

Enhancing Patients' Confidence in Access to Health Care: The Ontario or Québec Way?

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I. Introduction

Without a doubt, Health Care represents a hot topic for Canadians. Not a day goes by without hearing related stories in the media, sometimes positive, but more often than not shocking. Whether it is cases of patients that are the victims of medical malpractice, reports on bad living conditions in home care, or waiting lists, the range of "hot" topics is broad. The caricature of the health care system in the recent internationally acclaimed movie "The Barbarian Invasions" also aptly illustrates the general public's interest in the topic.¹ On a less glamorous but more important level, the subject is also a high priority for our governments. The conduct of many commissions in Health Care at the federal and provincial levels over the past decade demonstrates this widespread concern.²

The questions that therefore arise are: Is the system really in such bad shape? And if so, what can be done to improve it? Given the level of attention that the failures and shortcomings of the health care system receive in the media, Canadians may be led to overestimate their frequency.³ This is of great concern, as citizens' confidence in the health care system remains an essential element for its survival, and whose importance is compounded by the fact that every Canadian is destined to be linked to the health care system, at one point or another in their lives.

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¹ The movie "The Barbarian Invasions", by Québec director, Denys Arcand, received an Oscar in 2003. Part of the movie depicts conditions in the Québec Health Care system. The caricatured portrait (not so far off centre in some people's opinion) emphasises relations with unions and hospital administrators, and the conditions in which patients have to live.

² Among others: Canada, Commission on the future of Health Care in Canada, *Building on Values: The future of Health Care in Canada* by Roy J. Romanow (Ottawa: Commission on the future of Health Care in Canada, 2002); Canada, Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadian v. The Federal Role* (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2001) (the "Kirby Report"); Québec, Ministry of Health and Social Services, *Emerging Solutions: Report and Recommendations* (Québec: Commission of the Study of Health and Social Services, 2001); Alberta, Premier's Advisory Council on Health, *A Framework for Reform: Report of the Premier's Advisory Council on Health* (Edmonton: The Council, 2001).

³ "The extent to which fatalities [not only in the health sector] tended to be reported in the media correlated with overestimation" in Jeffrey J. Rachlinski, "The Uncertain Psychological Case for Paternalism" (2003) Nw. U.L. Rev. 1165 at 1188 [Rachlinski]. See also Jeffrey J. Rachlinski & Cynthia Farina, "Cognitive Psychology and Optimal Government Design" (2002) 87 Cornell L. Rev. 549 at 562 [Rachlinski & Farina].

An important ingredient in order to strengthen Canadians' confidence in health care is to provide them with adequate means to express their concerns and potentially influence decision-makers when facing a problem in accessing health care and services. This ultimately contributes to design a health system that better acknowledges the public's preferences and needs and, as such, is more responsive.⁴

In this paper, I examine the models of redress available in Ontario and Québec for patients facing access to care problems. As I shall later discuss, these accessibility problems to publicly funded care include refusal for "medical necessity" or resource limitations reasons, as well as, access to poor quality care — e.g. care that is not socially, scientifically or humanly adequate (for instance, timely access to care). The focus herein will be on the remedies available outside of the traditional court and disciplinary systems. Both provincial models offer patients who wish to complain about or appeal decisions related to access to care a combination of an administrative tribunal and an ombudsman. I have selected these models because they are both innovative yet different. While the Ontario approach relies more on its tribunal, its Québec counterpart puts more emphasis on its Ombudsman. Québec also has a Patient's Bill of Rights, which is not the case in Ontario. Indeed, even though Ontarians have discussed the possibility of introducing such a bill on various occasions, it has systematically failed to be implemented.⁵

Both models are relevant and contribute to enhance citizens' confidence in health care. More precisely, the question that I propose to answer in this paper is: which model better succeeds in achieving that end and, overall, provides the best opportunity for patients? In order to do so, I begin in Section II by exploring how access to health care works in Canada, most notably in Ontario and Québec. Since I propose to examine remedies available for issues related to access to care, this first step is important. In Section III, I describe the Ontario and Québec approaches. Finally, in Section IV, I analyse and compare both models. Throughout my analysis, I highlight some of the key elements of human judgment and behaviour which can provide for a more comprehensive analysis of the advantages and limits of each model.

⁴Commission on the Future of Health Care in Canada, *Public Participation and Citizen Governance in the Canadian Health System*, Discussion Paper No. 7 by Julia Abelson & John Eyles (Saskatoon: Commission on the Future of Health Care in Canada, 2002).

⁵See Ontario New Democratic Party, Press Release, "Temperature Turned up for Patients' Bill of Rights" *Health* (23 May 2002). Even currently, a Patients' Bill of Rights is before the Ontario provincial assembly after second reading, the Bill has been referred to the Committee of the Whole House. See Bill 22, *Tommy Douglas Act (Patients' Bill of Rights)*, 3rd Sess/, 37th Leg., Ontario, 2002. It is the same Bill that was previously proposed by the NDP and rejected. It can be expected that this new attempt will also result in rejection. The Bill proposed is far less sophisticated than the one in force in the province of Québec. Ontario has, however, a specific Bill of Rights for home-care, see *Long-Term Care Act*, S.O. 1994, c. 26.

II. The Underlying Dynamics of Access to Health Care in Canada

“Access to care is the major issue in the health care system”.⁶ It is a matter of great concern not only for decision-makers, but also for all Canadians citizens. Whereas access to care is often limited to its quantitative dimension, that is what care one can or cannot have access to, the concerns of Canadians are much broader in scope and also include qualitative issues. The quality issues relate to receiving adequate care on scientific, social and humane levels.⁷ In other words, people expect their health care providers to be competent, respectful and considerate, and they also want to receive their care in an appropriate timeframe.⁸

The reasons, justifiable or not, to deny access to care are various. They include: lack of “medical necessity”, unapproved or lack of formulary drugs, referral requirements not being met, exclusion from network services (for instance, alternative therapies), priority needs, and resource limitations (both human resource shortages and lack of equipment). Additionally, problems of access may also result from regional disparities or disparities of treatment⁹. As numerous as the reasons for refusing access to care are, so too are the decision-makers involved.

The people that have an influence over access to care for patients can be grouped in two principle levels of decision-makers: first, those within the system or macro level; and second, those at the treatment and delivery level.¹⁰ Whereas the first level refers to allocation or policy decisions taken by the governments, the second level refers to the health care providers.

At the first level, provincial governments are responsible for establishing what care and services are publicly-funded. Provincial governments, in order to receive federal funding, only have to respect the requirements contained in the *Canada Health Act* (CHA)¹¹. Section 9 of the CHA, which refers to the criterion

⁶Dr. R. Strasser, “Workforce Supply in Healthcare: the Impact of Demographics and Geography” (conference, Health Policy Summit, 20 April 2004) [unpublished].

⁷An Act Respecting Health Services and Social Services, R.S.Q. c. §-4.2, s.5 use such terms. The way people are treated are as important as the care they receive, see *infra*.

⁸Timely access is of great concern for Canadians, see; Colleen Flood & Tracey Epps, “Can a Patients’ Bill of Rights Address Concerns About Waiting Lists?” Draft working paper, Health Law Group, Faculty of Law, University of Toronto, 9 October 2001 [to be published in McGill Law Journal in 2004] [Colleen Flood & Tracey Epps]; Prime Minister Martin indicated that improving timely access would be a priority of his government: Minister Pettigrew, Address (Conference, Health Policy Summit, 20 April 2004) [unpublished].

⁹For example, Native Indians and individuals within lower socio-economic groups can have less access to certain care; see Colleen Flood, “The Anatomy of Medicare” in Jocelyn Downie, Timothy Caulfield & Colleen Flood eds., *Canadian Health Law and Policy*, 2d ed. (Toronto: Butterworths 2002) at 1.

¹⁰See Cathy Charles & Sal DeMaio, “Lay Participation in Health Care Decision Making: a Conceptual Framework” (1993) 18 J. Health Pol. 881. The authors, however, distinguish the treatment and the delivery levels.

¹¹R.S.C. 1985, c. C-6.

of “comprehensiveness”, requires that provincial plans insure “insured health services” provided by hospital and medical practitioners or dentists. “Insured health services” refers to “medically necessary” or “medically required” services, which services are not defined in the CHA. Each province is therefore responsible for defining these services.

Provinces have usually determined the range of “medically necessary services” by negotiating with medical associations.¹² During these negotiations, the fees physicians will receive for providing insured services are discussed; it is in this particular “fee negotiation context” that most decisions about what types of care should be publicly funded are made.¹³ In Ontario, for example, it is the Ontario Medical Association (“OMA”) that participates in these negotiations. Since 1997, and as a result of an agreement between the Ministry and the OMA, there is also a Physician Services Committee that assumes a significant role in making various recommendations concerning services in order to achieve certain financial targets.¹⁴ In Québec, the negotiations involve the “Fédération des Médecins Omnipraticiens du Québec”, which represents the interests of general practitioners, and the “Fédération des Médecins Spécialistes du Québec”, which represents the specialist physicians.

The process of determining what is publicly funded and what is “medically necessary” gave rise to an increase of concerns over the last years. Some authors have advocated in favour of a more transparent and “democratic” process.¹⁵ There is no doubt that the current process should be more open to public input and scrutiny. It remains very difficult to access more details about who is involved, how, and on what criterion decisions are made.¹⁶ This is also why there is a strong need to provide patients with adequate means for addressing their concerns since, as I will later discuss, such means contribute to more accountability, highlighting more responsiveness from policy-makers and decision-makers.

As for the second level of decision-making in access to care, the treatment and services delivery level, this includes the health care managers and all health care providers involved at the patient’s bedside, that is, physicians, nurses and other health care workers. All these individuals can influence patients’ access to care based, for instance, on their professional judgment, cost-containment considera-

¹² See *supra* note 8; Colleen M. Flood, Carolyn Tuohy & Mark Stabile, “What is In and Out of Medicare? Who Decides?” Working paper No. 5, *Defining the Medicare Basket*, CHSRF-OMHLTC Research Project, 2004 (available online at: www.law.utoronto.ca/healthlaw/basket/index.html) [Flood].

¹³ *Ibid.*

¹⁴ See *supra* note 11.

¹⁵ See for instance Daniel Baril “Qui doit décider de ce qui est médicalement nécessaire?,” *Forum*, (16 Septembre 2002; Mona Award, Julia Alberson & Colleen Flood, “The Boundaries of Canadian Medicare: The Role of Medical Directors and Public Participation in Decision-Making” Working paper No. 2, *Defining the Medicare Basket*, CHSRF-OMHLTC Research Project, 2004 (available online at: www.law.utoronto.ca/healthlaw/basket/index.html).

