THE ACCOUNTABILITY CHALLENGE IN HEALTH CARE: THE CONTRIBUTION OF A HEALTH OMBUDSMAN

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RÉSUMÉ

Les Canadiens se préoccupent grandement de la valeur de l'imputabilité (« accountability ») dans la gestion du système de santé. Cette valeur met en exergue l'importance des processus décisionnels – soit comment les décisions sont prises et par qui – et requiert un haut degré de transparence au sein de ces processus. Dans cet article, l'auteur explore le rôle et la capacité d'un ombudsman ayant une mission spécifique dans le secteur de la santé de favoriser l'atteinte d'objectifs d'imputabilité à trois niveaux décisionnels dans le système de santé : 1) politique, 2) managérial et 3) professionnel. L'analyse proposée est basée essentiellement sur l'expérience québécoise, ce modèle offrant l'exemple le plus distinctif d'un ombudsman santé à travers le Canada. En effet, le Protecteur du citoyen du Québec chapeaute un vaste régime de plaintes en deux étapes dans le secteur de la santé et des services sociaux. L'auteur conclut que ce type d'ombudsman offre un potentiel intéressant d'améliorer l'imputabilité aux trois niveaux. Contrairement aux tribunaux, les forces spécifiques de l'ombudsman sont d'offrir une flexibilité quant aux motifs d'intervention et de recommandation dans ce secteur, au surplus d'être aisément accessible aux citoyens. Avec le processus de plaintes qu'ils offrent, les ombudsmans permettent aux patients d'exprimer leurs doléances – leur « voix » – aux décideurs publics, aux administrateurs et aux professionnels de santé. Ainsi, les ombudsmans contribuent à la mise en œuvre des droits des patients et à la définition d'expectatives claires des citoyens envers leur système.

SUMMARY

Canadians are very concerned about accountability and rank this value among their top priorities. The value of accountability speaks to how decisions are actually made and by whom, and to the importance of decision-making processes, and calls for transparency in decision-making. In this article, the author explores the role and capacity of a health ombudsman institution to increase accountability in health care on three levels: 1) political, 2) managerial and 3) professional. The analysis is predominantly based on the Quebec experience as it offers the most distinctive illustration of this type of institution in Canada; the ombudsman in Quebec (*Protecteur du citoyen*) oversees a two-step complaint process in the health care and services network. The author concludes that ombudsman institutions, such as the one in Quebec, offer an interesting, yet not fully realized potential, to enhance accountability on all three levels. Their strengths are that, compared to courts, they have a flexible scope of intervention and discretion in their decision-making and remain accessible to citizens. With the complaint process they provide, they enable patients to voice concerns to policy makers, managers and professionals, and contribute – with varying degrees of success – to the effective exercise of patients' rights as well as to the definition of clear expectations towards healthcare.

INTRODUCTION

Canadians care greatly about accountability and rank such a value among their top priorities.[1] Arguably concomitant with the growing presence of economic discourse, declining trust in government and professional authority,[2] as well as a greater call for citizen and court involvement,[3] further accountability from decision-makers has been recommended by a number of high profile commissions as a key objective of reform in health care.[4] Some authors consider accountability to now

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1. See, for example, J. Abelson & F.-P. Gauvin, *Transparency, Trust and Citizen Engagement – What Canadians Are Saying About Accountability* (Ottawa: Canadian Policy Research Networks, 2004) [Abelson & Gauvin, *Transparency*] (based on four dialogue experiments involving over 1,600 Canadians). Although such experiments did not specifically focus on accountability, the importance of such a value nevertheless came up; the *Romanow Report* clearly points out this fact: Roy J. Romanow QC, Commissioner, *Building on Values: The Future of Health Care in Canada* (November 2002) [*Romanow Report*]; see also Susan V. Zimmerman, *Mapping Legislative Accountabilities* (Ottawa: Canadian Policy Research Networks, 2005).
2. See Abelson & Gauvin, *Transparency*, *supra* note 1, on the increasing lack of trust in governing institutions. R. Rowe & M. Calnan, "Trust relations in health care – the new agenda" (2006) 16:1 *European Journal of Public Health* 4. On the decreasing trust and confidence in representative democracy and traditional politic institutions, see [Nevitte 1996 and Ekos 1996]. Cited in discussion paper (Romanow) no. 7 at 3. The Gomery commission also emphasized the need for more accountability in public administration: John Gomery, Gomery Commission Report, Phase II (Ottawa: Gomery Commission, 2006) at Part 4.
3. For the link between citizen involvement and accountability, see, for example, C. Fooks & L. Maslove, *Rhetoric, Fallacy of Dream? Examining the Accountability of Canadian Health Care to Citizens* (Ottawa: Canadian Policy Research Networks, 2004).
4. For an extensive review of all commissions and other works that underline the importance of accountability in health care, see *supra* note 1. See also Abelson & Gauvin, *Engaging Citizens: One Route to Health Care Accountability* (Ottawa: Canadian Policy Research Networks, April 2004) at 3 [Abelson & Gauvin, *Engaging Citizens*]. To name only a few, see the following documents: *Romanow Report*, *supra* note 1; Canada, Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians–The Federal Role* (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2001) [*Kirby Report*]; Quebec, Ministry of Health and Social Services, *Emerging Solutions: Report and Recommendations* (Quebec City: Commission of the Study of Health and Social Services, 2001); Kenneth J Fyke, Commissioner,

be part of a new social contract, one which shapes Canadians' expectations regarding their Medicare system, as well as the governmental apparatus in general.[5] Nevertheless, despite the need for and acknowledgement of such a value, principles of accountability are still poorly reflected in health care systems across Canada (for practical, political and economical reasons).[6]

The emergence of accountability as a value/objective in health-related matters has had the advantage of encouraging a further exploration of the roles, responsibilities, and interactions of various actors in the Medicare system. The value of accountability speaks to how decisions are actually made and by whom, to the importance of decision-making processes – in this way, it shares a similar concern with procedural justice, yet with a different rationale, scope of reach, and goal – and calls for transparency in decision-making. It seeks to improve accountability relationships between health care providers and patients, health care managers and governments, and between citizens and governments (or public institutions).

Accountability is arguably important to ensuring the financial sustainability of the Medicare system. Abelson and Gauvin's work underlines that Canadians want information on where their money is going and how decisions in health care are actually made.[7] Until they have more evidence of effective management, which they currently doubt, Canadians will remain disinclined to support further public expen-

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Caring for Medicare – Sustaining a Quality System (Saskatchewan: Saskatchewan, April 2001) [*Fyke Report*]; Claude Castonguay, Joanne Marcotte & Michel Venne, *Report of the Task Force on the Funding of the Health System. Getting our Money's Worth* (Quebec City: Quebec, February 2008) [*Castonguay Report*]. Abelson and Gauvin, "Transparency", supra note 1, clearly put forward the link between people's need for more trust in health care and the call for accountability.

5. See *supra* note 3; M.P. MacKinnon, *Citizens Dialogue on Canada's Future: A 21st Century Social Contract* (Ottawa: Canadian Policy Research Networks, 2003).
6. See C.M. Flood, D. Sinclair & J. Erdman, "Steering and Rowing in Health Care: The Devolution Option?" (2004) 30 *Queen's L.J.* 156; Health Council of Canada, *Rekindling Reform: Health Care Renewal in Canada, 2003-2008* (Toronto: Health Council of Canada, 2008); M. Jackman, "Charter Review as a Health Care Accountability Mechanism in Canada" (2010) *Health L.J.* 18. There the increased concern for governance models which include more accountability is undeniable. See, for example, the interesting comments in R.H. Desmarteau & M. Nadeau, "La gouvernance dans les établissements sociosanitaires du Québec: diagnostic et prescription." In Le Point en Administration de la santé et des services sociaux, vol.4, no 4, p. 4; W. Lahey, "New Governance Regulation and Managerial Accountability for Performance in Canada's Health Care Systems" in R.P. Kouri & C. Régis, ed., *Grand Challenges in Health Law and Policy*, Cowansville, Éditions Yvon Blais, 2010.
7. Abelson & Gauvin, *Transparency*, *supra* note 1.

ditures in health care.[8] In other words, if governing institutions want to convince Canadians to continue funding Medicare or to invest more money in health care, they will need to prove their capacity for good management and be accountable for it. However, it might seem easier for governments to walk away from health care.

Accountability has captured the imagination and interest of politicians, health care providers (and their associations), academics from various fields, and citizens. Notions concerning forms of accountability are now more defined and refined, and also more intricate. There is no clear consensus about the components of such a value in the literature, and fields of study have tackled the issue from different perspectives.[9] For example, whereas economists may focus on the role of market tools in achieving more accountability, jurists might be more interested in the role of legal means to do so. The lack of consensus regarding the components of accountability in health care is, in part, representative of the complexity of such a field, as well as of the related difficulty in identifying clear responsibilities in our Medicare system.[10] Disagreement on the very goal of accountability (i.e. accountability for what, to whom and at what cost) makes it even more difficult to reach an agreement on the means to achieve it. In short, the quest for more accountability is far from over and its aim remains to be clearly defined.

