

Systemic Accountability Through Tort Claims Against Health Regions

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Introduction

The role of systemic actors in the health sector has changed dramatically since the inception of Medicare, with provincial ministries of health and health regions now significantly involved in the organization, coordination and management of health services. These evolving responsibilities have prompted increased public expectations and calls for greater accountability. These concerns with a lack of accountability at the systemic level are exemplified by a number of recent legal cases seeking redress for ministry of health decisions. Canadian courts have not been receptive to these claims, emphasizing the fact that governmental health sector decision making is an exercise in balancing scarce resources in the broader public interest, rather than examining its relationship with particular plaintiffs or groups of plaintiffs. Prospective plaintiffs may have greater success shifting their attention to filing claims against health regions.

The Changing Role of Systemic Actors in the Health Sector

Historically, physicians were perceived as solely responsible for the care received by patients, while systemic actors such as hospitals and government had limited involvement. Hospitals merely provided a facility for doctors to practice in and staff to assist them. However, medical care has fundamentally changed, becoming more complex, technologically advanced and specialized. Hospitals responded to these developments by taking on a greater role in organizing and managing

the delivery of services, and coordinating their diverse staff and programs.

Similarly, government's role in the health sector was restricted to the provision of public health services and limited funding of care for the destitute. This role also underwent a dramatic transformation, culminating in the government having three functions within the health care system – insurer, policy maker and manager. With the inception of Medicare, government's involvement expanded to include a significant financial commitment; however, it remained largely a passive payer. Government's responsibilities further evolved throughout the 1980s and 1990s to include a role in organization and policy-making. The functions of government have since extended to an active role in the management of the health care system. Government not only carries out its policy making and managerial functions directly through the ministries of health but, as discussed below, indirectly through entities it has devolved authority to.

These changes in the role of systemic actors in the health sector have resulted in increased public calls for their accountability. Brinkerhoff views the size and scope of health care bureaucracies as one of the key catalysts for accountability concerns,¹ both of which have continued to increase with the expansion of government's role in the health sector.² Although there are a number of means of addressing deficits in accountability,³ there is a growing body of literature which suggests that the law has a role to play. For example, Longley views the law as



“a means of promoting and ensuring accountability and legitimacy in public decision-making”⁴ and Brinkerhoff argues that “legal and regulatory sanctions are at the core of enforcing accountability.”⁵ To this end, plaintiffs are increasingly turning to the courts to hold government accountable.

Health Sector Tort Claims

Canadian courts have exhibited a reluctance to impose tort liability for government’s health sector decisions. For the most part, courts have not allowed these cases to reach trial, either striking the claims for want of a cause of action, or refusing to certify class actions. For example, the Ontario Court of Appeal recently struck claims based on the West Nile Virus (WNV)⁶ and Severe Acute Respiratory Syndrome (SARS) outbreaks.⁷ In the former case, the plaintiff’s main allegations were that the government failed to take adequate steps to deal with WNV, and failed to implement a plan it had developed to address the disease.⁸ In the SARS case, the plaintiffs claimed the government failed to control the outbreak, failed to manage prevention measures, failed to have an adequate public health system, failed to issue proper directives to hospitals to control the disease, and prematurely lifted the state of emergency.⁹

In both actions, the Court found that the plaintiffs did not have a close and direct relationship with government.¹⁰ The Court focused on the government’s obligations to the public at large, rather than its relationship with a specific plaintiff or group of plaintiffs. For example, in *Williams v. Ontario*, the Court emphasized that the powers to protect the public from disease “are to be exercised... in the general public interest” and they “are not aimed at or geared to the protection of the private interests of specific individuals.”¹¹ Acting in the public interest requires balancing “a myriad of competing interests,” which is inconsistent with a duty in tort.¹² Even if the plaintiffs had established proximity, the Court would have struck these claims for policy reasons:

...to impose a private law duty of care on the facts that have been pleaded here would create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health. Public health priorities should be based on the general public interest. Public health authorities should be left to decide where to

focus their attention and resources without the fear or threat of lawsuits.¹³

In *Cilinger v. Centre Hospitalier de Chicoutimi*,¹⁴ the plaintiffs argued that they did not receive radiation therapy for their breast cancer within a reasonable time. Quebec courts refused to certify a class action against the provincial Crown, focusing on government’s financial role.¹⁵ As the Supreme Court stated in *Just v. British Columbia*, “[a]s a general rule, decisions concerning budgetary allotments for departments or government agencies will be classified as policy decisions.”¹⁶ Courts will not review governmental policy decisions, but will impose negligence for the implementation of those policies.

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Unrealized Potential for Health Region Liability

Over the past few decades, governments have implemented reforms restructuring their health care systems. In most provinces, this took the form of regionalization, with governments replacing hospital boards with health regions.¹⁷ Even post-devolution, plaintiffs focus their legal claims on government. As Lewis and Kouri argue, the public continues to hold government accountable “by virtue of the prominence of healthcare in provincial politics and a traditional focus on the legislature as the arena for debating and resolving health issues.”¹⁸ However, while courts have not been receptive to cases naming governmental defendants, the door remains open for tort claims against health regions.

To date, the jurisprudence primarily addresses the narrow legal duties health regions inherited from hospitals, such



as vicarious liability for their employees,¹⁹ but does not consider the obligations these entities have as a result of their policy-making or managerial roles. Although there are questions regarding the extent to which government devolved power to these entities,²⁰ it is difficult to dispute that health regions have primary responsibility for the delivery of health services, and shared responsibility for the management of the health care system.²¹ As I discuss in the remainder of this section, a number of factors indicate that claimants injured as a result of the decision of actors at the systemic level – for example, a plaintiff who died waiting in an emergency room – may have greater success pursuing these claims against health regions rather than government.

An obstacle in the health sector claims is a perception that government is not involved at the managerial level, but rather its role is primarily financial and policy setting – in other words, its decisions are exempted from review through the policy/operational dichotomy.

One of the main stumbling blocks in claims against ministries of health has been the lack of a close and direct relationship between the parties. For example, in *Mitchell*, when the plaintiff died after awaiting treatment in a crowded emergency room, the Court remarked that the claim did not allege “that the Premier, the Minister or any government employee knew the Plaintiff personally, knew of their circumstances, made any representations to them or participated in [the Plaintiff’s] treatment.”²² In contrast, on similar facts, a health region would know the plaintiff and participate in her treatment through its employees. In this regard, proximity was satisfied in *Heaslip Estate v. Ontario*,²³ a recent claim where the plaintiff died waiting for an air ambulance operated by government. In other words, there was a close and direct relationship when the defendant actually delivered the service.

Another obstacle in the health sector claims is a perception that government is not involved at the

managerial level, but rather its role is primarily financial and policy setting – in other words, its decisions are exempted from review through the policy/operational dichotomy. In *Eliopoulos*, the Court concluded that any operational duties created by the government policy at issue “resided with local authorities and local boards of health.”²⁴ Despite questions over the extent to which government has devolved policy making decision authority to health regions, these entities can certainly be said to be implementing governmental policy.

A final factor which differentiates the legal position of health regions are government’s more general obligations to the public at large. Although health regions, indeed most actors working in the health sector including practitioners, must balancing competing programs, government must allocate scarce resources not only between health programs but between health care and other sectors. In emphasizing government’s broad obligations, the courts look to legislation. For example, in *Mitchell*, the Court concluded that the applicable statutes gave the Minister “wide discretion to make policy decisions with respect to the funding of hospitals” and “the power to act in the public interest.”²⁵ Contrastingly, Alberta’s legislation gives regional health authorities the more narrow duties to “ensure that reasonable access to quality health services is provided” and to “promote the provision of health services in a manner that is responsive to the needs of individuals and communities.”²⁶