¹⁶ See *ibid.* As for Québec, it was difficult to have more information about the process. If the process remains “obscure” for most people involved in the network, one can imagine how it must seem to regular citizens.

tions, and availability of services. The key players remain the physicians as they are the real “gate-keepers” of the system and exert considerable influence in deciding what care and services patients should receive. All in all, physicians remain centrally involved at every level of access to care in the system.

The various recourses that citizens have for making complaints can also influence their access to care. People may complain directly to the provincial minister concerned,¹⁷ go to courts for a judicial review or a *Charter* challenge, or go through the remedies further discussed in this paper, that is, administrative tribunals and ombudsmen. Judicial review has proven to be very difficult for patients wishing to overturn a decision due to the great deference towards administrative tribunals' expertise and decisions from the courts.¹⁸ As for *Charter* challenges, they only have limited influence on what is publicly funded or not. Although, in the past few years, more *Charter* challenges have been made to government decisions regarding public care funding,¹⁹ it remains arduous for patients to formulate a challenge, go through the process and ultimately be successful. Indeed, costs associated with a *Charter* challenge remain extremely high. It takes many years to receive a final judgement, and positive rights of publicly-funded health care are rarely recognized by the courts.²⁰ As for the other means available in Ontario and in Québec for access to care issues, that is the administrative tribunal and the Ombudsman, they offer more opportunities of redress for patients. I now turn to explore these means in greater detail.

III. Descriptive Analysis of Remedies Available to Patients when Facing a Problem in Accessing Health Care

In this section I start by describing the remedies available in Ontario, that is, those offered by the Ontario Health Services Appeal and Review Board (“Appeal Board”) and the Ombudsman of Ontario. I then turn to portray the remedies

¹⁷ In Ontario, there are “Medical consultants” — that is physicians employed with the Ministry — that can have great influence in decisions to deny or not certain care. Patients can try to have an influence over the decision at that level. See *supra* note 12.

¹⁸ Probably the most famous case of review is *Stein c. Québec (Régie de l'Assurance-maladie)* [1999] Q.J. No. 2724 (Q.S.C.). See *infra* section “Tribunal administrative du Québec”. The “patent unreasonableness” standard of review in administrative law is extremely high.

¹⁹ For instance, *Eldridge v. British Columbia (Attorney General)* (1997), 151 D.L.R. (4th) 577 (S.C.C.); *Cameron v. Nova Scotia (Attorney General)* (1999), 177 D.L.R. (4th) 611 (N.S.C.A.); *Auton v. British Columbia (Minister of Health)* [2000] B.C.S.C. 1142 (B.C.S.C.), *rev'g* SCC 78. For a more extensive discussion, see *supra* note 8.

²⁰ See *Auton, ibid.* As a rare demonstration to comply with the Charter equality rights. Nevertheless, the Supreme Court of Canada recently reversed this decision mentioning that there was no infringement of the equality right section in this case. The Court also shows great deference towards governments' choices of publicly funded care and services:

In summary, the legislative scheme does not promise that any Canadian will receive funding for all medically required treatment. All that is conferred is core funding for services provided by medical practitioners, with funding for non-core services left to the Province's discretion. Thus the benefit here claimed — funding for all medically required services — was not provided for by the law. at par. 35.

available in Québec, that is, the *Tribunal administratif du Québec* (“TAQ”) and the Health and Social Services Ombudsman (“Health Ombudsman”).

A. Ontario: A Strong Appeal and Review Board

i. The Ontario Health Services Appeal and Review Board

The Appeal Board is a quasi-judicial tribunal created in 1998 by the coming into force of the *Ministry of Health Appeal and Review Boards Act*.²¹ The Board conducts hearings and reviews under the auspices of fourteen different statutes, all related to the health sector,²² and notably reviews previous decisions made by the General Manager of the Ontario Health Insurance Plan (OHIP).

Appeals made under the *Health Insurance Act*²³ represent the most significant part of the Board’s work, and generally relate to questions of whether a treatment or service is insured under the *Act*.²⁴ More specifically, out-of-country services represent an important source of appeals.²⁵ These services concern individuals requiring treatment while abroad, or who require pre-approval from the General Manager to obtain treatment that is unavailable in Ontario — or that would only be available to them following a considerable waiting period.

The members of the Board, who work on a part-time basis, are from various practice sectors, although the majority are lawyers. In fact, the 2002-2003 *Annual Report*²⁶ of the Appeal Board indicates that ten of its members are lawyers, three are physicians, another three are managers, and one is a nurse. There is no public representative *per se*. The Minister of Health and Long Term Care appoints the members for a three-year mandate. As I will discuss in the following section, this strong representation of the legal community has a significant impact on the functioning of the Board as well as on the type of decisions it renders.

To appeal to the Board, prospective appellants must write a letter informing the OHIP and the Health Board of their wish to appeal. They have to do so within a fifteen-day period from the time they receive the OHIP’s decision, which is surprisingly short.²⁷ From the moment they make their request, appellants can expect a three-month delay until the Board schedules a hearing.²⁸

²¹ S.O. 1998, c. 18.

²² *Ibid.* at s.20.

²³ R.S.O. 1990, c.H-6.

²⁴ *Health Insurance Act*, R.R.O. 1990, Reg 552, s. 24 mentions the medical services excluded from the OHIP coverage.

²⁵ *Ibid.* at s.28.1. See also *supra* note 11 and Ontario, Health Services Appeal and Review Board, *Annual Report 2002-2003*. (Toronto: Health Services Appeal and Review Board, 2003), available online at: http://www.hsarb.on.ca/english/reports/ann_report_2001.htm (date accessed: April 2004).

²⁶ Ontario, Health Services Appeal and Review Board, *Annual Report 2002-2003*, *ibid.*

²⁷ Individuals may ask for an extension of that delay to the Board. The request must be motivated.

At the hearing, appellants will engage in a contradictory debate with the OHIP. They have to prepare their case with all the relevant documents and evidence. This task is often difficult and time-consuming for many individuals, particularly due to the fact that minimal assistance is offered to appellants from the Board's personnel.²⁹ In addition, appellants can only consult the Board's decisions *in situ*, in Toronto, and decisions are only available under parties' names, which makes precedent research complex³⁰. In order to help them to deal with the process, appellants may choose to be represented by a lawyer; however, while a lawyer's expertise can certainly be useful, it remains a more costly option, which probably explains why a majority of appellants choose to represent themselves.³¹

As for the use of medical expertise, it is a vital part of the appeal process. Whether, for instance, it is to evaluate the medical necessity of treatment,³² the acceptance of a practice in Ontario,³³ or the experimental nature of treatment,³⁴ physicians' opinions are essential to the Board's work. While access to medical expertise may not be an issue for the OHIP, it may nonetheless be one for patients, who must obtain favourable advice from a general practitioner and in certain cases, from a specialist. As noted by different authors, the burden of proof for patients is particularly difficult for cases related to out-of-country coverage.³⁵

As for the Board's role during the appeal process, it is confined by its enabling legislation. The well-defined functions of the Board, which allow for little discretion,³⁶ offers the government the possibility of providing an appeals mechanism to the residents of Ontario while maintaining, to a certain extent, control over the potential outcomes. For instance, it cannot order payment for non-insured services or grant partial payments.³⁷ Furthermore, the Board is not entitled to revise existing procedures or policies and cannot hear any appeals on the grounds of compassion³⁸

Appellants can consult the Appeal Board's website for the relevant details, online: Health Services Appeal and Review Board <www.hsarb.on.ca>.

²⁸ See Health Services Appeal and Review Board *supra* note 25. See also "FAQ's" section on the Appeal Board's website, *ibid*.

²⁹ See Caroline Pitfield, *Giving Patients a Louder Voice in the Health Care System? A Critical Evaluation of the Ontario Health Services Appeal and Review Board* (LL.M Thesis, University of Toronto, 2003) [unpublished]. For instance, no help is provided to appellants to prepare their request to appeal.

³⁰ *Ibid*.

³¹ *Ibid*.

³² *Health Insurance Act*, *supra* note 23 at s. 11.2.

³³ *Supra* note 24 at s. 24(1)17.

³⁴ *Ibid*.

³⁵ See *supra* note 29; Flood *et al.*, *supra* note 12. See also *Annual Report 2002-2003* where on nine decisions reported, only one was in favour of the complainant. The difficulty for patients to provide evidence for their case is particularly obvious in *D. and M.A v OHIP*.

³⁶ The Board has, however, more discretion about out-of-country services. See *supra* note 24 at ss. 28.2 and 28.3, Flood, *supra* note 12, and *supra* note 29.

³⁷ Moreover, the Board does not have jurisdiction to consider constitutional challenges to its enabling legislation. See *Ministry of Health Appeal and Review Boards Act*, *supra* note 21 at s. 6(3) (introduced 2002).

³⁸ This point is clearly mentioned on the Appeal Board website: "The Board cannot change or ignore the

or even efficiency³⁹. Thus, patients wishing to be heard for reasons other than those clearly set forth in the Health Insurance Act, or who seek remedial action other than those mentioned — for instance, an appeal based on a policy perceived as being unfair — would have to be directed to the courts or to the Health Minister.

The Ontario Health Services Appeal and Review Board presents various advantages. Most notably, it provides patients with an independent tribunal, which includes diverse procedural safeguards, to assess their requests concerning access to publicly-funded care. As I will further discuss in the last section of this paper, such an appeal mechanism can contribute to enhance patients' sense of fairness, and thus have an impact on their satisfaction with the process, regardless of the outcome. Also, over the years, the Board has developed an expertise in health matters which cannot be found in the common courts. Moreover, the fees for an appeal to the Board are considerably less than they would be for a similar matter within the tradition judicial system.

There are, on the other hand, manifest issues with the Board. There are significant confines to the Board's role and its capacity to adequately respond to patients' concerns. Most notably, the Board has a limited capacity to intervene rapidly. The appeal procedure takes many months — and the success rate of appellants remains very low.⁴⁰ Whereas the delays are most likely shorter than they would be for similar decisions from the courts, they remain a significant burden for patients for whom time and money are often key issues. Furthermore, there is no special procedure for urgent matters, which is, as I will later discuss, inadequate in a domain where time is a vital element. Secondly, the Board provides little assistance to appellants to prepare their case (such as research support, internet access to judgments or to adequate indexes, and writing assistance) which presents a considerable hurdle for some, particularly for those most vulnerable or challenged.

ii. *The Ontario Ombudsman*

The Ontario Ombudsman is another available recourse for patients when facing issues related to access to health care and services. Due to its broad public sector mandate, the Ombudsman's role remains, nevertheless, marginal in the Ontario health care sector, which explains why recourse to this actor is often overlooked.