In this article, it is not our goal to resolve the complex issues surrounding accountability in health systems. We have the far more modest objective of exploring the role and capacity of a health ombudsman institution to increase accountability in such a system.[11] We predominantly base our analysis on the Quebec experience as it offers the most distinctive illustration of this type of institution across Canada;[12] it is the only

8. *Ibid.* at 11. Besides, Abelson and Gauvin mention that including participants in the deliberative process tends to make them more aware of the complexities of decision-making in the health sector, and, as such, more respectful as concerns existing decision-makers: at 15.
9. As an example of an innovative perspective on the issue of accountability in health care, see W. Lahey, "New Governance Regulation and Managerial Accountability for Performance in Canada's Health Care Systems" in R.P. Kouri & C. Régis, ed., *Grand Challenges in Health Law and Policy*, Cowansville, Éditions Yvon Blais, 2010.
10. See among others, R.H. Desmarteau & M. Nadeau, *supra* note 6.
11. For an interesting analysis on the effectiveness of Charter Review as an accountability mechanism in health care, see M. Jackman, *supra* note 6. The author concludes that Charter Review currently does little to improve accountability in the health care system. Considering this, the exploration of other accountability mechanisms in health care is certainly relevant.
12. As we later discuss, what we refer to as the "Health Ombudsman in Quebec" is in fact the "Protecteur du citoyen." The Protecteur is the provincial ombudsman, yet with

province that has an ombudsman with such an overarching and dedicated mandate concerning health matters. The ombudsman in Quebec oversees a two-step complaint process in the health care and services network.

More precisely, we test the potential of an ombudsman to enhance accountability in health care on three levels: political, managerial and professional.[13] Political accountability insists on strengthening the relationship between the government and citizens[14] and entails responsiveness from the former group to the latter, as well as delivering on commitments.[15] Managerial or administrative accountability concentrates on the responsibility of demonstrating effective and efficient management of services or systems.[16] As for professional accountability, it focuses on the health care provider–patient relationship and is associated with ensuring the maintenance of professional standards,[17] practices and values.[18] All three models of accountability, which can connect and overlap,[19] seek to improve accountability at different levels of decision-making in health care, which is essential in such a complex and polycentric system as Canadian Medicare. Furthermore, transcendent to all three dimensions, we mentioned in previous work that accountability requires, on one hand, the presence of "justification" and "conse-

a specific and detailed mandate over health matters. See C.M. Flood & K. May, "A patient charter of rights: how to avoid a toothless tiger and achieve system improvement" *CMAJ*, October 2, 2012, vol. 184 no. 14 1583-1587; C. Régis, "Enhancing patients' confidence in access to health care: the Ontario or Québec way?" (2004) 12 *Health Law. L.J.* 243.

13. We limit our analysis to these dimensions of accountability as they bring forward three essential relationships in public health care systems that exist across Canada; however, we remain conscious that there are many ways to break down objectives and paradigms of accountability, which expand beyond these dimensions. For an overview of other dimensions, see among others: *Accountability and Responsibility in Health Care – Issues in Addressing an Emerging Global Challenge*, B. Rosen e*t al.*, eds., World Scientific Series in Global Healthcare Economics and Public Policy, vol. 1 (Singapore: World Scientific, 2012); W. Lahey, *supra* note 9. See among others, R.H. Desmarteau & M. Nadeau, *supra* note 6.
14. K.J. Woods*, A Critical Appraisal of Accountability Structures in Integrated Health Care Systems* (September 2002) Scottish Health Services Policy Forum, Public Health and Health Policy, University of Glasgow).
15. *Supra* note 3 at 6.
16. *Ibid.* at 6. The author also refers to J.K. MacDonald *et al.*, "An inventory and Analysis of Accountability Practices in the Canadian Health Care System" (Ottawa: Health Canada, 1999).
17. J.K. MacDonald, *ibid.*; *supra* note 3.
18. Woods, *supra* note 14 at 6.
19. Woods, *supra* note 14 at 6. As an illustration, physicians must be accountable both professionally and managerially, while provincial governments must be accountable both politically and managerially.

quences" for the decision-maker[20] and, on the other, sufficient means to meet these two requirements. Put otherwise, on top of the responsibilities and duties that each model infuses into the content of accountability, these two requirements define what the very dynamic of accountability needs in order to be operative. Actualizing accountability (as opposed to articulating what is required) turns out to be the biggest barrier to its achievement.

In using accountability models, one should be vigilant, however, regarding the highly economic connotation often attached to the concept. 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 in the sector.[21] The danger of focusing disproportionately on economic concerns lies in neglecting less quantifiable aspects of health care that are just as important and for which decision-makers should also be accountable, specifically patient/citizen satisfaction and the overall humane aspect of health care. Illustrations of the fact that these less quantifiable aspects are often neglected in the health care system are numerous. For

20. Emanuel and Emanuel summarize these two requirements when they state that "accountability entails the procedures and processes by which one party justifies and takes responsibility for its activities": Ezekiel J. Emanuel & Linda L. Emanuel, "What Is Accountability in Health Care?" (1996) 124:2 *Annals of Internal Medicine* 229. Jennifer S. Lerner & Philip E. Tetlock, "Accounting for the Effects of Accountability" (1999) 125:2 *Psychological Bulletin* 255 [Lerner & Tetlock, "Accounting"]; Abelson & Gauvin, *Engaging Citizens*, *supra* note 4 at 13; A. Schedler, "Conceptualising accountability" in A. Schedler, ed., *The Self-Restraining State: Power and Accountability in New Democracies* (London: Lynne Reinner, 1999). Some authors use the expression "answerability" and "responsibility" instead of "justification" and "consequences." Lerner and Tetlock add that expectations of justification can be either implicit or explicit, and may concern beliefs, feelings, and actions. Examples of explicit expectations can often be found in the law and in various private and public policies. As an illustration of an implicit expectation, Canadians would expect that their Minister of Health would provide them with an explanation for a decision to enter into a contract for the delivery of medical care in and the shipment of patients to Buffalo. Accountable individuals can expect to answer questions about the rationale for their decisions, give clear communications and provide information. Abelson & Gauvin, *Engaging Citizens*, *supra* note 4 at 16.

21. See for instance *Chaoulli* v. *Quebec (Attorney General)*, 2005 SCC 35 [*Chaoulli*]; Marie-Pascale Pomey *et al.*, "Améliorer la pertinence des soins au Québec: une alternative à la privatisation?" in François Béland *et al.*, ed., *Le privé dans la santé – Le discours et les faits* (Montréal: Les Presses de l'Université de Montréal, 2008) at 387. As an illustration of the presence of such discourse in health care, see David Levine, "La réforme des services de santé et des services sociaux au Québec" (Lecture, Agence de développement de réseaux locaux de services de santé et de services sociaux de Montréal, 2005), slides online: <http://www.cmis.mtl.rtss.qc.ca/pdf/publications/isbn2-89510-222-8.pdf>.

example, while a medical prescription is an easy action to measure, communication between physicians and their patients is a less measurable action and financing is done accordingly; however, lack of communication with physicians is one of the most recurrent and significant complaints of patients.[22] Since the way in which patients are treated may be just as important to them as the actual care they receive,[23] acknowledging such an elusive aspect as patient/citizen satisfaction and the overall humane aspect of health care is essential.[24] We propose in this article that accountability implies further responsiveness to a more comprehensive range of patient/ citizen concerns, needs, and preferences, which in turn calls for what we refer to as a holistic approach to access-to-care issues.

We will conclude that health ombudsman institutions, such as the one that exists in Quebec, offer a potential that is interesting, yet not fully realized, to enhance accountability on all three dimensions and to stimulate an actual dynamic of accountability. A health ombudsperson organization, and the complaint process it provides, allows patients to voice their concerns to policy makers, managers and professionals, and contributes – with varying degrees of success – to the effective realization of

22. See among others L.J. Marcus *et al.*, *Renegotiating Health Care: Resolving Conflict to build Collaboration*, 2nd ed. (San Francisco: Jossey-Bass Publishers, 2011); Quebec, Ministère de la santé et des services sociaux, *La gestion des risques, une priorité pour le réseau* (Quebec: Direction des communications, Ministère de la santé et des services sociaux, 2001); V. Charles *et al.*, "Why do people sue doctors? A study of patients and relatives taking legal action" (1994) 343 *Lancet* 1609; we further discuss this aspect in the following pages. As another example, physical pain has been underestimated and under-treated due to its difficult assessment and subjectivity. Thierry Delorme, *La douleur – un mal à combattre* (Evreux: Découvertes Gallimard Sciences, 1999).
23. See among others R.N. Ann J. Kellett, "Healing angry wounds: the roles of apology and mediation in disputes between physicians and patients" (1987) *J. Disp. Resol.* 123; C. Régis & J. Poitras, "Healthcare Mediation and the Need for Apologies" (2010) 18 *Health L.J.* 31; Pauline Gravel, "Quand le médecin voit au-delà de la maladie – Meilleure est la communication entre le malade et son médecin, meilleure sera la santé du patient", *Le Devoir* (28-29 January 2006) at p. A6. The article mentions a scientific literature rescension done by the epidiomologist Moira Stewart, director of the Department of Family Medicine at the Schulich School of Medicine and Dentistry of the University of Western Ontario. This brings forward significant data to illustrate that the better the communication is between a physician and his/her patient, the better the patient's health will be.
24. In this article, we use this need for respect and integrity as something for which decision-makers should be accountable in health care. See also Pauline Gravel, "Le pouvoir de l'esprit – Croire peut-il guérir?" *Le Devoir* (28-29 January 2006) on the influence that physicans' behaviours, such as listening and consulting, have on patients' recovery progress.

patients' rights as well as the definition of clear expectations (on qualitative as well as quantitative aspects) concerning health care.