One potential barrier to lawsuits against health regions should be mentioned. Although there is variation across Canada, some provinces include immunity clauses in their legislation. For example, Ontario’s *Local Health System Integration Act* precludes actions for damages against “a local health integration network...with respect to any act done or omitted to be done or any decision or order under this Act that is done in good faith in the execution or intended execution of a power or duty under this Act.”²⁷ In contrast however, the majority of Canadian jurisdictions only address immunity for the personal liability of board members.²⁸

Conclusion

There has been a dramatic expansion in the role of systemic actors in the quality of care received by patients, without accompanying accountability for these responsibilities. Claimants are increasingly looking



to the courts to impose tort liability on ministries of health, generally having these claims struck on pre-trial motions. Prospective plaintiffs may have greater success if they instead pursue claims against health authorities for three main reasons. Firstly, health regions have a more proximate relationship with patients, often having direct contact with them. Secondly, courts refuse to review governments' actions on the basis that they are policy decisions. In contrast, it would be difficult to argue that health regions, who directly deliver health services, are not involved in policy implementation. The third factor which may make courts more receptive to claims against health regions is the fact that while government has broad obligations to the public at large, making it difficult for plaintiffs to establish a close and direct relationship, health regions have more narrow obligations to respond to individual health needs.

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Endnotes

- 1 Derick W. Brinkerhoff, "Accountability and health systems: toward conceptual clarity and policy relevance" (2004) 19 Health Policy Plan. 371.
- 2 For instance, in addition to acting as health insurer, the Ontario Ministry of Health and Long Term Care administers a plethora of services and programs, such as addiction services, a colorectal cancer screening program, an emergency management unit, rabies awareness and telehealth. Ontario Ministry of Health and Long-Term Care, "Ministry Programs" online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/english/public/program/program_mn.html>.
- 3 These include, for example, calls to increase citizen participation (see *e.g.* J. Church *et al.*, "Citizen participation in health decision-making: past experience and future prospects" (2002) 23:1 Journal of Public Health Policy 12) and proposals to increase transparency in the governmental decision-making process (see *e.g.* Joel Lexchin & Barbara Mintzes, "Transparency in drug regulation: mirage or oasis?" (2004) 171 CMAJ 1363).
- 4 Diane Longley, *Public law and health service accountability* (Buckingham: Open University Press, 1993) at 4.

- 5 *Supra* note 1 at 372-373. He calls sanctions a "defining element of accountability" and argues that "[a]nswerability without sanctions is generally considered to be weak accountability."
- 6 *Eliopoulos Estate v. Ontario (Minister of Health and Long-Term Care)* (2006), 82 O.R. (3d) 321, 276 D.L.R. (4th) 411 (C.A.), leave to appeal to the Supreme Court denied, [2006] S.C.C.A. No. 514.
- 7 *Williams v. Ontario* (2009), 95 O.R. (3d) 401, 2009 ONCA 378. For other health sector claims struck by government see: *Drady v. Canada (Minister of Health)* (2009), 300 D.L.R. (4th) 443, 2008 ONCA 659; *Attis v. Canada (Minister of Health)* (2009), 93 O.R. (3d) 35 (C.A.), and *Mitchell (Estate) v. Ontario* (2004), 71 O.R. (3d) 571, [2004] O.J. No. 3084 (Div. Ct.).
- 8 *Supra* note 6 at para. 4. Other allegations related to government's removal of key scientists from the project, its failure to take timely and effective measures to reduce the mosquito population, its failure to coordinate efforts with the Center for Disease Control and neighbouring jurisdictions, and its failure to provide accurate information to the public.
- 9 *Supra* note 7 at para. 7.
- 10 The test for establishing duty has two steps. A plaintiff must establish that there is foreseeability and proximity – a close and direct relationship between the parties. The court will then ask whether there are any overriding policy considerations which ought to limit or negate that duty. *Cooper v. Hobart*, [2001] 3 S.C.R. 537.
- 11 *Supra* note 7 at para. 25.
- 12 *Supra* note 7 at para. 25. The Court repeatedly emphasized this focus on the general public throughout its decision, later commenting that "Ontario was required to address the interests of the public at large rather than focus on the particular interests of the plaintiff" at para 31. In deciding how to manage an outbreak, public officials "must weigh and balance the advantages and disadvantages and strive to act in a manner that best meets the overall interests of the public at large", at para 31.
- 13 *Supra* note 7 at para. 35. The Court in *Eliopoulos* adopted the same policy concerns, *supra* note 6 at para 33.
- 14 [2004] R.J.Q. 3083 (Sup. Ct.).
- 15 The Court focused on the yearly budget for health care, the allocation of this amount between hospitals, and the use of these funds. They reached this conclusion despite evidence regarding a wide