The *Ombudsman Act* defines the role of the Ombudsman.⁴¹ He investigates complaints about any governmental organization decisions, recommendations, acts

Act and it cannot take into account compassionate reasons or any other reasons that are not in the *Act*." Online: Health Services Appeal Review Board <<http://www.hsarb.on.ca/english/faq.htm>>.

³⁹ See *supra* note 29, at 78 and 105.

⁴⁰ See *ibid.* at 138. See also *supra* note 26 where some of the most important decisions are summarized.

⁴¹ R.S.O. 1990, c. 0-6.

or omissions. The Ombudsman's website specifically mentions his jurisdiction over complaints on health insurance (OHIP) issues and over patient care in psychiatric hospitals.

The Ombudsman, however, intervenes as a last recourse; complainants have to first use all other complaints processes or means of appeal available to them before the Ombudsman will conduct an investigation.⁴² Considering the Ombudsman's broad mandate, spanning over multiple governmental organizations from diverse sectors, the necessity for complainants to first resort to more sector-specific procedures for their complaints appears reasonable.⁴³ Because of this last resort jurisdiction, one can wonder how the Ombudsman's role fits in with that of the Appeal Board. Arguably, the Ombudsman will only intervene after the Board refuses to hear an appeal, thus, the two institutions have non-concurrent roles.

As for the Ombudsman's powers, the Act mentions that he can express various opinions or make recommendations to the appropriate governmental institution.⁴⁴ For instance, the Ombudsman can recommend cancelling a decision, rectifying an omission, reconsidering or reinterpreting a certain law, or altering a prevalent practice. Moreover, he can recommend that an organization financially compensate a complainant. The Ombudsman can request that a governmental organization notify him, within a certain delay, of the follow-up or of any steps that it intends to take. He also send his recommendations to the minister concerned.

The potential role of the Ombudsman in issues related to access to health care appears more obvious in light of an investigation conducted in 2002.⁴⁵ The Ombudsman recommended to the Ministry of Health and Long-Term Care to provide equal funding to northern breast and prostate cancer patients who must travel for radiation treatment (southern patients have been benefiting from a travel policy since 1999). Travelling costs were often very significant for patients, and consequently represented a direct limit to access to adequate treatment. The Ombudsman deemed such situations to be discriminatory for patients in northern Ontario. This high profile case and the ensuing recommendation of the Ombudsman had a significant impact and was the object of media coverage.⁴⁶ The Ombudsman's report was considered by the Standing Committee of the Legislative Assembly. While the majority of the Standing Committee did not support the Ombudsman's position, the Ministry later announced an increase in grants available under the

⁴² See Ombudsman Ontario, "Examples of Complaints," online: ombudsman Ontario <<http://www.ombudsman.on.ca/examples.asp#cantdo>>.

⁴³ To give an idea of the broadness of the Office of the Ombudsman's intervention, more than 21,000 complaints were received during the 2001-2002 fiscal year.

⁴⁴ *Supra* note 41 at s. 21.

⁴⁵ Ontario, Ombudsman Ontario, *Investigation into the Ministry of Health and Long-Term Care's funding for Breast and Prostate Cancer Patients* (Ontario: Ombudsman Ontario, 2001) online: Ombudsman Ontario <<http://www.ombudsman.on.ca/pdf/Cancer-Care-Ontario.pdf>>.

⁴⁶ See for instance Louise Elliott, "Northern Cancer Patients Demand Compensation" *Canadian Press* (26 June 2001).

Northern Health Travel Grant Program.⁴⁷ Although the Ombudsman's power of recommendation is non-binding on the government, its impact on the media and on courts⁴⁸ certainly contributes to pressure the government to act.

All in all, the Ontario Ombudsman remains an option, although exceptional, for patients looking for a remedy when facing access to health care issues. One of the principle advantages of the Ombudsman most probably lies in the impact his opinions and recommendations can exert on matters of social interest in health care and the resulting influence on certain laws and policies that he considers discriminatory, unjust, or unreasonable for users.⁴⁹ His role also provides for a certain degree of accountability from governmental organizations since they may have to explain and justify their actions.⁵⁰ However, the Ombudsman's overly broad mandate and lack of specific expertise significantly hinders his effectiveness in the health care sector.⁵¹

B. Québec: A Strong Ombudsman

i. The "Tribunal administratif du Québec"

The "Tribunal administrative du Québec" ("TAQ") is a quasi-judicial tribunal that hears appeals concerning health treatment or service coverage in Québec.⁵² Patients appeal previous decisions made by the "Régie de l'Assurance Maladie du Québec" ("RAMQ")⁵³. In comparison with the Appeal Board in Ontario, the TAQ does not have an exclusive mandate for health affairs. The tribunal is responsible for hearing appeals of all administrative bodies in the province. Patients' appeals fall under the social affairs section of the TAQ, and are heard by a lawyer (or a notary) and by physicians.

⁴⁷ See the Ombudsman Annual Report 2001-2002 Ontario, Ombudsman Ontario, Annual Report 2001-2002 Ontario, 2002) at 11, online: Ontario <http://ombudsman.on.ca/ann_reports.asp>.

⁴⁸ *Ibid.* In this case, following the Ombudsman's recommendation, a class-action was considered in order to pressure the government to correct the situation. The Ombudsman's recommendations can therefore encourage people to seek remedies in court.

⁴⁹ See *supra* note 41 at 2.21 for a complete list of motives.

⁵⁰ The current Ombudsman insisted on that aspect as he mentioned that his office was "working to ensure fair and accountable provincial government service". See Ombudsman Ontario, *Missing and Values*, online: Ombudsman Ontario <<http://www.ombudsman.on.ca/about.asp#>>.

⁵¹ The annual report of the Ombudsman indicates the origin of complaints. Health care complaints represent an extremely small proportion overall. See Ontario, Ombudsman Ontario, *Annual Report 2002-2003* (Ontario: Ombudsman Ontario, 2003) online: ombudsman Ontario <http://www.ombudsman.on.ca/ann_reports.asp>.

⁵² *Loi sur la justice administrative*, L.R.Q. c. J-3, s. v 14 and the following. The TAQ generally hears more or less ten cases per year that involve the RAMQ. In 2004 this number significantly increased to more than 40 cases. Only a minority of the cases heard every year are directly related to matters discussed in this article. Judgements are available online: <<http://www.jugements.qc.ca>>.

⁵³ *Loi sur l'assurance maladie*, L.R.Q. c. A-29, s s. 18.4 and 50.

As for the appeal process, patients who wish to go before the TAQ have to do so within a sixty-day delay from when the contested decision was rendered.⁵⁴ The appeal process follows the general rules that apply to other administrative tribunals and thus, is procedurally similar to the Appeal Board. The TAQ hands down its decision within a three-month delay from hearing the appeal.⁵⁵

The TAQ offers assistance in the drafting of appeal applications and sits in every administrative region of Québec, which facilitates the public's access to the TAQ.⁵⁶ Since the TAQ is a much larger organization than the Appeal Board in Ontario, based on its broader mandate, it may be easier for the former to obtain the required financing to offer such expanded access.

Interestingly, the TAQ offers a conciliation process for matters that are suitable for such an option.⁵⁷ If both parties accept, the conciliation procedure can take place with a member of the TAQ. This procedure allows parties to explore, on a confidential basis, a mutually satisfactory outcome. For the 2002-2003 period, only four cases were successfully completed in the "Other Matters" category, which may include the health services sector.⁵⁸ The available data, however, does not mention unsuccessfully completed cases. Such a result can be explained either by a lack of willingness of both parties to engage in the conciliation process or by the few cases involving the RAMQ before the TAQ each year.

The most well known case under the TAQ is *Stein v. Québec (Régie de l'Assurance-Maladie)*⁵⁹. Mr Stein was contesting a decision by the RAMQ refusing the reimbursement of his fees related to treatment received in a New York hospital. After being diagnosed with colon cancer, Mr Stein went to New York after doctors told him that his life was in danger and that he could only receive the necessary surgery four to eight months later. The RAMQ indicated that among the treatments received by Stein in New York, one was available in Canada, and the other was considered experimental. Therefore, no refund should be granted. The TAQ maintained the RAMQ's refusal. As a rare example of judicial review for such cases, the decision of the TAQ was ultimately overturned by the Québec Superior Court.⁶⁰ The Superior Court mentioned that the TAQ's decision was "irrational and unreasonable" as well as "contrary to the purpose of the *Health Insurance Act*".⁶¹ Arguably, these 'severe' comments will pressure the TAQ to better justify its decisions in such an area.

⁵⁴ *Ibid.* S. 110.

⁵⁵ *Supra* note 53 at s.146.

⁵⁶ See the TAQ's website at www.taq.gouv.qc.ca.

⁵⁷ *Supra* note 53 at s.120.

⁵⁸ Tribunal administratif du Québec, *Rapport annuel 2003-2004* (Montréal: Publications du Tribunal administratif du Québec, 2004) at 2.

⁵⁹ *Stein c. Tribunal administratif du Québec*, [1999] R.J.Q. 2416 (C.S.) (AZ-99021819).

⁶⁰ *Supra* note 18.

⁶¹ *Ibid.* at para. 32.

In sum, the TAQ offers the general advantages and inconveniences often associated with quasi-judicial tribunals. Nonetheless, although it has less expertise than the Appeal Board to examine access to care matters — which, as I will later discuss, presents some disadvantages⁶² — the TAQ appears to offer greater accessibility to patients.

ii. The Patients' Bill of Rights and the Health and Social Services Ombudsman

The Québec Reform of 1991 (Reform Centered on the Citizens) introduced a Patients' Bill of Rights and an Ombudsman with a mandate exclusive to health matters. An important gain for patients resulting from this reform is the implementation of a sophisticated complaints process in relation to health care and services in *public* institutions. It offers users a non-contentious opportunity to formulate a complaint regarding health services or social services they have received, ought to have received, or are receiving.