CONTRIBUTION OF A HEALTH OMBUDSMAN

Based on the political, managerial and professional models of accountability, each of which focuses on improving distinct aspects of decision-making practices in health care, we now seek to answer the following question: To what extent can a health ombudsman contribute to overcoming the accountability challenge? Yet two preliminary steps are useful before answering this question. First, some comments are needed on the distinctive potential of conflict resolution mechanisms (CRMs) in general in enhancing accountability. Considering that an ombudsman's complaint process is a CRM, this broader understanding is useful. Second, a brief description of the Quebec model is relevant to give the reader a better understanding of its characteristics and objectives.

There are various reasons why CRMs are important and unique in their capacity to achieve accountability in health care. Such tools should be understood here as any structure encompassed in a statute that aims at reviewing decisions and resolving disputes, such as a quasi-judicial tribunal and a complaints process (as with an ombudsman). Firstly, they are powerful instruments for forcing justification and consequences, two central elements of a dynamic of accountability. Concerning the first element – independent of the fact that some of these tools rely on mandatory and others on cooperative answerability – they mainly base their function on justification, both from decision-makers[25] who see their decisions reviewed and from the very people who review them (judges, ombudsmen, complaints officers, etc.). As such, adjudication mechanisms are significant tools for calling decision-makers to account by way of requiring them to explain their conduct to external institutions or individuals. Moreover, adjudication procedures often increase transparency at all levels of decision-making as all phases of contested decisions are regularly reviewed during the appeal/review procedure.

In addition to justification, CRMs also provide for formal consequences. These consequences range from the usual legal sanctions that belong to the courts and quasi-judicial institutions, to recommendations for institutional or personal changes and notices of infractions that

25. When we refer to the expression "decision-makers" in this article, we include all three levels of decision-making in health care (e.g. macro, treatment/delivery, as well as review/appeal levels).

belong to ombudsmen and governmental authorities. This capacity for CRMs to ensure formal consequences is possibly why various authors consider such procedures a prerequisite for accountability.[26] Most of these procedures also involve informal consequences, such as a possible loss of respect and reputation, costs, and negative publicity, all of which usually increase proportionately with the adversarial nature of the mechanism.

Secondly, CRMs are particularly important to health care accountability because the most difficult challenges regarding access-to-care today arguably lie in the very enforceability of the substantive norms set out in the law.[27] Such methods are, in fact, an important condition for moving accountability from a laudable goal to a concrete measure. On a regular basis, standards of care and service are not respected, rules of consent-to-care are ignored,[28] rules of access-to-care are rejected due to exceptions[29] or resistance from physicians,[30] and government policies are difficult to oppose, even when such opposition is based on Charter rights.[31] Adjudication mechanisms cannot realistically overcome all these problems; nevertheless, they not only contribute to the interpreta-

26. See, for example, N. Daniels, D.W. Light & R.L. Caplan, *Benchmarks of Fairness for Health Care Reform* (New York: Oxford University Press, 1996); "Accountability through Participation: Developing Workable Partnership Models in the Health Sector" (2003) 31 *Institute of Development Studies Bulletin* 1. Carolyn Tuohy mentions that "sanctions" should be part of accountability mechanisms. More broadly, there should be means to reward or punish. See "Agency, contract and governance: Shifting shapes of accountability in the health care arena" (2003) 28 *Journal of Health Politics, Policy and Law* 195-215.
27. N.M. Ries & T. Caulfield, *Accountability in Health Care and Legal Approaches* (Ottawa: Canadian Policy Research Networks, 2004) at 26, on the fact that Charter challenges are difficult to achieve. Abelson and Gauvin mention that there is a major "need for high standards that are enforceable and "vigorously enforced" through transparent and accountable systems": Abelson & Gauvin, *Transparency*, *supra* note 1 at 14.
28. D.E. Hall, Allan V. Prochazka and Aaron S. Fink, "Informed consent for clinical treatment"184 (2012) *CMAJ* 533; C.E. Schneider, "After Autonomy" (2006) 41 *Wake Forest Law Review* 41; R. Heywood, A. Macaskill and K. Williams, "Informed consent in hospital practice: health professionals' perspectives and legal reflections" (2010) 18:2 *Medical Law Review* 152.
29. *An Act respecting Health services and social services*, CQLR, c. S-4.2 ("*Health Services Act*"), s. 13: "The right to health services and social services and the right to choose a professional and an institution as provided in sections 5 and 6 shall be exercised within the framework of the legislative and regulatory provisions relating to the organizational and operational structure of the institution and within the limits of the human, material and financial resources at its disposal."
30. See Catherine Régis, "Physicians Gaming the Health Care System; Modern-day Robin Hood?" (2004) 13 *Health L. Rev.* 19.
31. Zimmerman, *supra* note 1. M. Jackman, *supra* note 6.

tion of unclear rules, but also are key institutions for the enforcement of laws and policies.[32] No other legal, economic, or political tool can substitute for this role. This also means that adjudication mechanisms are key institutions to strengthen the potential for accountability that legal norms (legislation, regulation, common law, etc.) themselves entail.

Considering that CRMs do not all have the same objective or function and vary from one province to another,[33] their potential for achieving accountability is not, however, the same across provincial health care systems. Adjudication (used here in the broad sense of the word) is in fact difficult to achieve in some provinces, considering the many constraints attached to court challenges and the fact that complaint mechanisms in health care are often non-existent. This situation may, in practice, leave different decision-makers under the radar of accountability. As such CRMs offer great potential with regards to accountability in health care, but often remain under-recognized and under-utilized.

Now turning to the specifics of the Quebec model, it is composed of a health ombudsman and a *Patients' Bill of Rights* (PBR). The "Health Ombudsman" is in fact the provincial ombudsman ("Protecteur du citoyen du Québec" or "Public Protector"), having, among other duties, a specific and detailed mandate over health matters in the public sector.[34] The PBR is included in the *Health Services Act,*[35] which is, more broadly, the main piece of legislation that sets down the rules for the administration of the public health care sector.

The Health Ombudsman oversees a complaint process that entitles Quebeckers to make complaints about health services or social services they have received, ought to have received, are receiving, or require.[36] The complaint procedure is a two-stage process. The first stage of resolution unfolds at the local level, within the institution. A Local Service Quality and Complaints Commissioner (Complaints Commissioner) is appointed by the board of every institution.[37] The first level can also be exercised by regional agencies (*agences de la santé et des*

32. Compared to courts and administrative tribunals, complaints processes or ombudsmen usually do not have formal power of enforceability. Their "enforcement power" usually relies on tools such as ministerial notification, public report or notification, etc.
33. See C. Régis, *Mind over Matter* (doctoral thesis, S.J.D., University of Toronto, 2008) at ch. 5.
34. The *Protecteur du citoyen* is responsible for applying *An Act respecting the Health and Social Services Ombudsman*, CQLR, c. P-31.1, s. 9 [*Health Ombudsman Act*].
35. *Health Services Act*, *supra* note 29.
36. *Ibid.*, s. 34.
37. *Health Services Act*, *supra* note 29, s. 30.

services sociaux), which are the Quebec equivalent of Regional Health Authorities in other provinces.[38] These agencies have the mandate to organize, manage, and evaluate health care and services within their regions.[39] If the matter remains unresolved to the satisfaction of the complainant, they then turn to the Health Ombudsman, i.e. the Public Protector. In addition, the Ombudsman is empowered "by any appropriate means"[40] to ensure that users are respected, that their rights are enforced, and that institutions and regional agencies[41] uphold and apply the complaint process. The Ombudsman can also intervene whenever there are reasonable grounds to believe that a person or a group of persons has been or may likely be wronged by an act or omission.[42] Thus, in these circumstances, there is a possibility for people to circumvent the two-step process and complain directly to the Ombudsman, and for the Ombudsman to intervene without an actual complaint.[43] As such, the Health Ombudsman in Quebec can seek justification and recommend consequences with respect to all decision-makers involved in public health care institutions.

There is, however, a distinct procedure for complaints concerning physicians, pharmacists and dentists. Patients wishing to complain about these professionals need to contact the Medical Examiner and appeals will go through a Review Committee.[44] Although such complaints follow a parallel dispute resolution procedure, this still leaves more systemic issues, about medical services for instance, under the

38. See section 60 and the following of the *Health Services Act*. These agencies replaced the Regional Boards in 2005.
39. For more details, see section 60 and following of the *Health Services Act*. For instance, such complaints can be related to the organization or financing of services in a region. Private nursing homes do not have complaint commissioners assigned within their institutions, as they are not public organizations; therefore, to ensure a certain overview over these private institutions, the *Health Services Act* allows people to complain directly to their Agency.
40. *Health Ombudsman Act*, *supra* note 34, 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 institution, special mentions in the annual report presented to the National Assembly, and inquiries about the patients' condition.
41. In the next pages, I give more details on the role of such agencies.
42. *Health Ombudsman Act*, *supra* note 34, ss. 20 to 26. It should be noted that, since 2006, complaint commissioners are also empowered to intervene on their own initiative when they have reasonable grounds to believe that the rights of a user or a group of users are not being upheld: see *Health Services Act*, *supra* note 29, s. 33 at para. 2 and s. 7.
43. However, presumably the Ombudsman will be informed of specific problems through complaints or information given by patients or people working within the health care network.
44. See sections 41 to 59 of *Health Services Act*, *supra* note 29.

purview of the Health Ombudsman.[45] We will now explore the potential – and limitations – of the Health Ombudsman in more depth.

