparatus, then they will have the capacity to be an important instrument of on-going system reform and change. If such is not the case, then the LHINs will be in a very difficult position. They will not have the powers to exercise system governance from a regional perspective and they will not have the authority to manage from a system perspective either.

Like the relationship between RHAs and ministries of health, LHINs and the MOHLTC will share responsibility for health system planning; one from a regional perspective and the other from a provincial one. Since there is a significant interdependence between the two this can be expected to generate on-going tension between the two system governing organizations.

In conclusion, there has been an evolution of health system governance throughout Canada that has most recently come to Ontario. As a very complex system there are no easy or straightforward answers or solutions. The introduction of LHINs in Ontario represents an evolutionary step toward sharing responsibility for system governance with an important cautionary note. To be successful the MOHLTC and its leaders will have to be prepared to formally share and divest power to the LHINs and the LHINs will need to be in a position to exercise true system governance, system planning and system coordination at the regional level. If LHINs take on a largely 'one step removed' system management role then its lack of direct responsibility for service delivery will likely create unworkable tensions between itself and the multitude of long-standing health service delivery organizations. If this occurs the capacity of health service organizations to exercise their political influence individually and collectively will likely serve to make the LHINs largely ineffective in being able to address their integration mandate.

Ontario prides itself in not having followed the same RHA route as other provinces. Ironically it has looked more to the USA (e.g. Kaiser Permanente and the Veterans Health Administration) and the UK for models

of healthcare reform than to its Canadian brothers and sisters. Now that the “looking” phase is over, it’s imperative that the LHINs as the governments “transformation” agents in the field, be given the necessary tools to be as effective as possible. **L&G**

Endnotes

1 “Principles for Good Governance in the 21st Century”, Policy Brief No. 15 – August 2003 by John Graham, Bruce Amos, Tim Plumptre, Institute On Governance. <http://www.iog.ca>

2 “Governance DO’S & DON’TS, lessons from Case Studies on Twenty Canadian Non-profits”, Final Report, Mel Gill, April 23, 2004, Institute On Governance. <http://www.iog.ca>

3 “The New Rules of the Board Game: The Changing World of Corporate governance and Its Implications for Multilateral development institutions”, Tim Plumptre, Institute On Governance, February 4, 2004. <http://www.iog.ca>

4 “Hospital Governance and Accountability in Ontario”, a report for the Ontario Hospital Association by Maureen Quigley and Graham W.S. Scott, April 2004. [http://www.oha.com/client/oha/oha_lp4w_ind_webstation.nsf/resources/Hospital_GovernanceandAccountability_Report_Quigley_and_Scott/\\$file/Hospital_GovernanceandAccountability_Report_Quigley_and_Scott.pdf](http://www.oha.com/client/oha/oha_lp4w_ind_webstation.nsf/resources/Hospital_GovernanceandAccountability_Report_Quigley_and_Scott/$file/Hospital_GovernanceandAccountability_Report_Quigley_and_Scott.pdf)

5 Best Practice Guidelines. Governance and Disclosure Guidelines for Governing Boards of British Columbia Public Sector Organizations. Board Resourcing and Development Office, Office of the Premier, February 2005. www.fin.gov.bc.ca/abc

6 For more information about Regional Health Authorities visit the Canadian Centre for Analysis of Regionalization and Health (CCARH) website at www.regionalization.org

7 Canada Health Infoway website - <http://www.infoway-inforoute.ca/>

8 For details on Local Health Integration Networks go to the Ontario ministry of Health and Long-Term Care website at http://www.health.gov.on.ca/transformation/lhin/lhin_mn.html

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Medical Services for Ontarians Outside of Canada

William P. Georgas and Louise Shap

In the last year, the Health Services Appeal and Review Board of Ontario (the “Board”)¹ rendered two noteworthy decisions that considered the circumstances under which a person may seek medical treatment outside of Canada and have such treatment covered under the Ontario

Health Insurance Plan (“OHIP”). The Board granted Ontario residents David King² and Sandra Posluns³ their requests for reimbursement of expenses incurred for hip replacement surgery obtained in the United States of America (the “U.S.”). Both patients were able to satisfy the requirements for reimbursement by demonstrating

1 The Board was established by the *Ministry of Health Appeal and Review Boards Act, 1998*, S.O. 1998, c.18, Sched. H, to conduct appeals and reviews of, among other statutes, the *Health Insurance Act*, R.S.O. 1990, c.H.6 and its Regulations. It is an independent, adjudicative board that is not part of OHIP or any other part of the Ontario Ministry of Health and Long-Term Care.