The complaints procedure is a two-level process. The first stage of resolution is held at the local level, within the institution. A Local Service Quality Commissioner is appointed by the Board of Directors of every institution⁶³ and has a forty-five day delay in which to provide a justified response to the complainant⁶⁴. The second and final stage of resolution is carried out at the provincial level by the Health and Social Services Ombudsman (the "Ombudsman"). The Ombudsman is appointed by the Government and no specific delay is set within which to assess complaints.⁶⁵ Complainants can benefit from assistance services from various individuals or organizations at every level of the complaints process.⁶⁶

Two acts define the complaints process: *An Act respecting Health Services and Social Services*⁶⁷ (the "Health Services Act") and *An Act respecting the Health*

⁶² See, in particular, *infra* section IV B i. "A need for specialised institutions"

⁶³ For more details about the Local Quality Commissioner's functions in the handling of user complaints, see *Health Services Act*, *infra* note 67 at s.33. In certain circumstances, users can file a complaint directly to the Regional Care Board, see sections 60 and subsequent. This procedure is useful when a function, or an activity of the Regional Board personally affects a user. This procedure is also useful for residents in nursing homes.

⁶⁴ *Infra* note 67 at s. 40.

⁶⁵ Based on the 2002-2003 Annual Report statistics, the Ombudsman resolves the majority of complaints within a delay of more than 120 days (30%), 23% within a delay of 61 to 90 days, and 21% within a delay of 46 to 60 days. See Protecteur des usagers en matière de santé et de services sociaux, *Rapport sur l'application de la procédure d'examen des plaintes 2002-2003* (Québec: Les Publications du Québec, 2003) online: Protecteur des usages en matière de santé et de services sociaux <<http://www.protecteur-des-usagers.gouv.qc.ca/fr/publications/rapports/20022003-rapport-plaintes.pdf>>.

⁶⁶ For instance, they can ask for technical help (in drafting a complaint), information, and assistance during formal or informal meetings. Among others, such help can be provided by the local commissioner or not-for-profit organisations specially appointed by the Government. See *infra* note 67 at ss. 34 and 76, and *infra* note 68 at s.10.

⁶⁷ R.S.Q., c. S-4.2.

and Social Services Ombudsman (the "Ombudsman's Act").⁶⁸ The *Health Services Act* is more general in application as it applies to health care services at large and mentions various patients' rights, whereas the Ombudsman's Act specifically addresses the role of the Ombudsman.

The Ombudsman provides an independent, ultimate review and evaluation of complaints. Indeed, the organization's sole mandate is to protect users' interests in the health care system and it is external to the general network of health care providers. As for its governmental independence, the Minister can consult the Ombudsman, but the Minister cannot intervene in the governance of the Ombudsman's affairs. The Minister also has to present the Ombudsman's annual report to the National Assembly. Moreover, the Ombudsman is appointed for a fixed-term, non-renewable mandate, which allows for greater freedom to criticize governmental decisions. This level of independence, although less extensive than that in place for the magistracy and still improvable, undoubtedly lends extra credibility to the complaints process.

The 2002-2003 annual report of the Ombudsman indicates that the organization received 568 new complaints and 4,850 information requests along with 349 requests for support coming from people working within the health care network.⁶⁹ Complaints are divided into the following general categories: Accessibility and Continuity of Services; Clinical and Professional Aspects of Health Care and Services; Particular Rights; Financial Aspects; Interpersonal Relationships; Environmental and Material Resources; and Others. The Accessibility and Continuity of Services category is the most important representing 25% of the total number of complaints.⁷⁰

Other than being the last resort in the complaints process, the Ombudsman has a broader role in the health care system in Québec. Ultimately, and by any appropriate means,⁷¹ the Ombudsman has the responsibility to see to it that users are respected and their rights enforced. For instance, he can advise the Minister, whenever necessary, on any matter relating to users dignity and the enforcement of their legal rights and remedies or to the improvement of the quality of services provided to the public and, if necessary, make recommendations for the appropriate corrective action.⁷² Thus, the Ombudsman can provide some important input on

⁶⁸ R.S.Q., c. P-31.1.

⁶⁹ *Rapport d'activités*, *supra* note 65.

⁷⁰ *Ibid.* More precisely, the motives of complaints in that category are Continuity of Services (43%), Delays (24%), Refusal of Services (11%) and the Choice of the Professional (7%).

⁷¹ *Supra* note 68 at s.7. The expression "by any appropriate means" is, however, not defined in the Act. Based on the Ombudsman's history, one can presume that such means will mainly consist of written advice to the Minister or institutions and inquiries about the patients' conditions.

⁷² *Supra* note 68 at s.27. The Ombudsman has already provided three opinions and recommendations. They are related to the financial contribution for admission of minors, homecare services, and financial help for user movements within the health care and services network. For each of these cases, the Ombudsman provides a detailed portrait of the situation as well as various recommendations in order to improve current problems brought to his attention by complainants or interveners in the health care

users' concerns in the Québec health care system and help identify emerging or recurring health issues to the appropriate authorities. For instance, in his last annual report, the Ombudsman noted increased concern about home care services, the lack of specialized services (for instance speech language pathology), delays concerning health care and services and the lack of information about available services.

In addition, the Ombudsman oversees the regional health boards. The *Ombudsman's Act* mentions that when a complaint raises a matter under the responsibility of the regional health boards, for example access to services, and the organization or financing of services, the Ombudsman may allow the concerned board to present its observations.⁷³ Thus, users have an opportunity to file complaints about more systemic access to care and services issues.

As for the special powers of the Ombudsman, since 2002, he can intervene and inquire on his own initiative when the rights of a person or a group have been or may likely be adversely affected by an act or omission.⁷⁴ Consequently, it is feasible for a user or a group of users, for instance a patients' association, to signal problems directly to the Ombudsman in certain situations. The Ombudsman should nevertheless only intervene if, in his opinion, recourse to the usual complaints process would likely be compromised, serve no purpose or be illusory. The law especially mentions that such a special procedure can apply when a vulnerable clientele is involved or when there are concerns about possible reprisals against complainants.

The fear of reprisals has always been an area of concern under the complaints process, particularly for individuals that are completely dependant of their institutions (for example, those in long-term health care facilities). The Commission des droits de la personne et des droits de la jeunesse (Youth and Human Rights Commission in Québec) has judged the issue sufficiently serious to set up a specific task force in order to discuss the subject⁷⁵. Although since 2002 the Ombudsman *must* act immediately when informed of any attempt of reprisals, one can wonder what measures the Ombudsman will use when facing such an issue. Since the Ombudsman's powers are more of a moral nature, the remedies available remain limited. One can hope that the Ombudsman will use such an opening in the Law to encourage the development of institutional protocols or other means (education,

network. It is noticeable that the Ombudsman gives a central importance to users' concerns in these opinions. These opinions and recommendations are available on the Ombudsman's website: www.procteurdesusagers.gouv.qc.ca.

⁷³ See *supra* note 68 at s.10. In such a case, the Ombudsman ensures the necessary follow-up with the Regional Service Quality Commissioner.

⁷⁴ *Supra* note 68 at s.10.

⁷⁵ Commission des droits de la personne et des droits de la jeunesse, *L'exploitation des personnes âgées, Rapport de consultation et recommandations* (Québec: Commission des droits de la personne et des droits de la jeunesse, October 2001), online: Commission des droits de la personne et des droits de la jeunesse <<http://www.cdpcj.qc.ca>>.

awareness campaigns, etc...) to enhance collaboration and awareness with respect to such an issue among actors in the health care network and the public.

Within thirty days of the receipt of a recommendation from the Ombudsman, the body concerned must inform him in writing of the actions it intends to take as a result of the recommendation or, if it has decided not to act upon the recommendation, of the reasons for such a decision.⁷⁶ The last annual report of the Ombudsman mentions that 12% of the institutions that had received recommendations did not follow up as is required⁷⁷. The Ombudsman can, nevertheless, exercise pressure on recalcitrant institutions by mentioning the case in a special report or, if the refusal appears justified, raise the issue to the attention of the Health Minister.⁷⁸

As an exception, the Ombudsman does not have jurisdiction over medical, pharmaceutical and dental acts.⁷⁹ There is a special procedure for complaints regarding these specific acts. At the first level, a physician examiner must try to resolve the complaint by "conciliating the interests"⁸⁰ of those involved. The second level then falls within the jurisdiction of a revision committee specially created for that purpose.

Moving on to the second novel item of the 1991 Québec Reform, and as mentioned at the beginning of this section, the *Health Services Act* is also the seat of a Patients' Bill of Rights. The Act specifies various patients' rights "in" and "to" health care.⁸¹ These rights fall under three major categories: right to receive care; right to choose the professional or the institution; and right to information⁸². The

⁷⁶ *Supra* note 68 at s.25.

⁷⁷ The 2002-2003 annual report mentions that among all complaints for which an examination has been completed (91% of the total), 43% have been subject to corrective recommendations. The report indicates that this result is unsatisfactory and that measures must be taken in order to improve responsiveness from institutions.

⁷⁸ *Supra* 67 at s. 26. If the Ombudsman is dissatisfied with the action undertaken as a result of his recommendation, he can advise the Health Minister or mention the case in his annual report or in a special report to the Minister.

⁷⁹ *Supra* note 67 at s. 42.

⁸⁰ This use of the terminology "conciliation of interests" is very interesting as it usually relates to amicable conflict resolution modes such as mediation and, obviously, conciliation. Whereas no mention of the required training for such a physician examiner is specified in the law, it can be argued that such a role can be based, to some extent, on the functions usually attributed to mediators and conciliators. The mention of "interests" by opposition to "rights" is equally insightful as it invites the physician to seek a solution on a 'win-win' basis as opposed to an enquiry-type approach and thus, to find a solution that is minimally satisfying for all parties involved.

⁸¹ See Colleen Flood & Tracey Epps, *supra* note 8. They establish a distinction "in" and "to" health care, the former including for example the right to consent to treatment and the latter including rights such as the entitlement to treatment.