1. On Political Accountability

The model of political accountability seeks to employ accountability in pursuit of good governance and is concerned with access-to-care issues that fall under the responsibilities of governmental institutions, including the allocation of health care resources among citizens, as well as tax spending. Accountability in health care (especially in a universal system financed by taxpayers) calls for transparency, responsiveness[46] and responsibility[47] from public institutions towards citizens/patients. To enhance political accountability, there is a need to strengthen the channels of communication between governments and citizens, as well as to build, within a democratic society, a sensitive relationship between these two poles of society. Without such a relationship, responsiveness from public bodies to citizens can hardly be achieved. Election and/or "voice" is often seen as a fundamental instrument in providing accountability at this level; nonetheless, there are noticeable limits to democracy as a means of ensuring adequate representation in health care.[48] Abelson and Gauvin mention that Canadians are now looking for new ways to ensure political accountability and to renew their contract of democracy. They want to be able to give their opinions and advice between elections and know that the government will actually hear and act upon their concerns.[49] Considering the decrease of public trust in governing institutions, strengthening political accountability becomes a key component in regaining confidence in Canadian Medicare.[50] Interestingly, this mistrust

45. For instance, the Health Ombudsman could make an inquiry about the lack of access to general practitioners in the health care system or for the lack of access to certain medical services in health care institutions.
46. Flood defines accountability as the level of response by public institutions to their citizens, Flood, *International Health Care Reform: A Legal, Politic and Economical perspective* (London: Routledge, 2000) at 128.
47. "Political accountability in its broadest sense is simply a reference to those with delegated authority being responsible for their actions to the people": Mona Awad, Julia Abelson & Colleen M. Flood, "The Boundaries of Canadian Medicare: The role of Medical Directors and Public Participation in Decision-Making", *Working Paper No. 4 – Defining the Medicare Basket*, (CHSRF-OMHLTC Research Project "Defining the Medicare Basket" (RC2-0861-06), Draft March 2004, available at <http://www.law.utoronto.ca/utfl_file/count/health_basket/docs/working4_boundaries.pdf>) at 8.
48. In addition, political accountability has been explored in health care by methods such as citizens' panels, deliberative polls, scenario workshops, and public consultations. Despite these various attempts, political accountability still remains weak and difficult to achieve.
49. Abelson & Gauvin, *Transparency*, *supra* note 1 at 21.

of governing institutions has triggered a demand for independent oversight bodies to protect the public interest and for more horizontal (rather than hierarchical) and negotiated state-citizens relationships.[51] In that sense, institutions such as tribunals and ombudsmen take particular significance in the increasing demand for accountability.

The Health Ombudsman helps to create a dialogue between political decision-makers and citizens and plays an important role in analysing and distributing information (which necessarily occurs in a dispute resolution process) between these two poles of our democratic society. The Health Ombudsman has direct access to the National Assembly and the Minister of Health and Social Services,[52] which gives this actor a formal and clear channel of communication with political decision-makers. Indeed, the Health Ombudsman organization can report problems to the Government and the National Assembly, as well as act on its own initiative when deemed necessary.[53] The institution can, therefore, create a valuable dialogue between citizens/patients and political decision-makers about what the issues are and about concerns that most affect the former group. This process could be revelatory for the latter group in ensuring responsive policies and allowing the citizens' voice to influence policies on a regular basis, thus enabling them to compete with other interest groups in health care that more readily voice their concerns and needs to the government. If the Health Ombudsman were to have the power to actually force the implementation of its recommendations, the impact on the political level, and on resource allocation, would be considerable.[54]

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50. *Ibid*. at 4: some eighty percent of Canadians would feel better about government decision-making if greater political accountability relationships existed.
51. Abelson & Gauvin, *Transparency*, *supra* note 1 at vi; Canadian Policy Research Networks, *CPRN Policy Brief. Restoring Citizen Trust – The Heart of Accountability*, No. 5 (Ottawa: 2006) online: <http://www.cprn.ca/documents/42564_en.pdf>; Lori Turnbull & Peter Aucoin, *Fostering Canadians' Role in Public Policy: A Strategy for Institutionalizing Public Involvement in Policy* (Ottawa: Canadian Policy Research Networks, 2006); Rowe & Calnan, *supra* note 2.
52. Health Ombudsman Act, *supra* note 34, s. 38.
53. For example, the Ombudsman could mention the particular case in its annual report or in a special report. See sections 16, 26 and 28 of *Health Ombudsman Act*, *ibid*. See also section 20 of the same *Act* for the office of the Health Ombudsman to act on its own initiative. Section 16 reads as follows: "If, after having made a recommendation as referred to in section 15, the Health Services Ombudsman considers that no satisfactory action has been taken or that the reasons given for not acting upon the recommendation are unsatisfactory, the Ombudsman may advise the Government in writing. The Health Services Ombudsman may also, if he or she sees fit, report the case in the Ombudsman's annual report or make it the subject of a special report to the National Assembly."
54. The impact would possibly be too much considering that the Ombudsman is not an elected representative, is not part of the three branches of power that represent the

There are some concrete examples of the possible influence of an ombudsman on broader resource allocation issues, in particular with respect to recommendations proposed by the Health Ombudsman in Quebec, including one for improving the traveling policy for handicapped people and other health care users in order to improve access to care, as well as another for improving homecare services.[55] The first decision clearly led to public policy changes,[56] while the second has not had the hoped-for impact.[57] Furthermore, there is the cancer patients' case from Ontario (provincial ombudsman), which resulted in greater access to treatment by increased funding for traveling costs (here highlighting similar concerns as the Quebec example).[58] Flood and May also give the

heart of our democracy, and should not therefore end up governing a key public program.

55. Protecteur des usagers en matière de santé et de services sociaux, *Quand la distance a de l'importance – Le soutien financier au déplacement des usagers du réseau de la santé et des services sociaux* (Quebec: Brief presented to the ministère d'État à la Santé et aux Services sociaux, 2002); Protecteur des usagers en matière de santé et de services sociaux, *Les services à domicile – Vivre parmi les siens en sécurité et dans la dignité* (Quebec: Brief presented to the ministre d'État à la Santé et aux Services sociaux, 2003).
56. The traveling policy for patients in the health care network changed within a year following the opinion rendered by the Health Ombudsman. See Ministère de la santé et des services sociaux du Québec, le Sous-Ministre, *Politique de déplacement des usagers, Normes et pratiques de gestion* (Bulletin, 2003) online: MSSS <http://msssa4.msss.gouv.qc.ca/fr/document/d26ngest.nsf/1f71b4b2831203278525656b0004f8bf/ef5ef35e981aafbf85256d4b00561f75/$FILE/2003-007.pdf>.
57. The Health Ombudsman, now part of the provincial ombudsman's organization ("Le Protecteur du Citoyen"), mentioned in a press release on June 7, 2007 that the elements needed to enhance access to and continuity in homecare services are not in place: Le Protecteur du Citoyen, *L'accessibilité et la continuité des services sur le territoire doivent être mieux assurés, notamment pour la clientèle à domicile* (Québec: 2007). The government presented a broad plan of action for 2005-2010 in order to improve such services for the elderly dealing with a loss of autonomy, but this plan is limited in comparison to what the Health Ombudsman had hoped for. The Health Ombudsman, in comments made in the press release of June 2007, added that homecare services remain the subject of the vast majority of complaints the office receives. For another example of government follow-up on a Health Ombudsman's recommandation, outside the range of access-to-care issues however, see Protecteur du citoyen, *Rapport annuel d'activités 2012-2013*, Québec, 2013 at p.156. For illustrations of the kind of dialogue the Protecteur du citoyen can create with the Ministry of Health, see generally the Rapport Annuel (among others, at pp. 80, 83).
58. See the Ombudsman Annual Report 2001-2002: Ontario, Ombudsman Ontario, *Annual Report 2001-2002* (Ontario: Ontario Government, 2002) at 11, online: Ontario <http://ombudsman.on.ca/ann_reports.asp.> The Ombudsman recommended that the Ministry of Health and Long-Term Care provide equal funding to breast and prostate cancer patients from the north who must travel for radiation treatment (southern patients have been benefiting from a travel policy since 1999). Traveling costs were

example of the Ontario's Psychiatric Patient Advocate Office as a well-known driver of systemic change having led to policy changes on hospital management of patient funds and the use of Tasers.[59]

We should mention that the Quebec experience also contributes to greater accountability from health care decision-makers, including at the political level, via the existence of a Patient Bill of Rights (PBR), which, as mentioned earlier, exists in parallel to the Health Ombudsman. Indeed, while one of the most important benefits of the Quebec Bill is the complaint process it creates, it also provides for positive rights for patients in the health care system. Legislation can be a powerful instrument for increasing accountability. Suzan Zimmerman posits that effective legislation offers great potential for answering the question "who is responsible to whom," focusing on relationships and how we define them.[60] This benefit is not negligible, as responsibilities for planning, delivering, financing and evaluating in health care often diffuse as well as overlap, mainly to the disadvantage of patients.[61] As an illustration, physicians, hospitals, regional health authorities (RHAs), and provincial governments all exert a significant influence on planning what care and services people can access. In addition, rights are a key mechanism in regulating relationships between a government, its institutions and its citizens. They contribute to creating a better balance between the government's wish to control costs and the patients' desire to receive appropriate care.[62] For example, the right to be treated with dignity and without discrimination partially helps to ensure that the government, and its institutions, will not focus (at least exclusively) on rationing financing in those programs that are less politically-profitable, such as mental health programs and aboriginal health care. As well, the right to access forms of care that are scientifically, humanly and socially adequate[63] helps ensure a standard of care that acknowledges the multifaceted nature of health and human needs. We will come back to this contention in the next pages.