2 *David G. King v. The General Manager, The Ontario Health Insurance Plan* (December 9, 2004), 04-HIA-0007 (Health Services Appeal and Review Board) [“King”].

3 *Sandra M. Posluns v. The General Manager, The Ontario Health Insurance Plan* (January 10, 2005), 04-HIA-0121 (Health Services Appeal and Review Board) [“Posluns”].

that the delay in obtaining surgery in Canada would result in medically significant irreversible tissue damage, and that it was necessary to travel outside of Canada to avoid such delay.

These decisions highlight the potential implications of long wait times, and the avenues that may be available to Ontarians to seek treatment elsewhere. Such mechanisms to reduce wait times have taken on new significance in light of the Supreme Court of Canada's recent decision in *Chaoulli v. Québec (Attorney General)*⁴ concerning timely access to healthcare.

Requirements for Obtaining Insured Services Outside of Canada

The *King and Posluns* decisions demonstrate the tests that must be met under Ontario law to obtain insured services outside of Canada.

In April 2001, David King began to experience pain in his right hip and was subsequently diagnosed with advancing deterioration of the right hip socket. By January 2003, Mr. King's condition reached a stage where he could perform few daily functions without experiencing severe pain. For example, Mr. King was not able to get out of bed or put on his own socks and shoes without assistance.

In May and June 2003, King sought to meet with several orthopaedic surgeons, and was told that an appointment could not be scheduled before September, 2003. He was further advised that he would have to wait an additional twelve months to obtain the required surgery. King then contacted the OHIP office to inquire about the possibility of undergoing surgery in the U.S. He was told that OHIP would probably not cover the costs of hip replacement surgery performed outside of Canada as the treatment was offered in Ontario. At no time was King advised by OHIP or his family physician of the requirement to make an application to OHIP to seek approval from OHIP prior to obtaining surgery in the U.S. In July 2003, X-rays demonstrated that the deterioration had doubled within a ten week interval. Later that month, King elected to

obtain hip replacement surgery in the U.S.

Sandra Posluns, a sixty-year-old woman, was diagnosed with severe osteoarthritis requiring a total hip replacement. After consulting with an orthopaedic surgeon, she was advised that she would have to wait between 18 to 24 months to obtain surgery. Posluns subsequently contacted two other orthopaedic surgeons, who advised her that she would have to wait several months just to obtain an initial assessment. At this time, she was in "agony" and "could not function in any normal capacity." For example, she could not walk across her living room floor, get on and off the toilet, or get in and out of a car without assistance because of the pain." Consequently, Posluns opted to obtain total hip replacement surgery in Naples, Florida, U.S.

Both King and Posluns applied to the General Manager of OHIP for reimbursement of the costs incurred as a result of obtaining surgery in the U.S. Both applications for reimbursement were denied and subsequently appealed to the Board.

In rendering its decisions, the Board in both cases considered the *Health Insurance Act*⁵ (the "Act") and the Regulations made under it as they apply to "insured services". Section 12 of the *Act* states that every insured person is entitled to be provided with, or to receive payment for "insured services".⁶ For the most part, "insured services" under the *Act* only include health services rendered in Ontario.

However, Regulation 552⁷ under the *Act* provides, among other things, for payment of out-of-country health services in two circumstances: first, when an insured person is outside Canada and an emergency arises which requires immediate medical treatment; or second, when the services are rendered outside of Canada with the prior approval of OHIP.

In the latter situation, section 28.4 of Regulation 552, establishes the criteria and conditions under which out-of-country treatment will qualify as an "insured service"

4 [2005] SCC 35 ["Chaoulli"].

5 R.S.O. 1990, c.H.6.

6 Section 12(1) reads: Every insured person is entitled to payment to himself or herself or on his or her behalf for, or to be otherwise provided with, insured services in the amounts and subject to such conditions and co-payments, if any, as are prescribed.

7 R.R.O. 1990, Regulation 552, amended to O. Reg. 502/05.

under the *Act*.⁸ In determining whether the requirements of this section have been satisfied, the Board had to decide the following:

1. Is the treatment generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person?
2. Is the treatment performed in Ontario by an identical or equivalent procedure?
3. If the treatment is performed in Ontario, is it necessary for the Appellant to travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage?