⁸² This includes the right to be informed of any accident having occurred during the providing of services or that can prevent such an accident *supra* note 67 at s. 8. This specification was introduced in 2002 and is the result of increased concern relating to patients' and families' access to information when accidents occur in the health care system. See, for example Québec, Ministère de la Santé et des Services sociaux, *La gestion des risques, une priorité pour le réseau* (Québec: Direction des communications, Ministère de la Santé et des Services sociaux, February 2001) ("Rapport Francoeur"). The *Health Services Act* also

Act is also interesting as it addresses an often neglected aspect in health care: the human aspect of services. The Act specifies that “every person is entitled to receive, with continuity and in a personalised and safe manner, health services and social services which are scientifically, humanly and socially appropriate”⁸³. It also provides in its guideline that users are at the center of the health care system and should be treated with courtesy, fairness and with respect for their dignity.⁸⁴ However, section 13 of the Act may significantly limit patient expectancies — and by the same measure providers’ duties — since it specifies that all services are to be provided within the limits of available resources. Nevertheless, the courts seem to have restricted the risk of abusive use of section 13 by institutions.⁸⁵

To summarize, the existence of a complaints process and a Patients’ Bill of Rights in Québec provides Québécois with a very interesting and accessible means to address access to care issues. It allows patients to file complaints regarding a various range of issues and to benefit from an external review level via the Ombudsman. The data collected by the Ombudsman also provides valuable information about user satisfaction and their greatest health care system concerns. Ultimately, the Ombudsman can contribute to shaping more responsive policies in health care. On the other hand, this complaint process remains limited to public institutions, thus its scope ignores the private sector, for instance, medical clinics. Besides, the rationale of such a complaints process is based on voluntary compliance from health care providers and institutions; although this might represent the best model to encourage collaboration from the health care network, it also limits patients in their capacity to force the execution of certain recommendations, which can be a source of great frustration. Finally, the patients’ trust in the process, mostly at the first level, remains fragile, thus calling for constant effort to maintain and even assess the sustained independence of the Ombudsman.

IV. The Ontario or Québec model? A Diagnosis

In this last section, I put forward a comparative analysis of the previously described Ontario and Québec approaches. I begin with a discussion on the

provides for very detailed specifics about access to users’ files, such as, file access by minors, representatives and descendants, access for research purposes, temporary restriction in case of serious prejudice.

⁸³ *Supra* note 67 at s. 5.

⁸⁴ *Supra* note 67 at s. 3.

⁸⁵ When services are offered within an institution, restrictions are only acceptable when based on motives set out in the Law, see comments at s. 13 in *Services de santé et services sociaux*, *Judico*, coll. *Lois et Règlements*, (Montreal: Wilson & Lafleur, 2002). For instance, restriction should not be based on discriminatory motives, see among others *Hôpital Laval c. Samson*, [1992] R.J.Q. 2438 (C.A.) conf. J.E. 91-1189 (C.S. Québec). A user can seek injunctive relief to remedy an illegal refusal of care and services, see *Poirier c. Hôpital du Haut-Richelieu* [1982] C.S. 511 (1 R.J.S.S.) at 117). In *Poirier*, the court mentions that the evaluation of the prejudice depends on the parties involved. In this case, the patient was 71 year-old and seriously sick. For the requirement in order to obtain an injunction, see *Code of Civil Procedure*, R.S.Q. c. C-25, s. 751 and following.

fundamental values which serve as a basis for my analysis and then go on to provide a diagnostic of these two approaches.

A. Strengthening confidence in Health Care: a Common Ground for Assessment

As mentioned at the beginning of this paper, strengthening citizens' confidence in health care is essential to its sustainability. Fortifying Canadians' trust in the health care system inevitably leads to a greater commitment towards it, thus engaging citizens to adhere to the values of solidarity and tolerance.⁸⁶

One important way by which to improve Canadians' confidence in the health care system is to enhance their participation or their voice in the system on issues that concern them.⁸⁷ Remedies available in Ontario and Québec both provide for an opportunity for issue-based participation in health care; one of the most effective ways to enhance citizen/patient participation.⁸⁸ Indeed, appeals and complaints mechanisms allow patients to be involved in the system when they need it.

Strengthening Canadians' confidence in health care not only strongly advocates in favour of further means to improve citizen/patient participation, but also implies a correlative commitment from the relevant decision-maker(s) towards the public. Most notably, the principles of accountability and fairness are essential components of such a pledge.

Accountability is defined by Colleen Flood as the level of response by public institutions to their citizens.⁸⁹ It is also a call for greater transparency from those institutions. Due to a consensus over its importance and a "political crisis of legitimacy"⁹⁰ towards the governments, accountability is now an inevitable component of every debate in health care.⁹¹ For full accountability, Canadian citizens should be able to request explanations for decisions made that affect them from all

⁸⁶ Commission on the Future of Health Care in Canada, *How Can the Public Be Meaningfully Involved in Developing and Maintaining an Overall Vision for the Health System Consistent with Its Values and Principles?*: Discussion paper No. 33 by Harley D. Dickinson (Ottawa: Commission on the Future of Health Care in Canada, 2002).

⁸⁷ There are many supporters of increasing citizens' participation in health care, for instance, the WHO and provincial governments. See Commission on the Future of Health Care in Canada, *Practical Strategies for Facilitating Meaningful Citizen Involvement in Health Planning*, Discussion paper No. 23 by Jayne R. Pivik (Ottawa: Commission on the Future of Health Care in Canada, 2002).

⁸⁸ *Supra* note 4 at p. VI.

⁸⁹ Colleen M. Flood, *International Health Care Reform: A Legal, Economic and Political Analysis* (London: Routledge, 2000) at 128.

⁹⁰ *Supra* note 86 at 11.

⁹¹ See for example Romanow, *supra* note 2; Accountability was a central item in the last Health Policy Summit 2004 (Toronto: 19-20 April 2004) [unpublished]; The Canadian Policy Research Networks (CPRN) is also producing a series of seven papers on the concept of accountability in health care. See on the CPRN's website at: www.cprn.org.

levels of deciders that influence access to health care in Canada.⁹² As mentioned in Section II, these deciders are numerous: governments, physicians, administrators, etc. Thus, increased accountability in health care involves giving Canadians a voice and its resulting influence over all these aforementioned deciders.

The economic emphasis in health care discussions over the last decade has, without a doubt, highlighted the significant issues relating to efficiency and has contributed to a call for greater accountability.⁹³ However, the danger of focussing too much on economic concerns lies in neglecting less quantifiable aspects to health care that are nonetheless just as important and for which decision-makers should also be accountable: patients'/citizens' satisfaction and the general "human" aspect of health care.⁹⁴ Since the way in which patients are treated may be just as important to them as the actual care they receive,⁹⁵ acknowledging such an elusive aspect is essential. Accordingly, I propose that accountability implies further responsiveness to a more comprehensive range of citizens/patients concerns, needs and preferences. As such, the remedies available to patients should adequately take into consideration the reality of patients in health care.

In addition to accountability, the perception of fairness is also crucial for strengthening citizen/patient confidence in health care. The fairness requirement is particularly significant in a sector where decisions may considerably affect patients' lives and their capacity to function in society.⁹⁶ It is often associated with procedural requirements for administrative tribunals and involves, among others, the right for citizens to be heard. While these traditional components of fairness are present in

⁹² Furthermore, Sutherland and Fulton mention that the general principal of fundamental justice involves the possibility for an individual to confront the system as a whole. Ralph Sutherland & Jane Fulton, *Spending Smarter and Spending Less: Policy and Partnerships for Health Care in Canada* (Ottawa: Canadian Hospital Association Press, 1994).

⁹³ See for instance *supra* note 4.

⁹⁴ Illustrations of the fact that these less quantifiable aspects are often neglected in the health care system are numerous. For instance, while a prescription is an easy action to measure, communication between physicians and their patients is a less measurable action and financing is made accordingly. However, lack of communication with physician is one of the most important complaints of patients. See Leonard J. Marcus *Renegotiating Health Care: Resolving Conflict to build Collaboration*, (San Francisco, Jossey-Bass Publishers, 1995); Commission Francoeur *supra* note 82; Vincent Charles *et al.*, "Why do people sue doctors? A study of patients and relatives taking legal action", (1994) 343 *Lancet* 1609 [Charles]. I further discuss this aspect in the following pages. Also, pain has been, and still remains, underestimated due to its difficult assessment and its subjectivity. See Thierry Delorme, *La douleur: Un mal a combattre* (Evreux, Gallimard, 1999).

⁹⁵ See for example, *infra* note 113; Catherine Régis, *La médiation dans le domaine médicale: jalons de réflexion et considérations pratiques dans une perspective de mise en œuvre* (LL.M. Thesis, University of Sherbrooke) [Régis]; "emotional well-being is one measure of health outcomes", William M. Sage, "Unfinished Business: How Litigation Relates to Health Care Regulation" (2003) 28 *J. Health Pol.* 387.

⁹⁶ See Katherine Cherniawsky, "Enforcement of Health Care Rights and Administrative Law" (1996) 4 *Health. L. J.* 35; Martha Jackman, "The Right to Participate in Health Care and Health Resource Allocation Decisions under Section 7 of the Canadian Charter" (1995-96) 2 *Health Law Review* 3.; See also *Knight v. Indian Head School Division No 19* (1990), 69 D.L.R. (4th) 489 (S.C.C.) and *Baker v. Canada*, [1999] 2 S.R.C. 817. In Baker, Justice Heures-Dubé mentions that the impact of a decision on an individual has to be taken into account when determining the nature of the duty of fairness.

my analysis, I also argue that it is a matter of perspective. Professor Rachlinski mentions that fairness is, indeed, often assessed on philosophical or legal grounds, and therefore ignores important cognitive bias and sources of human behaviour.⁹⁷ A more complete vision of fairness is essential, as people are more likely to accept outcomes that they *perceive* as being fair.⁹⁸

Therefore, in the following section, I will discuss and compare the Ontarian and Québec approaches from the perspective of the voice they offer to patients, and the opportunity they provide for greater accountability and fairness from decision-makers. All these aspects impact on the overall objective of strengthening citizen/patient confidence in health care.

B. Analysis

The fact that Ontario mostly relies on a quasi-judicial institution as Québec does on an ombudsman with a patients' bill of rights in order to deal with access to care issues, provides for an interesting comparison between both provinces. Nevertheless, both models also share common pros and cons based on their similar combination of remedies. These pros and cons are often exacerbated depending on what remedies are emphasized in the particular province. In this analysis, I examine both approaches by mostly insisting on the advantages and inconveniences of quasi-judicial institutions, versus ombudsmen in health care, that is the Appeal Board and Health Ombudsman. This analysis ultimately leads to a set of recommendations in the conclusion of this paper.

i. The need for specialised institutions

When assessing the Ontario and Québec models, one can begin by wondering if there are great benefits in providing specialised institutions like the Appeal Board and the Health Ombudsman. Is health care such a particular sector that it requires various specialized institutions to deal with issues related to it, and more specifically, with issues related to access to care? As I will now discuss, there are undeniable advantages to providing patients with specialised institutions in health care. By creating a specialized Appeal Board in Ontario and a specialized Ombudsman in Québec, both provinces recognize this necessity. These institutions provide for more opportunity and flexibility than non specialized institutions — like the general courts, the ombudsman in Ontario or the TAQ in Québec — to address the needs and concerns of patients and, to that extent, the very reality of health care.