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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 attracted significant media coverage and, as such, had a significant impact on public opinion and ultimately on the Ministry involved.

59. *Supra* note 12.
60. Zimmerman, *supra* note 1.
61. See also *ibid*.
62. See Richard Sorian & Judith Feder, "Why Do We Need a Patients' Bill of Rights?" (1999) 24 *J. Health Pol.* 1137.
63. *Health Services Act*, *supra* note 29, s. 5.

A further strength of the Health Ombudsman in enhancing political accountability is that the institution is highly accessible. This is, in fact, a usual characteristic of less-adversarial conflict resolution mechanisms. Arguably, a more accessible mechanism has more chances of being representative of citizens' concerns. This is especially true with the Health Ombudsman in Quebec where the complaint process is not only open to patients, but also to families, legal representatives, and citizens who, without being affected by a specific and long-term condition, wish to complain after a half-day stay in the emergency room. This allows for a broader scope of viewpoints and concerns to be addressed by the Ombudsman, which in turn increases the representativeness of the message that the institution sends to political decision-makers. In fact, the Health Ombudsman receives an average of more than 1,000 complaints per year regarding health matters, which gives the institution many opportunities to intervene in health care and have a better understanding of the needs in such a sector of activity.[64] The private sector, such as private medical clinics, is however out of reach of the complaint process.[65] The representativeness of the message is thus limited to concerns that exist in the public sector, which leaves an important part of the health care system outside the scope of the Ombudsman.[66]

While as an institution the Health Ombudsman contains significant potential to enhance political accountability, it does have some weaknesses that reduce the full realization of such promise. The weaknesses essentially result from one key characteristic of the institution, namely a broad yet limited power of *recommendation*. The Ombudsman could eventually force someone to justify his or her conduct and provide the relevant documents and information based on its power and immunity as specified in the law,[67] but the consequences for not respecting its recommendations are essentially informal and potentially weak. Within thirty days of receipt of a recommendation from the Health Ombudsman, whether following a complaint or an intervention,[68] the body concerned

64. See the last annual reports of the Health Ombudsman. For example, in 2012, 1186 complaints were registered. In Protecteur du citoyen, *Rapport annuel d'activités 2012-2013*, Québec, 2013.
65. Private nursing homes are however an exception to this principle: section 60, *Health Services Act, supra* note 29.
66. This also has an impact on professional and managerial accountability, as we later discuss.
67. *An Act respecting public inquiry commissions*, CQLR, c. C-37, s. 6. The Health Ombudsman is vested with the regular power and immunity of commissioners, as mentioned in the *Health Ombudsman Act*, except for the power to order imprisonment. See also s. 14 of the *Health Ombudsman Act* for the power of the Ombudsman to require someone to provide relevant documents.
68. See *Health Ombudsman Act*, *supra* note 34, s. 15 for the complaint; and see *ibid.*, s. 25 for the intervention.

must inform the Ombudsman 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.[69]

As underlined earlier, the Ombudsman organization can exert pressure on recalcitrant institutions by mentioning the case in a special or annual report to the National Assembly, or otherwise advising the government.[70] In fact, any report, opinion or recommendation can be released to the government when the Ombudsman considers that no satisfactory action has been taken following recommendations or an intervention report or if the interest of the patients requires it.[71] This highlights the fact that the Ombudsman's ultimate remedial tool is that of publicly disclosing his or her concerns.[72]

The danger here is having a "toothless tiger";[73] in other words, an institution that has great authority, in principle, but no ability to enforce it. This characteristic has an influence on the dynamic of accountability, as it cannot enforce the duty to respond to the given consequences; response is essentially left to moral compliance and the good will of health care actors and institutions involved in the complaint process. That being said, as underlined earlier, consequences can also be informal and, therefore, do not necessarily have to be formally enforceable in all cases for a dynamic of accountability to take place. Informal consequences can range from a loss of credibility, reputation, or power, to shaming. Public shaming, for instance, can be the consequence of reporting by the Ombudsman on a non-compliance case at the National Assembly or in the media.

In other words, ombudsman institutions are not so limited by what they can do as by what they can enforce. Compared to courts, this may reduce the influence of the institution on the political level, especially in the context of financial constraints where the government is less likely to increase funding for certain services and thus less prompt to follow recommendations that are not binding and are politically costly – which

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69. *Ibid.*, s. 25. The 2004-2005 annual report of the Ombudsman indicates that 93% of the institutions that had received recommendations did follow up as required. In 2012-2013, this number increased to approximately 98%, which means that the responses were almost all positive: Protecteur du citoyen, *Rapport annuel d'activités 2012-2013*, Protecteur du citoyen, Québec, 2013.
70. *Ibid.*, s. 26.
71. *Ibid.*, s. 28.
72. I will come back to this point in the next pages.
73. C.M. Flood & K. May, "A Patient Charter of Rights: How to Avoid a Toothless Tiger and Achieve System Improvement", *supra* note 12 (10).

is more likely to be the case with highly publicized and binding decisions from the highest courts such as *Eldridge*[74] and *Chaoulli*.[75]

Ultimately, this strongly advocates in favour of supporting and nourishing the legitimacy of the organization within the health care network and the population, which is likely to play a key role in enhancing the moral power of the ombudsman. The more respected an institution, the more likely people will be to follow its recommendations and listen to its public acknowledgement of problematic situations, even if none are binding. The independence and public awareness of the Health Ombudsman are key factors in ensuring such legitimacy. The process followed by the Health Ombudsman when dealing with complaints, which should include consideration for procedural justice, is another important factor.[76]

We do not propose that a health ombudsman institution be granted additional enforcement powers, similar to adversarial conflict resolution options, as this is not the logic on which it is based. The full potential of a complaint process lies in its complementarity with respect to other conflict resolution mechanisms (such as courts and administrative tribunals) that remain available to patients/citizens. In fact, the complaint process in Quebec was originally put in place with the objectives of providing health care users a less adversarial environment for resolving their disputes and enhancing communication in the health care system.[77] We believe that this objective is still relevant today as it fits with what many patients are looking for when a conflict occurs.[78] Also, the less formal

74. *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624.
75. *Chaoulli c. Québec (Procureur général)*, [2005] 1 R.C.S. 791. For a critical point of view on the impact of health rights litigation on the publicly-funded health care, see C.M. Flood and Y.Y. B. Chen, "A Charter Rights & Health Care Funding: A Typology of Canadian Health Rights Litigation" (2009-2010) 19 *Annals Health L.* 479.
76. See among others Tom Tyler, *Why People Cooperate: The Role of Social Motivations* (Princeton: Princeton University Press, 2011).
77. Commission Rochon, *Rapport de la commission d'enquête sur les services de santé et les services sociaux*, Québec, Publications du Québec, 1988; Eric Gagnon *et al.*, *Les insatisfactions et les plaintes: L'accessibilité des usagers et des usagères aux mécanismes de recours*, research report, Beauport, Direction de la santé publique de Québec, 2001; C. Régis & J.-F. Roberge, "Repenser le régime de plaintes dans le système de santé au Québec pour implanter une philosophie de médiation" (2013) 50e numéro (hors série) *Revue Droit & Santé* 215-237.
78. This includes the need to understand what happened, the need to receive an apology or the recognition of the impact that the incident had on the patients'/family's lives, and the assurance that the mistake will not repeat itself. Lack of good communication and interpersonal issues remain amongst the most numerous complaints. See our earlier comments and references made in that respect (among others, *ibid*, Régis & Roberge). Adversarial mechanisms are not the best forum to respond to such needs due to their mandate and procedural requirements.

and procedural environment that the complaint process offers, which flows in part from the lack of formal powers of enforcement, gives the flexibility to adapt the conflict resolution process to the specificity of each case, for instance, by exploring mediation instead or a more fact-finding procedure. Literature has started to show that people tend to be more respectful of outcomes or decisions when they participated in designing them.[79] This could consequently be strength of a more mediation-focused dispute system plan, which tries to involve parties in the definition of a commonly agreed upon decision.

In a nutshell, the Health Ombudsman possesses a wide scope for overview of governmental actions and decisions and therefore provides for needed dialogue between citizens and the government on a variety of health care issues; however, it has no means to impose its dialogue. The Health Ombudsman institution can contribute to ensuring a representative citizens' voice through the significant case-flow of health care complaints it receives and the possibility it has to hear complaints from a wide range of citizens, including long- or short-term patients, parents, legal representatives, grassroots organizations, and so on. The Health Ombudsman, therefore, is a useful mechanism for enhancing political accountability in health care.