range of governmental involvement in breast cancer services: a health policy indicating the intention to reduce mortality, a report by a ministerial committee, a publication addressing Quebec's program to fight cancer, information bulletins regarding wait times, and a press conference announcing a series of measures to reduce wait lists. The Court did not consider whether there was negligence in the implementation of any of these policies.

16 [1989] 2 S.C.R. 1228 at 1244.

17 The major exception is Ontario, which left hospital boards in place, but implemented Local Health Integration Networks. These entities are responsible for planning, funding and integrating health care services.

18 Steven Lewis & Denise Kouri, "Regionalization: Making Sense of the Canadian Experience" (2004) 5 Healthcare Papers 12 at 23.

19 For example, see *Gemoto v. Calgary Regional Health Authority* (2006), 67 Alta. L.R. (4th) 226, 2006 ABQB 740 at para. 11, in which the Court stated that the Calgary Regional Health Authority "owned and operated the Hospital and is vicariously liable for the actions of the nurses." Similarly, see *Melanson Estate v. Calgary Regional Health Authority* (2008), 100 Alta. L.R. (4th) 224, 2008 ABQB 692 in which the detailed style of cause refers to the "Calgary Regional Health Authority, carrying on business under the name and style of The Foothills Provincial General Hospital."

20 For example, Colleen M. Flood, Duncan Sinclair & Joana Erdman, "Steering and Rowing in Health Care: The Devolution Option?" (2004-2005) 30 Queens L.J. 156 at 191 argue that devolution "occurred in form rather than substance", with many health authorities remaining "subject to micro-management by the provincial Ministry of Health."

21 The extent of the responsibilities of these entities is particularly significant in Alberta, which has recently replaced the regional health authorities with a single Board, concentrating accountability for all health delivery within a single entity. Alberta Health and Wellness, News Release, "Alberta Health Services moves toward one provincial health system to increase patient access and enhance care" (8 July 2008), online: Alberta Health and Wellness <<http://alberta.ca/acn/200807/2396103C91662-0478-C870-4CC1E6A130100E35.html>>.

22 *Supra* note 7 at para. 19. Although this arguably goes beyond what is required by the test for governmental liability in other contexts (see e.g. *Just v. British Columbia*, *supra* note 16), in the health sector cases courts seek such a connection (for example, see also *Eliopoulos*, *supra* note 6, in which the identification of West Nile hotspots was insufficient, even on the law threshold required on a motion to strike).

23 2009 ONCA 594.

24 *Supra* note 6. Similarly, in *Mitchell (Estate) v. Ontario*, the Court stated that "The *Public Hospitals Act*... provides for a hospital-appointed administrator, who is an employee of the hospital, who has direct and actual superintendence and charge of the hospital, and for a hospital board" *supra* note 7 at para. 27.

25 *Supra* note 7 at para. 28.

26 *Regional Health Authorities Act*, R.S.A. 2000, c. R-10, s. 5(a)(iv) and (v).

27 S.O. 2006, c. 4, s. 35.

28 For example, Nova Scotia's *Health Authorities Act*, S.N.S. 2000, c. 6 s. 26 states that "no member of a board of directors [of a district health authority] is personally liable for anything done or omitted to be done or for any neglect..."