⁹⁷ Jeffrey J. Rachlinski, "The "New" Law and Psychology: A Reply to Critics, Skeptics, and Cautious Supporters" (2000) 85 Cornell L. Rev. 739.

⁹⁸ For example, Paul G. Chevigny, "Fairness and Participation: A Review of E. Alan Lind & Tom R. Tyler, *The Social Psychology of Procedural Justice*" (1989) 64 N.Y.U.L. Rev. 1211; Lynne L. Dallas, "Teaching Law and Socioeconomics" (2004) 41 San Diego L. Rev. 11 (the author refers to other work such as Raymond Paternoster *et al.*, "Do Fair Procedures Matter? The Effect of Procedural Justice on Spouse Assault" (1997) 31 Law & Soc'y Rev. 163, 167-71).

Most notably, the reality of health care calls for better taking into account of three critical elements: time, vulnerability and increased conflicts. Both the Appeal Board and the Health Ombudsman could still take better advantage of the potential their specialisation in the health sector offers to cope with these elements; nevertheless, overall, it is the latter, as a less contentious option, that is best equipped to do so.

First, time issues are central in health care; physicians and patients know this. Delays in obtaining certain care and treatment are an important source of stress for patients,⁹⁹ can influence chances of recovery and at worse can precipitate death. Review processes for access to care issues should take this aspect into account and provide patients, at a minimum, with rapid case review in emergency situations — when delays cause severe harm or disability. In addition, review processes should focus on consistently improving their efficiency. As for the Appeal Board, however, there is currently no emergency procedure and delays to examine appeals remain, in most cases, very long. Of particular concern for most Appeal Board cases, more rapid intervention would also help patients to fully assess their options to seek care elsewhere, for instance in the United States, since they would know in advance if the required care will be reimbursed or not. This is particularly important since fearful or angry patients typically ignore relevant information when making choices.¹⁰⁰ Thus, patients could be prompt in deciding to get care without further thinking about the costs they may encounter or the degree of efficacy of the considered treatment. As for the Ombudsman in Québec, although complaints that fall under this process are potentially less urgent than cases that fall under review by the Appeal Board, improving current delays should also be a priority. The many months a complaint review can take in some cases still remains quite long for patients hoping for a rapid correction of their problem and who must, in the interval, suffer the consequences thereof. Nevertheless, it remains that such a complaints process offers more opportunities to rapidly resolve patients' grievances than can a quasi-judicial institution and courts in general.

Second, concerning the vulnerability aspect, access to review mechanisms should consider that some individuals may be less capable of going through the process, whether because they are highly dependant on the health care system, or due to physical or mental challenges. Commissioner Romanow mentioned that special considerations for more disadvantaged groups are among the problems that have to be prioritized, or Canada risks seeing the erosion of the health care system.¹⁰¹ Whereas there are various assistance programs that can help vulnerable complainants in Québec (and a possibility for patients' associations to make a complaint on behalf of certain patients), support is much more limited for appellants

⁹⁹ I have previously mentioned that timely access to care remains of great concern for Canadians. A study of cancer patients in Ontario indicates that one in five Canadians experienced worry, stress, anxiety, pain, or diminished health as a result of waiting for care. Online: Statistics Canada <<http://www.statcan.ca/english/freepub/82-575-XIE/findings.htm>>.

¹⁰⁰ See Eric A. Posner, "Law and Emotions" (2001) 89 *Geo. L. J.* 1977.

¹⁰¹ *Supra* note 2.

before the Appeal Board. Surprisingly, one would have expected the Appeal Board to have been able to offer better services to appellants — notably when compared to the TAQ — due to its specialization in a defined sector. However, and as previously mentioned, there is little technical help for appellants in accessing all the information that could be relevant in preparing their cases. This may also be an enormous burden for those Ontarians residing far from Toronto who must apply directly to the Board to access previous Board decisions. Preparing an appeal can be very demanding — financially, physically and emotionally — as well as time consuming for patients; particularly if they are sick or otherwise limited.

On the other hand, whereas the Appeal Board may insufficiently acknowledge the needs of more vulnerable individuals in general, and should therefore adjust its functioning accordingly, certain dependent patients may forego complaints procedures altogether for fear of reprisals from their health care providers. Appeals to the Board may represent a lesser source of such concerns when compared to complaints to the Ombudsman. First, the public nature of the appeals process, due to greater scrutiny, offers patients an extra measure of protection. Also, the appeals concern decisions from the OHIP or RAMQ, which do not specifically implicate day-to-day care issues, and are thus further removed from the patient. Lastly, quasi-judicial institutions can make use of the legal remedies at their disposal to curtail any risk of harm to the appellants. As for Québec, complainants can be reluctant to criticize their immediate health care providers, for instance their physicians or their institutions, for fear of subsequent repercussions regarding their access to services. Although the Ombudsman of Québec has recently acquired greater means to intervene when he suspects any risk of reprisals, these means nonetheless remain limited and depend on the willingness to collaborate of various people in the health care sector. Thus, regarding his capacity to take into account the requirements of more vulnerable patients, the Health Ombudsman presents greater opportunities, even though he is arguably weaker than the Appeal Board dealing with the specific fear of reprisals.

Third, the new reality in health care involves a rise in the number of conflicts over the last few years, notably between health care providers and patients.¹⁰² This is in part due to the fact that more people are implicated at patients' "bedside", and patients are increasingly engaged and demanding with respect to the care they receive. Considering this constant augmentation of conflicts, access to appropriate conflict resolution mechanisms now appears as an essential component of the health care system. Quasi-judicial institutions remain limited in their capacity to deal with

¹⁰² See, for instance, the Canadian Medical Protective Association (CMPA) annual reports from 1978. Between 1978 and 1985, the number of medical malpractice cases has increased threefold. Available on the CMPA website: www.cmpa-acpm.ca. This phenomenon seems to be of international concern. In France, complaints related to medical practice has increased by 62% over the years, see M. Dupuy-Dauby *et al.*, *Problèmes assurantiels — responsabilité juridique au quotidien*, Institut national de la santé et de la recherche médicale, online at: www.inserm.fr/ethique/cours.nsf/0/f769a29c4ba93677c12568a10048639c?OpenDocument (date accessed: 4 August 2003).

this increase in the number and variety of conflicts. There is a need for effective complaints mechanisms capable of dealing with day-to-day service delivery issues and a need for a broader role of conflict management. For instance, a non-contentious mechanism of complaints can significantly contribute to improve communication between health care providers and patients. Since lack of communication represents one of the principle elements of discontent of patients,¹⁰³ more effective communication may greatly improve overall patient satisfaction towards health care. Therefore, non-adversarial, specialized mechanisms, such as the Ombudsman in Québec, provide an important tool in the resolution of a vast range of health care related issues.

Having specialized institutions in health care also has the advantage of providing a higher degree of expertise in the review process. The expertise is particularly present on the Appeal Board and arguably more important for this institution since it has real decision-making powers. Members of the Appeal Board are selected among specific categories of professionals and exclusively hear appeals regarding access to health care. Such expertise represents a significant advantage when compared to the general courts and more general quasi-judicial tribunals. The members are more knowledgeable in the relevant sector and develop decision-making competence that can also help to reduce the cognitive bias in judgment.¹⁰⁴ For instance, seeing a problem as “one of a general type” provides for more perspective.¹⁰⁵ That generally leads to less reliance on misleading thoughts¹⁰⁶ and enhances accurate decision-making.¹⁰⁷ By having more comparatives to refer to, the members of the Appeal Board could be less impressed and influenced by certain arguments than would be other general judicial institutions; for instance, they could be less influenced by financial (such as treatment and impacts on a government’s budget) or statistical arguments (including chance of success or failure of certain therapies). Experts may also be less inclined to overestimate risks than would lay people,¹⁰⁸ which is useful in decisions related to access to health care issues where risks represent an important consideration.

Relying too much on expertise may, nonetheless, present certain disadvantages that also need to be addressed. The disadvantages mostly apply to the Appeal Board and plead in favour of combining the Appeal Board with a stronger

¹⁰³ See *supra* note 94.

¹⁰⁴ Rachlinski, *supra* note 3. As an example of such cognitive bias, there is the “framing effect”: depending on whether a treatment option is described in terms of mortality or survival, one’s preference for treating, or not, can change: See Amos Tversky & Daniel Kahneman, *Choices, Values and Frames*, (Cambridge: Cambridge University Press, 2000) at 10. Experience and knowledge about such cases as well as about the prevalence of such bias in judgment — which can be more reasonably expected or required from decision-makers working in more specific area of practice — can help to improve decision-making.

¹⁰⁵ Rachlinski, *supra* note 97.

¹⁰⁶ For instance, the “framing effect” indicates that a way a problem is framed can influenced people’s decisions.

¹⁰⁷ Rachlinski & Farina, *supra* note 3 at para.559.

¹⁰⁸ *Ibid.*

Ombudsman Institute. The Appeal Board principally relies on legal and medical expertise. Indeed, most members of the Board are lawyers and medical evidence is a central element of consideration in the Board's decisions. Such a concentration of expertise may lead to an over-representation of the legal and scientific norms. This can have the advantage of reducing the complexity of conflicts since they are only approached on the basis of their legal and scientific components¹⁰⁹; however, ignoring complexity can also lead to overly simplistic analysis.¹¹⁰ The specificity of access to care conflicts is much more complex and includes an interaction of deontological, personal, administrative, religious and ethical norms.¹¹¹ In addition, strong reliance on medical expertise fails to fully address the fallibility of the medical judgment.¹¹² This question is even more significant since, as was previously mentioned, physicians considerably influence every level of access to care decisions in Ontario, including the appeal level. In order to better account for the various norms involved in health care, the Appeal Board could probably increase the variety of its members *and* its flexibility. For instance, more managers could increase efficiency considerations, more nurses could better acknowledge the human aspects related to care, and more general public representatives could better take into account a various range of values present in the public at large. Nevertheless, judicial institutions aim to create precedents and societal guidelines and remain, to a certain extent, limited in dealing with the more complex reality of health care.¹¹³ Adding a complaints process in health care, like the one in Québec, is a great opportunity to explore a broader range of norms and to tailor processes and possible available outcomes — for instance apologies¹¹⁴ or changes in certain institutional practices — that are better adapted to the actual needs of patients.¹¹⁵

Similarly, relying on the Appeal Board to review most decisions in access to health care matters leaves people mainly dependant on an elite, that is, legal experts and physicians.¹¹⁶ All in all, this can constitute a barrier to a broader collective goal of citizen participation and advocates for a more comprehensive range of means

¹⁰⁹ See A.-J., dir., *Dictionnaire encyclopedique de theorie et de sociologie du droit*, 2e ed. (Paris: 1993).