2. On Managerial Accountability

Within the second accountability model, namely managerial or administrative, lies the responsibility for demonstrating effective and efficient management of services or systems.[80] Therefore, for a health ombudsman institution to enhance managerial or administrative accountability, it should be able to ask for justification from, and impose consequences on, the people responsible for managing health care services in Medicare.[81] People and institutions involved at this level of decision-making must account for how and why decisions are made, not just for how money is spent.[82] Political accountability is already intended to hold the government accountable in that regard. In health care, the managerial model is useful for other decision-makers involved in the

79. See, for example, T.R. Tyler, *Why People Obey the Law?* (New Haven: Yale University Press, 1990); M. Deutsch, "Justice and Conflict" in Morton Deutsch & Peter T. Coleman, eds., *The Handbook of Conflict Resolution – Theory and Practice* (San Francisco: Jossey-Bass, 2000) at 41.
80. *Ibid.* at 6. The author also refers to MacDonald, *supra* note 16.
81. Fooks & Maslove, *supra* note 3 at 6; J.K. MacDonald *et al.*, *An inventory and Analysis of Accountability Practices in the Canadian Health Care System* (Ottawa: Health Canada, 1999).
82. Fooks & Maslove, *supra* note 3 at 6.

administration of Medicare – that is in making publicly funded services available to citizens – namely people working within provincial health insurance plans, hospitals, or other "public" institutions.[83] Sanctions associated with this form of accountability can be legal, financial, and political. As an illustration of sanctions, bad management could lead the government to withdraw a long-term care institution's operating permit.

Amongst the means available for achieving more managerial accountability in health care, there are monitoring programs (concerning adverse events in health care institutions for instance), quality system performance in hospitals, public reports or hearings, hospital and other health institution boards (which can include public representatives, in Quebec for example)[84], licensing,[85] management and accountability agreements,[86] as well as financial constraints or rewards.[87] These measures are usually associated with a managerial model.

At this point, a comment is needed with respect to the particular issue of the relationship between accountability and economic analysis. There is an increasing demand for measurement of health outcomes, which can sometimes be difficult to meet – particularly for highly sensitive kinds of care such as the treatment of geriatric or psychiatric patients, or of the terminally ill. The monitoring of outcomes is demanding and costly, and its criteria and results often depend on subjective and erratic evaluation from experts and patients. For instance, agreement on what is an acceptable outcome might vary from one patient or profes-

83. *Ibid*. at 6, see Figure 1.
84. *Health Services Act*, *supra* note 56, s. 129.
85. Ministers of Health have the power to grant permits and licensing. They can do so sometimes through indirect institutions such as Regional Health Authorities (RHA). They issue licenses for certain health care facilities, for example long-term care and intermediary institutions for psychiatric patients. Ministers can revoke licensing when the operators of these institutions do not respect institutional standards. See Zimmerman, *supra* note 1.
86. In Quebec, "the Minister shall determine, within the scope of a management and accountability agreement entered into with an agency, the objectives to be achieved by the agency": *Health Services Act, supra* note 56, s. 385.1. This agreement must contain elements such as the definition of the mission and strategic directions of the agency, key indicators to be used in measuring results as well as an annual management report: s. 385.2. The agreement is a public document: s. 385.3. In case of non-compliance with the agreement, section 385.6 mentions that the Minister may suspend or cancel the management and accountability agreement.
87. For more detail and concrete examples of those means in Canadian Medicare, see Alberta, *Accountability An Action on Health Initiative* (Discussion Paper) (Alberta: Standards and Measures Development, 1997); Alberta Health and Wellness, *Who is accountable in health? Roles and responsibilities in Alberta's health system* (Alberta: Alberta Health and Wellness Standards & Measures, 1999).

sional to another and outcomes depend on a multitude of changing factors such as the patient's own medical history as well as his or her compliance with the treatment. Monitoring often gives only probabilities rather than indicating what care is appropriate in any particular case.[88] Measurement of health outcomes is therefore useful, yet not a panacea in reaching accountability in health systems.

At this level of accountability, the relationship between citizens and the people responsible for managing the system is rarely direct, while it is more direct between the government and health care managers (hospital managers, regional health authority managers, etc.). This is in part explained by the fact that it is ultimately the government, not patients, that manages the finances of the Medicare system; the government represents (or is meant to represent) the larger public interest in this regard.[89] It is important to acknowledge the varying nature of directness in relationships as it often corresponds, in practice, to the magnitude of "voice mechanisms" currently available to citizens for expressing concerns in cases of dissatisfaction. As such, a health ombudsman with a complaint process could represent a unique opportunity for Canadians to express their concerns to managers.

The Health Ombudsman has no competency over the provincial health plan in Quebec. That being said, nothing prevents the Ombudsman from taking the initiative to notify the Health Minister about specific issues related to the plan. The Ombudsman has oversight of various issues of interest for the model of administrative accountability within health care institutions (hospitals, long-term care institutions, etc.) and regional health authorities.

Due to the fact that the office of the Health Ombudsman is not limited with respect to the type of norms it can acknowledge and options it can propose, it can potentially review complaints about the principles of good management within health care institutions, such as delays in accessing physicians in hospitals, waiting list management,[90] lack of

88. See the following articles for a more complete discussion on the topic: Arnold M. Epstein, "The Outcomes Movement- Will it Get Us Where We Want to Go?" (1990) 323 *New Eng. J. Med.* 266; David M. Eddy & John Billings, "The Quality of Medical Evidence: Implications for Quality of Care" (1988) 7:1 *Health Affairs* 19. The 2004 health care reform in Québec is an illustration of such a call for measurement.
89. Canadians fund the health care system through taxation; however, they are not the ones who manage the money or directly pay health care institutions and providers.
90. Which could include asking physicians to explain on what criteria they based their decisions in that respect or what protocols are available in managing the waiting list in a health care institution.

security or cleaning, overcrowded corridors with stretchers, lack of staff, etc. It can also intervene on the more humane aspects of health care services and delivery, such as lack of communication and respectful behaviour in health care institutions. Furthermore, it can evaluate more systemic issues in the organization of health care services at the regional level, for instance, the lack of specialized medical services or equipment in certain areas, inaccessible transportation for patients from their long-term care institution to hospitals, etc. The Health Ombudsman can recommend, for example, that health care institutions change their allocation policies and practices, reimburse patients who paid for certain services, provide for more personal care and services in long-term care institutions, and so on. This means that the Health Ombudsman can review a broad number of stakeholders (hospital managers, physicians who make management decisions, head nurses, etc.) and decisions identified in the managerial model of accountability.

Nevertheless, as with the other two models of accountability, this benefit is worthy to the extent that decision-makers involved at this level agree to collaborate in the complaint process. This could be a problem when the Ombudsman's decisions push for change in managerial practices that are deeply entrenched within organizational cultures or when decisions entail a "dissuasive" amount of money in order to be implemented.

A good example is seen in the case where the Health Ombudsman recommended that incontinence diapers be provided by public long-term care institutions, therefore, asserting that such institutions should not be allowed to charge patients an extra fee for those items. We followed the complaint process for this case while a lawyer for the Conseil pour la Protection des Malades (CPM) in Quebec. The process lasted for more than a year. There was strong resistance from the long-term care institution involved in applying the Health Ombudsman's recommendation, and at the time we left the CPM, this recommendation was yet to be applied. This case illustrates how the complaint procedure within the Health Ombudsman organization can be very frustrating for complainants who find themselves with an unenforceable decision at the end of the day. If such cases were to become commonplace, the organization would lose a lot of credibility among complainants and in the health care network more broadly.

In summary, the Health Ombudsman is likely to offer a unique opportunity for some patients to bring forward issues of good management in health care and to oversee a broad spectrum of decisions identified in the managerial model of accountability. Nevertheless, reflecting a

similar concern as regards the other two models of accountability, making health care managers collaborate with the Ombudsman's recommendations can be a challenge.

3. On Professional Accountability

This dimension of accountability is deeply concerned with the quality of care and services provided by health care professionals.[91] From a paternalistic standard, especially regarding the physician-patient relationship, the paradigm of professional accountability has shifted to the standard of an informed and involved patient, which implies a more, though still not fully, equal relationship between providers and patients (who in economic terms are the consumers of health care services). This form of accountability ultimately relies on deontological and legal sanctions to ensure its effectiveness; tools such as institutional and professional guidelines, codes of conduct, discipline committees within hospitals,[92] professional inspections, and licensing are regularly employed. These measures work as incentives or control mechanisms for maintaining good standards of practice within the Medicare system.

To enhance professional accountability in the health care system, an ombudsperson should be able to seek justification from, and impose consequences on, health care professionals. Ultimately, he or she should be able to establish channels of communication with such decision-makers in order to send signals back to professionals about what standards of conduct, practices, and values are expected from them. This is an important challenge since many health care practices, including those in the medical field, are rarely questioned; in fact, for professionals in health care, there are few opportunities to learn from others or from their own mistakes.[93] Yet, as Rosen, Chinitz and Israeli mention,

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91. Fooks & Maslove, *supra* note 3.
92. In Quebec, every hospital has a "Conseil des médecins, dentistes et pharmaciens (CMDP)" in charge, among others, of evaluating and controlling the professional practice of these three professionals. See s. 214 of the *Health Services Act*, *supra* note 29.
93. Thomas S. Ulen, "The Growing Pains of Behavioral Law and Economics" (1998) 51 *Vand. L. Rev.* 1747. We underlined the reasons why throughout this paper: decisions escape scrutiny due to discretionary decision-making, decision-making that is deeply embedded within health ministries, highly-specialized medical decisions, and polycentric decisions. On the specific difficulty of learning from errors and adverse events in health care, and therefore improving patient safety, see Joan M. Gilmour, *Patient Safety, Medical Error and Tort Law: An International Comparison* (Final Report prepared for the Health Policy Research Program, Health Canada, 2006): the author notes that the tort system does not encourage disclosure of errors. Efforts should be made to improve reporting and sharing of information for patient safety

responsible professionals would want to learn about discrepancies between their own performance and their professional responsibilities in order to take corrective action and might appreciate monitoring programs that alert them when their performances fall short compared to accepted benchmarks of best practices.[94]