In both cases, the Board found that the first two questions or criteria had been satisfied.

The only remaining issue was whether it was necessary for the appellants to travel outside of Ontario to avoid a delay that would otherwise result in “death” or “medically significant irreversible tissue damage”. This required the appellants to prove that: (1) a delay would result in “death” or “medically significant irreversible tissue damage”; and (2) to avoid such delay, it was necessary for them to travel outside of Canada.

In both cases, the Board considered competing medical evidence before holding that a delay in hip surgery would lead to “medically significant irreversible tissue damage”. The Board then considered the amount of time and effort made by both appellants to secure surgery in Ontario. Ultimately the Board found that both appellants had made significant efforts to secure surgery in Ontario, and that it was necessary for each of the appellants to travel to the U.S. to avoid delay. In *King*, the Board noted the following:

We find Mr. King did everything reasonable to find earlier surgery in Ontario: he consulted with his

family physician - who, in turn, telephoned some orthopaedic surgeons in Ontario - and he telephoned OHIP directly, still, he was not able to get the surgery any earlier in Ontario. On this evidence we find that it was necessary to travel out of the country to avoid the delay in getting this surgery.

These decisions demonstrate the current requirements under Ontario law for obtaining reimbursement for medical services obtained outside of Canada. Reimbursement in Ontario is clearly difficult to obtain. While the province’s power of reimbursement has been exercised sparingly, it may now need to be re-examined in light of the recent decision in *Chaoulli*.

The Right to Life and Security of the Person

In a 4-3 decision, the Supreme Court of Canada in *Chaoulli* ruled that the prohibition of private insurance or the payment of medical or hospital services that are covered under the province’s health care plan, contravenes the *Québec Charter of Human Rights and Freedoms*.⁹ However, the Court further split 3-3 in its ruling on whether the prohibition on private health insurance violated Section 7¹⁰ of the *Canadian Charter of Rights and Freedoms*,¹¹ with Madam Justice Deschamps declining to make a ruling on the *Canadian Charter*. Because *Chaoulli* was decided on a 4-3 split in respect of the *Québec Charter*, the 3-3 decision leaves open the question of how wait times are to be scrutinized under the *Canadian Charter*. However, because the *Canadian Charter* applies to all provinces, it is instructive to examine the conclusions of the justices on this issue.

While the judges who considered the application of the *Canadian Charter* were divided as to whether the prohibition on private health insurance ultimately violated Section 7 of the *Canadian Charter*, they all agreed that a lack of timely health care may nevertheless infringe a patient’s right to life and security of the person.

⁸ The relevant portions of the section reads as follows: 28.4(2) Services that are part of a treatment and that are rendered outside Canada at a hospital or health facility are prescribed as insured services, if, (a) the treatment is generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person; and (b) either, (i) that kind of treatment is not performed in Ontario by an identical or equivalent procedure, or (ii) that kind of treatment is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage.

⁹ R.S.Q., c. C-12.

¹⁰ 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 the principles of fundamental justice.

¹¹ Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [the “*Canadian Charter*”].

Chief Justice McLachlin and Justice Major, who were in the majority of the 4-3 split, found that where lack of timely health care can result in death, the Section 7 protection of life is engaged.

They further found that the right to security of the person is infringed where a lack of timely health care results in “physical and psychological suffering” that meets a threshold test of “serious”, and that such physical and psychological suffering is not in accordance with the principles of fundamental justice:

In addition to threatening the life and the physical security of the person, waiting for critical care may have significant adverse psychological effects. Serious psychological effects may engage s. 7 protection for security of the person. These “need not rise to the level of nervous shock or psychiatric illness, but must be greater than ordinary stress or anxiety”...¹²

...The impact [on security of the person], whether psychological or physical, must be serious. However, because patients may be denied timely health care for a condition that is clinically significant to their current and future health, s. 7 protection of security of the person is engaged.¹³

Based on the decision of the majority in *Chaoulli*, it would appear that Section 7 protection is engaged when lack of access to treatment gives rise to both physical and psychological suffering.

