Mapping Legislative Accountabilities

by

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Executive Summary

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Executive Summary

The primary purpose of this paper is to provide an overview of the types of accountabilities enshrined in provincial, territorial and federal legislation related to health. The paper focuses primarily on provincial and territorial legislation, given that the key responsibilities within the health care system rest with the provinces. Due to time and resource constraints, it does not cover the myriad of regulations that accompany such legislation and which could provide a more nuanced picture of accountability. The paper is designed to map how we frame accountability relationships within the health care system rather than to give detailed descriptions of how those relations may be operationalized. In short, it looks at 'who is responsible for what' rather than detailing how they do it.

Methodology

The paper looks at legislation that pertains to the health care system generally – statutes governing regulated health professions, health departments, health facilities, public health, and regional health authorities. With respect to health care providers. We have chosen physicians as a representative sample, on the basis that they would be as likely as, if not more likely than other health care professionals to be held accountable for the health and safety of the public. Even with this narrowed focus, the paper covers a review of over one hundred statutes as reflected in the attached tables.

It categorizes the key accountability activities of key players within the health care system (within the limits described above and represents them in a matrix form.[1] The idea was to sketch a map of where accountabilities currently lie, and where clear gaps may be identified. For the purposes of the paper the key players considered are:

- government;
- government agencies and commissions;
- regional health authorities;
- professional colleges (that is, the regulatory bodies for each health profession);
- facilities (predominantly public and private hospitals, psychiatric facilities, nursing homes and long-tem care facilities); and
- providers (that is, individual health care providers).

With respect to each player, the paper considers the types of accountability activities for which they are responsible in legislative terms. These legislative responsibilities are divided into four broad categories:

- standards;
- resources;
- public engagement and responsiveness; and
- quality and evaluation.

[1] A copy of the matrix is included as Appendix A.

Findings

Responsibility for establishing **standards** in the health care system lies primarily with provincial ministers and departments of health, in conjunction with specialized government agencies. Regional health authorities have an important role to play in helping to develop and especially to implement their respective government's priorities and objectives. Professional colleges play a significant role in setting standards of practice and standards of ethical conduct for those health care providers in regulated professions. Those who operate health care facilities also play a role in establishing and upholding the operational and professional standards in their institutions.

Only health ministers and regional health authorities have significant authority over financial **resources**. The specific appropriation of financial resources is one not ordinarily addressed in legislation. As for human resources, there is little in the way of legislative accountability for any of the main actors identified. This may mean that issues of human resource planning are dealt with at the level of policy, or administration. It may, however, signal a lack of focus on strategic planning in the area of health human resources.

Public engagement and responsiveness is also an area which few legislative provisions address. In this domain, professional colleges appear to rank highest in terms of providing for public representation in decision-making, transparency, and complaint mechanisms. Regional health authorities also rate reasonably well in terms of statutory attention to public representation, public participation and transparency.

Finally, in the area of **quality and evaluation**, the government takes the lead in all aspects: monitoring quality, providing information, and sponsoring research. Government agencies and professional colleges also have a significant monitoring function, while regional health authorities are a significant source of information for the public.

A review of statutory provisions without reference to their accompanying regulations does not provide a complete picture of legislative accountability. It can however provide a rough measure of the types of accountability on which governments are most focused, and it can provide a good indication of the parties primarily responsible for such accountability.

The requirements for effective accountability were defined in an earlier paper in this series as: clarity of purpose, clarity of responsibilities, appropriate resources, and evaluation and feedback. Accountability to the public for health care and for the proper functioning of the health care system is distributed, though unevenly, among all the main actors identified.

What does this unevenness reveal? In very broad terms, one can say that governments and their agencies are primarily concerned with setting standards and monitoring them. They seem to be less occupied with engaging the public and responding to the concerns of the public whether expressed individually or collectively. Professional colleges afford the individual opportunities to express dissatisfaction with services they have received from a health care provider. The current system of accountability offers few parallel

structures for members of the public to express, individually or collectively, their dissatisfaction with access to or the quality of services provided by the health care system.

The legislation surveyed relies heavily on a model of accountability that, in its emphasis on licensing and inspection, runs predominantly between the government (directly or indirectly) and the service provider or facility operator. The power to enforce standards may be exercised in the public interest, but it does not provide much room for direct accountability to or direct engagement by members of the public.

In the end, health care is a public trust, and the ultimate responsibility for assuring the quality of those who deliver it lies appropriately in the hands of public officials. By the same token however, no one has a greater interest in or more direct knowledge of the quality of health care services than the members of the public who receive them. Providing more direct avenues for accountability to the public in legislation would send a strong message that government understands to whom it is answerable. A more direct relationship between government and the public could also provide the feedback that government needs to clarify the appropriate purpose, responsibilities and resources for an effective health care system.