Tuohy mentions that accountability measures must situate responsibility for actions while allowing for the exercise of professional judgment.[95] Therein lies the delicate balance of accountability, especially within a professional model. The relationship between health workers and patients/citizens in general is more direct than the relationship that exists at the political and managerial level. The chance for a citizen to communicate and interact with health practitioners is more probable, as they often represent a citizen's only contact with the health care system. This fact increases the chances of having more responsive decision-making from health professionals than from politicians; there is also more opportunity to build trust in such a close relationship.[96]

As an institution, the Health Ombudsman has the potential to enhance professional accountability due to the fact that it can overview the decisions and behaviours of many health care workers working in public institutions, such as nurses, psychologists, social workers, and so on. Nevertheless, as underlined earlier, physicians, pharmacists and dentists do not answer to the Health Ombudsman but to a Medical Examiner and a Review Committee. In this case, the latter two stakeholders will be able to increase professional accountability. Considering the easy access to the complaint process and the opportunity for the Health Ombudsman to act on its own initiative when deemed necessary, the possibility to ask for justification from health care professionals is of unique scope and frequency. The organization, therefore, has a significant window of opportunity to send signals back to health care professionals about what is expected from them, even as regards more humane aspects of health care such as respect in patient/health care

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purposes by, for instance, providing for a limited qualified privilege legislation that shields information gathered in this context; see Recommendation 1.1.

94. Bruce Rosen, David Chinitz & Avi Israeli, "Accountability in Health Care Reconsidered" in B. Rosen, A. Israeli and S. Shortell, eds., *Accountability and Responsibility in Health Care – Issue in Addressing an Emerging Global Challenge* (World Scientific Series in Global Healthcare Economics and Public Policy, Singapore, 2012) 7 at 12.
95. Carolyn J Tuohy, "Agency, Contract, and Governance: Shifting Shapes of Accountability in the Health Care Arena" (2003) 28:2-3 *Journal of Health Politics, Policy and Law* 195-215.
96. Rowe & Calnan, *supra* note 2; Julia Abelson *et al.*, "What does it mean to trust a health system; A Qualitative Study of Canadian Health Care Values" (2009) 91 *Health Policy* 63.

professional relationships; this is difficult to accomplish with more adversarial CRMs, such as courts and administrative tribunals.

The potential that the Health Ombudsman offers for enhancing professional accountability needs to be mediated, however, with the same limitations expressed in the previous sub-sections. Unlike courts, the Health Ombudsman is not a public (the complaint process is mostly confidential), powerful, or highly legitimate (at least from the perspective of certain health care stakeholders)[97] conflict resolution process, a fact or perception which potentially reduces the impact of the signal the organization sends to health care professionals.

On one hand, these limitations could mean that the professional standards proposed by the Health Ombudsman are not a sufficient match when they need to overcome strong resistance, and *status quo* biases[98] on the part of professionals. The capacity (and legitimacy) to bypass the *status quo* bias and force change from a bottom up perspective (from citizens to decision-makers), for legal purposes, is a significant contribution of adversarial CRMs in general. Due to the *status quo* bias and a power limited only to recommendation, it might be difficult, for instance, for the Ombudsman to require employees in health care institutions to vary their lunch hours to make sure that patients and long-term-care residents can take theirs at reasonable hours, especially if this is a practice that has been going on for some time or if employees consider it to be their right to do so.[99] People are likely to view the rights and privileges that they have, or consider they have, as the *status quo*.

97. Patients and health care users more broadly have also expressed some doubts about the legitimacy of the complaint process, especially at the first level where the matter is resolved within the institution. See, for example, Quebec, Commissaire aux plaintes en matière de santé et de services sociaux, *Rapport de la tournée des régions (1998-1999) de la Commissaire aux plaintes*, Montreal, November 1999. See also generally Trevor Buck *et al.*, *The Ombudsman Entreprise and Administrative Justice* (Farnham, UK: Ashgate, 2011); the authors discuss some key elements that need to be present for ombudsmans to be perceived as legitimate.

98. For interesting readings of the role and impact of status quo bias in law and public policy, see Amos Tversky and Daniel Kahneman, Loss Aversion in Riskless Choice – A Reference-Dependent Model in *Choices, Values and Frames*, ed. by D. Kahneman & A. Tversky (Cambridge: Cambridge University Press, 2000)143; Russel B. Korobkin & Thomas S. Ulen, "Law and Behavioral Science: Removing the Rationality Assumption from Law and Economics" (2000) 88 *Cal. L. Rev.* 1051. The *status quo* usually defines the reference level for decision-making. People have a propensity to weigh losses and disadvantages more heavily than gains and advantages, which produces a bias on the part of decision-makers toward the *status quo*.

99. This example is based on an actual case that we had to deal with when we were working for the Comité Provincial des Malades (CPM), a patients' rights advocacy group in Quebec. We helped patients draft a complaint to the Ombudsman based on the fact

The situation might be especially problematic in a field already crowded with a multitude of norms influencing, to various degrees, the professionals in their decision-making.[100] When norms compete with one another, it might be the one that bears more consequences and legitimacy that wins the battle for influence. This situation could be especially problematic if provinces (or communities, institutions, and so on) were to rely only on non-adversarial institutions in their conflict resolution plans. That being said, the Health Ombudsman has another potentially advantageous characteristic to cope with this normative reality, as we further discuss in the next pages.

We should clarify that the law, similarly to adversarial CRMs, can help countervailing *status quo* biases since it is also a tool that can force change. Scott mentions that legal norms are especially relevant if one wants to achieve certain behavioural results when inconsistent with other norms,[101] which is likely to happen in a highly inter-normative field such as health care. As noted earlier, the law defines rights and privileges that apply to everyone, not a select few who exert control in their environment. This could be another argument in favour of implementing PBR in health care systems, when there is a strong culture of entitlement and reluctance to change among employees; in other words, such a bill could have more than just a legal value. Nevertheless, the law and CRMs are stronger when used in combination. We previously underlined that rights can remain highly theoretical if there are no means to enforce them, and CRMs are of little use without the legal framework that defines their scope of action.

On the other hand, the complaint process of the Health Ombudsman is more open to acknowledging various norms, which can allow it to incorporate, rather than being forced to choose between, this variety of norms. We were able to realize this porosity to inter-normativity when we had access, on a non-identifying basis, to the Health Ombudsman's decisions for a year.[102] The organization addresses a variety of norms in its analysis of complaints and recommendations, for example patients' needs and values, institutional and administrative policies, ethical codes of conduct, legal norms, scientific norms, etc. An anticipated benefit of

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that they had to take their lunches between 10:30 and 11:15 as employees started theirs at 11:30.

100. See, for example, Guy Rocher, "Les « phénomènes d'internormativité » : faits et obstacles" in Jean-Guy Belley, ed., *Le droit soluble. Contributions québécoises à l'étude de l'internormativité* (Paris: Librairie générale de jurisprudence, 1996) at 25.

101. Robert E Scott, "The Limits of Behavioral Theories of Law and Social Norms" (2000) 86 *Va. L. Rev.* 1603.

102. We had access for research purposes and had to sign a confidentiality agreement.

the highly inter-normative nature of the Health Ombudsman is therefore to propose standards that are ultimately more connected and applicable to health care realities and the needs of patients and health care stakeholders more broadly.[103] Besides, since the Health Ombudsman is usually a flexible and accessible CRM, it can more rapidly adapt to the evolving reality of health care and allow for development of standards that ensure a closer fit between actual needs for professional standards and the reality on the ground.

As well, the Health Ombudsman is in a privileged position to enable the implementation of a regular back-and-forth dialogue with health care professionals, and also ensure that professionals have a valid interpretation of the proposed standards. Professionals can contact the Health Ombudsman, even after the complaint process is completed, for more information and guidelines.[104] This is in sharp contrast with courts where people have to limit themselves to interpreting the written decision.

The less adversarial nature of the Health Ombudsman reduces the likelihood that this institution will, as a side effect, exert an inappropriate influence on professionals' judgement due to a fear of significant negative consequences. Non-adversarial CRMs mostly rely on a collaborative logic, with lower costs (psychologically, professionally, etc.) for all people involved in the dispute resolution process.[105] This is another argument that militates in favour of maintaining the less-adversarial logic that characterizes the Health Ombudsman institution instead of increasing its coercive powers.

Furthermore, to the extent that the Health Ombudsman can provide for a neutral (or "without prejudice") ground that encourages the disclosure and provision of information in health care, the collaborative logic

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103. For further discussion on this point, see C. Régis & J.-F. Roberge, "Repenser le régime de plaintes dans le système de santé au Québec à la lumière d'une philosophie de médiation" (2013) 50e numéro (hors série) *Revue Droit & Santé* 215-237.

104. Professionals who are members of a professional order could also contact the latter organization to receive information about what conduct is expected from them on certain issues or matters. Orders are mostly focused on the interpretation of the disciplinary code and some professional guidelines. It gives a predominant importance to the deontological norm and sometimes ethical standards as well.