¹¹⁰ *Supra* note 97.

¹¹¹ For a more extensive discussion on the components of each norm and their interactions in health care, see Guy Durand, *Introduction générale à la bioéthique; histoire, concepts et outils* (Saint-Laurent, Québec: Fides, 1999).

¹¹² Donald A. Redelmeier *et al.*, "Problems for Clinical Judgement: Introducing Cognitive Psychology as One More Basic Science" (2001) 164 *Canadian Medical Association Journal* 358. This is also why physicians have an obligation of means and not of results.

¹¹³ See *B(N) c. Hôtel Dieu de Québec*, [1992] R.J.Q 361 (C.S.); *In re Jobes*, 108 N.J. 394, 529 (1987).

¹¹⁴ Receiving apologies consists of one of the most important needs of patients in conflicting situations. See Charles, *supra* note 94; Catherine Régis & Jean Poitras, "The Legal and Psychological Aspects of Apologies in Medical Mediation" (2003) 1 R.P.R.D. 51. See also Régis, *supra* note 95; *infra* note 136.

¹¹⁵ Professor Lalonde mentions that the potential to consider more norms in the resolution process is one of the most promising aspects offered by alternative dispute resolution mechanisms. See Louise Lalonde, "Les modes de PRD: vers une nouvelle conception de la justice?", 1 (2003) R.P.R.D. 17. See also Régis, *supra* note 95.

¹¹⁶ See Robert Howse, "Retrenchment, Reform or Revolution? The Shift to Incentives and the Future of Regulatory State" (1993) 31 *Alta. L. Rev.* 455.

that encourages the public to have a more direct role in policy and delivery programs.¹¹⁷

ii. Accountability

The appeal/complaints mechanisms available in Ontario and Québec all lead, in various degrees, to more accountability from decision-makers in health care. Both the tribunal and the ombudsman pressure decision-makers into justifying their decisions, an important element towards providing more responsive decisions. Due to its formal procedural aspects, the tribunal is, nonetheless, the only one capable of imposing an actual obligation on decision-makers; the ombudsman counting more on voluntary compliance from decision-makers to justify their decisions. The duty to justify also applies to the tribunal and the ombudsman themselves, as both must present motivated decisions to patients.¹¹⁸

Furthermore, the fact that the tribunal and the ombudsman provide for external and independent review of access to care grievances has great potential to encourage, overall, better decisions from the health care system decision-makers. Indeed, knowing in advance that they may have to provide justification for their decisions, decision-makers, such as the OHIP, the RAMQ, or hospital administrators, tend to articulate factors more relevant to their decisions, assess alternative courses of action and offer meaningful comments.¹¹⁹ However, between the Appeal Board and the Ombudsman, it is the former, as a judicial instance, that has a greater potential for such 'review impact'. As mentioned throughout this paper, the Appeal Board has the power to enforce its decisions and furthermore, benefits from the additional credibility afforded to judicial institutions, thus creating further apprehension from decision-makers to see their decisions reviewed or overturned. Nonetheless, despite this greater potential for 'review impact', the limited number and restricted scope of the decisions that the Board ultimately reviews may ultimately limit the intended impact. For the Ombudsman in Québec, who has the potential to review a greater number of decisions, his influence is lessened by the moral nature of his powers. Considering these current limits in both mechanisms that reduce their potential for fully improving the overall decision-making process in health care, a strong argument can be made for improving access to the Appeal Board as well as strengthening guarantees of independence — and the credibility of — the Health Ombudsman. Ultimately, a solid combination of these means could be a key factor in improving the review impact, thus augmenting accountability in both provinces.

¹¹⁷ *Ibid.*

¹¹⁸ The obligation to provide a motivated response is mentioned in the *Health Services Act*, *supra* note 67.

¹¹⁹ Professor Rachlinski mentions that such a review process reduces cognitive bias that decision-makers can have and enhances the rationality of the regulatory process. See Jeffrey J. Rachlinski & Cynthia R. Farina, "Foreword: Post-Public Choice?" (2002) 87 *Cornell L. Rev.* 267.

There are, however, generally more obstacles in the Ontario model for enhancing accountability in health care. This is notably due to the fact that the Appeal Board's jurisdiction is restricted to only certain decision-makers that influence patients' access to care. Whereas the Ombudsman in Québec can oversee all levels of service delivery — physicians, administrators, public institutions and the government — the Appeal Board mainly has jurisdiction over decisions from the OHIP.¹²⁰ The Ontario Ombudsman is also significantly limited in that respect since he only has jurisdiction over governmental institutions, excluding all health care professionals. Consequently, a whole range of decisions-makers that can have a significant and more regular impact on patients' access to health care are not subject to overview by either the Appeal Board or the Ontario Ombudsman. This consequently leaves Ontarians with only the more traditional institutions to rely on (e.g. the government and courts) for most of their access to care issues. Such a situation is among the crucial reasons to advocate for the implementation of another recourse in Ontario, which will make more people directly involved in patients' access to care, accountable.

Another consequence of the limited jurisdiction of the Appeal Board is, on a larger scale, a limited capacity to influence the macro policy level, and thus, the public's demands for more legitimate and effective health care policy decisions. In addition to the jurisdictional issue, there are also other factors that limit the Appeal Board's potential to influence policies. Most notably, the quasi-judicial institution provides review on a case-by-case basis, mostly functioning via a fact-finding procedure (as opposed to an evaluation of rationale, the "why" of laws and policies), and does not make any recommendations to government authorities. Besides, as I have discussed, the decisions of the Appeal Board are not easily accessible, which makes it difficult for anyone who wants to review them and utilise them to provide input in order to bring about policy changes. Thus, if there is no doubt that input from patients with respect to their health care concerns should be further encouraged — with the broader objective of strengthening citizens' participation in the health care system — quasi-judicial tribunals do not represent, based on their mandate, the best means to achieve such a goal. To the extent that the government wishes to encourage patient input in health care, the ombudsman institutions arguably represent a more appropriate means than quasi-judicial tribunals. In Québec, the Ombudsman specifically has the mandate to provide the health minister with recommendations regarding the improvement of health care and services. The Ombudsman is also charged with collecting public data, which provides valuable information concerning patients' satisfaction with the system and highlights certain of its specific problems.¹²¹ As a consequence, predominantly focussing on a quasi-judicial tribunal to address access to care issues, as in Ontario, considerably diminishes the potential for patient input in health care.

¹²⁰ *Supra* note 21.

¹²¹ For instance, in his last annual report, the Québec Ombudsman indicates increased public concern regarding access to specialized services and delays in access.

The Ontario model also fails to take into account quality issues in health care to the same extent than in Québec. Quality issues are a significant element in patients' overall satisfaction towards health care and, as previously mentioned, are insufficiently acknowledged by many decision-makers. Indeed, the Québec Ombudsman offers an opportunity for patients to express their concerns and seek solutions regarding a wide array of issues related to access to care. For instance, patients can complain about waiting lists, problematic institutional cost-containing practices, and dehumanising behaviour from institution personnel. On the other hand, the Appeal Board's jurisdiction is restricted to adhere to the requirements of the law relating to questions of funding and leaves its members with little liberty in the kinds of arguments they can hear or base their decisions on. For instance, the Appeal Board expressly mentions to appellants its incapacity to examine compassionate-based arguments. But to what extent is it acceptable to eliminate compassionate considerations — notably for cost-containment practices, whether admitted or not — in all decision-making processes in health care? As life and health are, as Descartes so aptly put it, the “chiefs among all goods,”¹²² it would arguably advocate in favour of providing greater consideration of patients' needs and concerns. Whereas a quasi-judicial tribunal might not be the adequate forum in which to address such concerns due to the role of judicial institutions — that is, a mix of providing legal redress and social guidelines — this deficiency in the Ontario model is one of the most compelling arguments for implementing a stronger ombudsman in the Ontario health care system.

That being said, and although many factors advocate for the use of a stronger ombudsman in Ontario, it can be argued that at the opposite range of the spectrum, overly relying on an Ombudsman to resolve access to health care issues can leave patients with insufficient means to enforce decisions in health care. Governments can underestimate the necessity to also improve access to quasi-judicial options, such as the Board and the TAQ. As previously mentioned, the Québec or Ontario ombudsmen do not have powers to impose the execution of their recommendations. In specific cases, patients should also have access to enforceable mechanisms, especially when their problems involve significant financial repercussions, since such issues will typically bring about greater resistance from providers.

Finally, the Québec experience also contributes to greater accountability from decisions-makers via the existence of a patients' bill of rights. Indeed, while one of the most important benefits of the Québec Bill is the complaints process it creates, it also provides for positive rights for patients in the health care system. Rights are a key mechanism in regulating the relationship between the government, its institutions and its citizens.¹²³ It thus creates a better balance between the government's wish to control costs and the patients' desire to receive appropriate

¹²² Cited in Ronald Dworkin in *Sovereign Virtue: The Theory and Practice of Equality* (Cambridge: Harvard University Press, 2000).

¹²³ Donna Greschner, “Public Law in the Romanow Report” (2003) 66 Sask. L. Rev. 565.

care.¹²⁴ Therefore, a patients' bill not only has an important symbolic value, but would also serve to reconcile concurrent interests in health care, among which those of the patients are often underrepresented. Such a bill can also address quality issues in health care¹²⁵ and the interests of the majority as well as those of minorities among patient groups. Since the majority of citizens are often less organized than the groups of patients with specific characteristics and/or ailments (cancer patients, the elderly, etc.), a patients' bill of rights is a valuable means to embody a more comprehensive range of interests in health care.

Moreover, and as odd as it may at first seem, a patients' bill of rights also stands as an adequate response to the lack of concern most people demonstrate towards issues that are covered by a patients' bill of rights. Although everyone is an eventual patient, cognitive illusions lead people to be overly optimistic and underestimate their future health care and service needs.¹²⁶ Therefore, the government should take precautionary measures on behalf of patients, present and future, since most only realise the importance of a patients' bill of rights when they are in need and potentially in a more vulnerable state.