Access to Out-of-Country Treatment, post-*Chaoulli*

The mechanism in section 28.4 of Regulation 552 that allows Ontario patients to seek, and be reimbursed for, medical services in the U.S. is meant to act as a safety valve when wait times become so long that they significantly endanger the life or health of the patient and treatment becomes required on an urgent basis. This safety valve was in place well before the Supreme Court of Canada rendered its decision in *Chaoulli*.

The fact that that Regulation 552 allows patients to seek out-of-country medical services when a delay in treatment could lead to death is clearly consistent with the decision in *Chaoulli* that wait times are unacceptable when a patient can die while waiting for medical services.

However, it is less clear as to whether allowing patients to seek out-of-country treatment when a delay could lead to “medically significant irreversible tissue damage” is consistent with that part of the *Chaoulli* decision that holds that wait times are unacceptable when a patient can suffer “serious physical or psychological harm” while waiting for medical services.

The threshold test of “serious physical or psychological harm” not entirely clear and has a significant subjective component. This makes it a difficult test to apply to determining when a patient should qualify for out-of-country insured services. Madam Justice Deschamps, in finding that the right to personal inviolability¹⁴ in the *Québec Charter* was affected by waiting times, noted that “patients on non-urgent waiting lists are in pain and cannot enjoy any real quality of life.”¹⁵ Chief Justice McLachlin and Justice Major accepted that “the harm suffered by patients awaiting replacement knees and hips is significant. Even though death may not be an issue for them, these patients ‘are in pain’, ‘would not go a day without discomfort’ and are ‘limited in their ability to get around’, some being confined to wheelchairs or house bound.”¹⁶ Reasoning such as this suggests that a patient need not be at the point where he or she risks suffering “medically significant irreversible tissue damage” before his or her right to security of the person is engaged.

It is noteworthy that the Québec government has successfully applied for a suspension of the Supreme Court’s ruling in *Chaoulli* that the prohibition on private health insurance is of no force or effect. The Supreme Court has granted Québec one year from the date of its decision in *Chaoulli* (i.e. June 9, 2005) to make the changes necessary to bring its health care system into compliance with the decision.

¹² *Chaoulli* at para. 116.

¹³ *Chaoulli* at para. 123.

¹⁴ While the right to personal inviolability under the *Québec Charter* is broader than the right to security of the person under the Canadian Charter, it has been held that if the evidence that the right to security of the person has been engaged, it supports the finding that the right to the inviolability of the person will have been infringed as well. See *Chaoulli* at para. 43.

¹⁵ *Chaoulli* at para. 42.

¹⁶ *Chaoulli* at para. 114.

While government officials in Québec have thus far been silent as to the measures they are considering in order to comply with the *Chaoulli* decision, it has been suggested that if the Québec government were to reduce wait times to the point where people do not die or suffer serious physical or psychological harm while waiting for treatment, then it would not be necessary to eliminate its prohibition on private health insurance.

This is instructive to Ontario, and any other province that may seek to avoid having their single-payer, public health care systems subjected to the scrutiny of Section 7 of the *Canadian Charter*, by reducing wait times to ensure that people do not die or suffer serious physical or psychological harm while waiting for treatment. It has been suggested that allowing patients to seek out-of-country insured services would relieve wait times and ensure that patients do not experience the suffering that would infringe their rights to security of the person. However, it remains to be seen as to whether the current requirements that must be met in order to qualify for out-of-country insured services pursuant to Regulation 552 set a clinical standard that exceeds the serious physical and psychological suffering that would otherwise engage a patient's Section 7 rights.

The *King* and *Postluns* decisions clearly demonstrate the high standards that must be met in order to qualify for reimbursement for out-of-country insured services. Given the burden that must be met to qualify, this process may only be a safety valve for patients in the most dire need of medical treatment. Patients who do not yet risk suffering the "medically significant irreversible

tissue damage" necessary to qualify for out-of-country insured services may nevertheless already be suffering from serious physical and psychological pain that affects their quality of life. This certainly raises the question of whether the current requirements for obtaining reimbursement for out-of-country treatment would successfully prevent the suffering that would trigger a violation of a patient's right to security of the person.

As provinces examine ways to reduce wait times in order to avoid being subject to a *Chaoulli*-type of decision, they will need to closely examine whether they have adequate safeguards in place to protect the lives and health of their patients on waiting lists. A lack of consistency between these safeguards and the standards set out in *Chaoulli* may very well make a province's public health care system vulnerable to a challenge alleging an infringement on patients' rights to life and security of the person. **L&G**

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