The current resistance from the government of Ontario to implement a patients' bill of rights — and a corresponding complaints process — may be explained by various factors. Compared to the United States, where patients' bill of rights have represented an easy way for governments to respond to consumer concerns about the quality of health care at almost no political or financial cost,¹²⁷ the latter costs are potentially more of a concern for Canadian provincial governments. The rise in costs that may result from increased demand of quality services, pressure for institutional policy changes and the administrative costs related to a complaints process, directly impact governmental budgets. That said, there is no evidence that such a bill has affected the Québec government's health care budget. Notwithstanding the foregoing, a bill of rights is certainly of political value since "no government really wants to be on record for opposing a bill of rights".¹²⁸ This is particularly true as a vast majority of Canadians are in favour of the implementation of such a bill.¹²⁹ With respect to the overall objective of strengthening the

¹²⁴ See Richard Soriano & Judith Feder, "Why Do We Need a Patients' Bill of Rights?" (1999) 24 J. Health Pol. 1137.

¹²⁵ See the section of this paper on the Ombudsman in Québec.

¹²⁶ Rachlinski states that this cognitive illusion on judgment supports a claim for paternalistic intervention of the State. See *supra* note 97.

¹²⁷ The cost increase is being shifted on the HMOs, which assume the delivery of the majority of health care services in the United States. See David A. Hyman, "Regulating Managed Care: What's Wrong with a Patient Bill of Rights" (2000) 73 S. Cal. L. Rev. 221.

¹²⁸ *Ibid.*

¹²⁹ IBM Business Consulting Services, "HealthInsider" (Survey, Toronto, Fall/Winter 2002). Still, opposing a patients' bill of rights arguably remains less "dangerous" than opposing some of the medical community's interests. Physicians remain extremely powerful in our political system. See for example Geoffrey R. Weller & Pran Manga, "The Development of Health Policy in Canada" in Michael M. Atkinson & Martha A. Chandler, eds., *The Politics of Canadian Public Policy* (Toronto: University of Toronto Press, 1983) at 223.

public's confidence in health care, the benefits of providing a patients' bill of rights and an adequate complaints process greatly outweigh the potential costs that they may generate. Such regulation strategy would, without a doubt, result in improving the condition of patients in Ontario.

iii. Fairness

I now turn to examine the Ontario and Québec models as considered in light of another important element, the requirement for fairness. Fairness includes three key aspects: the possibility for patients to be heard, impartial consideration of patients' grievances, and control over the process.

Firstly, patients should have an opportunity to be heard. But more than simply being heard, fairness requires that patients are offered a real opportunity to have their argument weighed¹³⁰ and therefore, to have an actual possibility of influencing the review process. The Appeal Board and the TAQ, as quasi-judicial tribunals, respect due process requirements and offer a formal setting in which patients can present their arguments. On the other hand, although both the Québec and Ontario Ombudsmen allow complainants to present their observations during the process, they lack any formal audition process.¹³¹ Hence, quasi-judicial tribunals appear to offer greater prospects for a fair audit of patients' grievances; nonetheless, concerning the Appeal Board, given the imbalance of means between the OHIP and appellants, one wonders if equal weight can be given to their respective arguments.¹³² As previously mentioned, it remains difficult for patients to adequately prepare their case. In addition, the burden of proof is heavy for patients who have to find medical expertise and fulfill the "medical necessity" or "practice acceptance" requirement,¹³³ which based on the documented success rates, appears very difficult for patients to attain.¹³⁴ Compounded to the fact that patients are usually self-represented and that the OHIP is familiar with the Appeal Board's procedures and requirements, a strong argument can be made for the Appeal Board to reduce the clash of means between parties by providing greater assistance to patients in order to prepare their cases. Such an initiative would better secure the possibility for patients to be heard and exert true influence within the review process, thus enhancing the benefit that a quasi-judicial institution provides with that component of fairness.

¹³⁰ *Supra* note 98 at 6.

¹³¹ In Québec, the Law mentions that users and the organisation or institution concerned by the complaint must have an opportunity to present their observations at every level of the complaints process. The Law does not mention if that includes the right to an audition, but the general precepts of Administrative Law would generally answer that question negatively. See Jean Louise Baudouin & Patrick A. Molinari, *Services de santé et services sociaux*, 12^e ed. (Montréal, Wilson et Lafleur, 2002) Section 32 at 78; Yves Ouellette, *Les tribunaux administratifs du Canada — Preuve et procédure*, (Montréal, Éditions Thémis, 1997) 150 and subsequents.

¹³² The same comment could be made with the TAQ, but since this analysis focuses on the main remedy in both provinces, I discuss the situation of the Appeal Board.

¹³³ See the section of this paper on the Appeal Board.

¹³⁴ *Ibid.*

However, even if the requirement for a "fair hearing" can be better assured by a quasi-judicial institution, this may not be an adequate basis for establishing a comparison between the Appeal Board and the complaints process in Québec. Both mechanisms are based on different underlying principles: the quasi-judicial tribunal's logic is rights-based, therefore strongly argumentative, while the complaints process under the auspices of the Health Ombudsman is interest-based, thus more conciliatory.¹³⁵ Consequently, the usefulness of "weighing" arguments is noticeably reduced in the Québec complaints process, in which the focus is not on finding who is right or wrong, but rather on finding solutions that best respond to the parties' interests or needs. In that sense, this particular requirement for fairness is less appropriate or less necessary considering the objective of the complaints process in Québec.

Secondly, fairness also requires the opportunity for impartial consideration of patients' appeals and complaints. Based on a study heralding from the United Kingdom, impartial assessment represents an important need of complainants.¹³⁶ Quasi-judicial tribunals clearly present greater guarantees of impartiality than do ombudsmen. Judicial institutions hold the right to an impartial audition as a fundamental requirement.¹³⁷ People also perceive the adjudicatory procedures as being fairer due to the formalism of a tribunal.¹³⁸ The lesser guarantees of impartiality from ombudsman institutions therefore leave their processes more vulnerable to perceptions of unfairness on behalf of citizens, which can result in their reluctance to avail themselves of such an option.¹³⁹ As a consideration for both Ontario and Québec, the foregoing fairness requirement thus confirms the importance of maintaining and enhancing access to judicial institutions for citizens and, again, strongly pleads in favour of taking active measures to strengthen the independency of ombudsmen from the government.

Thirdly, another dimension to the fairness requirement lies in control over the process. Arguably, the adversarial process characteristic of a quasi-judicial

¹³⁵ The Law specifically mentions that "interests" focus many times. For instance, the examiner physicians has to "conciliate parties' interests", *supra* note 67 at s. 47. For an interesting discussion of the difference between rights-based and interest-based conflicts resolution mechanisms and their impact, see William L. Ury, *Getting Disputes Resolved: Designing Systems to Cut the Costs of Conflict* (San Francisco: Jossey-Bass Publishers, 1988).

¹³⁶ See the study conducted by John Elder, *Who Cares About the Health Victim?* (Chepstow: Klaxon Books, 1998).

¹³⁷ Even though quasi-judicial tribunals present less guarantees than regular courts with respect to "impartiality".

¹³⁸ See the results of a study in *supra* note 136 at 46; see also *supra* note 98. Even though quasi-judicial institutions are less formal than general courts, they still remain much more formal than the ombudsman.

¹³⁹ See *supra* note 136 and Québec Ombudsman section of this paper. While the Ombudsman of Québec provides for great potential, it nevertheless remains underutilized. See Commissaire aux plaintes, *Rapport de la tournée des régions (1998-1999) de la Commissaire aux plaintes*. (Montreal: Commissaire aux plaintes en matière de santé et de services sociaux, 1999). This is partly due to a lack of confidence in the institution, especially at the first level, and a lack of knowledge about the very existence of the Ombudsman and the complaints process in general.

tribunal induces greater control of patients over the process. The authors Thibault and Walker present evidence that procedural fairness, in the sense of process-control by the parties, directly impacts individuals' satisfaction regarding the performance of institutions and in the acceptance of their decisions.¹⁴⁰ When before a tribunal, patients are able to decide on the arguments they want to submit and how to present them. In comparison, the complaints process associated with ombudsman institutions are more of an inquisitional nature, whereby parties are asked to answer questions. However, the illusion of process control can be greater with the Appeal Board when, in fact, little liberty is granted to the Board on how to decide and the solutions it can offer are limited.¹⁴¹ An adequate combination of grievance procedures, with the greater *choice* it would offer, represents an option to increase patient control over processes.¹⁴² As a result, combining the Appeal Board with a health care ombudsman would necessarily improve overall patient control and confer Ontarians a greater opportunity for fairness in their health care system.

V. Conclusion: Recommendations

Both a specialised quasi-judicial institution, like the Appeal Board, and the institution of an ombudsman, like the Ombudsman in Québec, contribute in various degrees to better address specific concerns of citizens/patients, and make the system more accountable and fair. It is nevertheless a combination of a patients' bill of rights and a strong Ombudsman in health care with a quasi-judicial institution, e.g. the Québec model, that better enhances these benefits and therefore better contributes to strengthen citizens' confidence in health care.

To predominantly rely on the Appeal Board for most decisions in access to care remains a limited option in various aspects. First, the appeal process is not adequately adapted to the reality of care. Second, the Appeal Board has a very narrow jurisdiction that restricts many levels of decision-makers that influence access to care for patients from its overview. Third, there are several objects of complaint most notably related to the quality aspect of care and broader policy concerns that cannot be addressed by the Appeal Board. In sum, there are strong arguments for the implementation in Ontario of another institution similar to the Ombudsman in Québec to better compensate for these inherent limitations that the Appeal Board presents.

As for more specific recommendations that should apply to each province, I have mentioned throughout my analysis that the Appeal Board needs to improve its accessibility to patients and that the health ombudsman needs to stay a fully independent, credible institution. For the Appeal Board, this notably requires better assisting and providing information to appellants. For the Health Ombudsman, this

¹⁴⁰ Mentioned in *supra* note 98.

¹⁴¹ *Ibid.* at 6.

¹⁴² Chevigny mentions that higher choice of procedures lead to higher process control, *ibid.* at 3.

means ensuring the independence of the organization from the government at all times.

All in all, this paper highlights the need to provide patients/citizens with adequate means to express their concerns in health care. Whereas the focus herein is on the Ontario and Québec experience, every Canadian should be able to have access to adequate complaints/appeals mechanisms when facing access to care issues. Let us hope that our deciders will judge the objective of strengthening Canadians' confidence in health care of great enough significance to work towards such a goal.