105. J.R.S. Prichard, *Liability and compensation in health care – A report to the conference of deputy ministers of health of the federal/provincial/territorial review on liability and compensation issues in health care* (Toronto: University of Toronto Press, 1990); Marcus *et al*., *supra* note 34; see the discussion in Joan M. Gilmour, *Patient Safety, Medical Error and Tort Law: An International Comparison* (final report prepared for the Health Policy Research Program, Health Canada, 2006) at 35.

can overcome, at least partially, resistance associated with questioning actual health care practices. Put otherwise, a non-adversarial option can lead to more willingness to divulge information that can improve institutional practices (which in fact interests advocates of both professional and managerial models of accountability). Indeed, the Health Ombudsman complaint process offers guarantees with respect to confidentiality; there are no possibilities to later use information obtained during the complaint procedure in courts.[106] As such, the Ombudsman institution does represent another promise for enhancing accountability in health care.

As for the impact of the Health Ombudsman on the relationship between patients and professionals, one of the main goals of non-adversarial CRMs is to enhance communication between parties, intending to preserve the relationship between them – or at least try to do so – and use the positive power of transformation that conflicts have. As underlined earlier, the objective of enhancing communication between health care stakeholders and patients was a key point in the introduction of the complaint process more than twenty years ago. This illustrates that preserving relationships between individuals, or at least not worsening them, could be, and perhaps should be in some cases, a key concern of the complaint process. Moreover, easy access to the mechanism can empower patients and even family members to ensure that their health care rights and needs are respected in the course of their relationships with health care workers.

In short, the Health Ombudsman can reach most health care professionals, and engage in a dialogue, which is an important aspect with respect to enhancing professional accountability. This CRM can maintain communication with both patients and professionals before, during, and even after the complaint process, thus being able to provide guidelines on a regular basis. It allows for a relatively "safe environment" for discussion due to confidentiality protection. Also the Health Ombudsman adapts more easily to the reality and needs of professional standards as the health care field evolves. Due to the competition of norms in health care, professionals can, nevertheless, resist those coming from the Health Ombudsman given their lack of enforcement and, possibly, legitimacy.

Now that we have explored the potential of the Health Ombudsman institution for enhancing political, managerial and professional accountability in health care, it is important to comment on "patient accountabil-

106. Health Ombudsman Act, *supra* note 34, ss. 34 to 36.

ity." Canadian citizens should also have responsibilities in health care. Ideally, Canadians should not only have a role to play in defining accountability expectations,[107] but they should also have a role in achieving accountability, which would benefit the whole system. If notions of accountability are only used to put Canadians in a position of "demand" with regards to people and outcomes, the formula of accountability in Medicare remains incomplete.[108] If patients' and citizens' roles are ignored, they are forced to remain outside the system looking in.[109] Canadians should try to respect their part of the "social contract" in the Medicare system by making judicious use of resources, by being involved in decision-making processes affecting their health (whether at an individual or societal level), and by being accountable to other citizens and to government for their actions.[110] The correlative responsibility of governing bodies is to provide Canadians with accessible and meaningful ways for such involvement. Yet advocating for citizen/patient accountability might be easier said than done; nobody is against virtue, but what happens afterwards?

Mechanisms to hold patients/citizens accountable are currently almost non-existent. It is not well-viewed, at least publicly and politically, to make patients bear the costs of their own health choices and health care use. In practice, nevertheless, some physicians seem to make patients bear the costs and consequences of their "health" choices or habits.[111] While imposing formal consequences on patients/citizens probably represents an unrealistic or unacceptable option (notably on grounds of logistics, individual freedom rights and social inequities), people should, to start with, be aware and reminded of their own role and impact on a publicly-funded health care system dealing with rationing issues. It remains true, however, that unless we find ways of increasing

107. Abelson & Gauvin, *Transparency*, *supra* note 1. The authors mention that Canadians should be involved in defining their expectations of people, institutions, and mechanisms that support accountability, at p. VI. The Romanow Commission is a good example of a process that made Canadians more specific in their expectations.

108. Abelson & Gauvin take a similar view in *ibid*.

109. Zimmerman, *supra* note 1.

110. Abelson & Gauvin, *Engaging Citizens*, *supra* note 4 at 12.

111. See N. Kohler & B. Righton, "Overeaters, Smokers, and Drinkers, The Doctor Won't See You Now" *Maclean's* (24 April 2006) online: <http://www.macleans.ca/science/health/article.jsp?content=20060424_125702_125702>. The article points out that obesity is among the health conditions that influence the practices of physicians. Considering that such physicians' practices are made under the cover of clinical judgment, there is, however, no possibility to make physicians accountable in that respect. This speaks to the contention mentioned earlier in this article concerning the fact that many medical decisions escape scrutiny.

citizen/patient accountability in health care, an important part of the health system will remain unaccounted for.

CRMs can to some extent encourage accountability from patients, but the capacity of these mechanisms in that regard is limited to situations where conflicts arise and disputes follow the path of formal resolution. Mechanisms based on a legal rationale, such as courts and administrative tribunals, are less prompt in forcing justification if no legal responsibilities on the part of citizens are set forth in law. As an illustration, courts can ask for justification from patients on how they minimized damages in a medical liability case (whether the patients promptly contacted a physician, followed medical recommendations, etc), but they cannot force a patient to demonstrate "reasonable" efforts at trying to quit smoking. In Quebec, the law states that users must be encouraged, through the provision of adequate information, to access services in a judicious manner.[112] As mentioned in the law, this statement is in fact a guideline intended to guide the management and provision of health services and social services. It is expressed in general terms, and we doubt that courts will ever use such a provision to limit access to health care services. In other words, to the extent that a legal duty previously existed from the patient/citizen perspective, these means can force a person to justify his or her conduct. If, however, there are no formal or precise responsibilities, such dispute mechanisms are limited in their capacity to obtain justification.

Ombudsman institutions, by being able to incorporate considerations that go beyond the legal framework in their decisions (ethical, financial, and social considerations for example) offer, arguably, a more flexible means for asking for accountability from patients/citizens – and from other stakeholders as well. As an illustration, there is a case where the Quebec Health Ombudsman asked a patient why she refused many offers of help from her local (public) home care service provider.[113] The patient wanted to be reimbursed for private home care services for which she had had to pay. Due to her repeated unwillingness to collaborate with the public provider without any good reason (e.g., this was not due to personal, psychological, or physical problems), the Ombudsman recommended that the patient not be reimbursed for her personal fees. Regardless of the value of this decision, it demonstrates the Ombudsman's capacity, *to a certain extent*, to ask for justification and conse-

112. *Health Services Act*, *supra* note 29, s. 3.

113. As underlined earlier, we accessed the Health Ombudsman's decisions on the exceptional ground of research purposes, and we signed a confidentiality agreement. Therefore, we cannot reproduce or name the very decision we are talking about.

quences in regards to patient behaviour. In any case, patients should always be given all the necessary means (information, medical and financial support, appropriate follow-ups in health care relationships and services, etc.) before being asked to demonstrate any measure of accountability.

CONCLUSION

Increasing accountability in health care, especially within the context of a publicly-funded system, is crucial. For Canadians, accountability is a key option for increasing their trust in professional and governing institutions, for attaining a "healthier democracy". This is essential, as we have emphasized that lack of confidence is a significant issue in the health care system and within the governmental apparatus in general. The major benefit of accountability from the perspective of Canadians is trustworthiness. This value, therefore, is vital in strengthening confidence in the health care system, in order to ensure that discretion is being exercised justly, fairly and efficiently.

We have tried to illustrate that accountability is a multifaceted concept in health care. We explored three main models of accountability that help define the content and goals of the concept, namely the political, managerial and professional models. Based on each of these models, accountability should enhance the standards and responsibilities of good governance, effective and efficient management, and quality of care and services. Put another way, these models help to give substance to a concept that could otherwise remain overly diffuse and obscure.

Furthermore, we have insisted on two key components that should be found throughout any model of accountability, namely 1) justification, and 2) consequences. These are requirements through which we can make sure that a real dynamic of accountability exists in every model. Various tools have been put in place to help accountability move from a laudable aim to a concrete measure. We briefly pondered the specific importance that conflict resolution mechanisms play in achieving more accountability in health care, notably because they are particularly good tools for forcing justification from, and imposing consequences on, governmental institutions and other decision-makers involved in Medicare. Based on this specific role that CRMs can play in enhancing accountability, we have focused our analysis on the particular contribution of a health ombudsman. Ombudsman institutions, by being – or at least offering the potential for being – a non-adversarial mechanism, offer different strengths and weaknesses than courts and other adversarial options

with respect to their capacity to enhance accountability. Their strengths are that ombudspersons in general have a flexible scope of intervention and discretion in their decisions and remain accessible to citizens. Here, the Quebec experience has provided useful insights for better understanding of such a contribution.

In the end, we come to the conclusion that a health ombudsman, especially when supported by a patients' bill of rights, can increase measures and objectives of accountability in all models. It also incorporates consideration for a more holistic approach to accountability, one that acknowledges the importance of humane – yet more intangible – aspects of health care and services. An ombudsman institution also leaves room, to a lesser degree however, for addressing issues of citizen/patient accountability in health care systems.

As the Quebec experience illustrates, ombudsman institutions do not always have the capacity to intervene in the private health care sector, which could become a noticeable limitation with the growing presence of such a sector in the future; consequently, an important part of the health care system remains out of reach of the Health Ombudsman. Options could be explored to adapt to this reality, as other countries have required the inclusion of both private and public sectors in their legislation.[114] For instance, Finland's *Act on the Status and Rights of Patients* requires the appointment of an ombudsman to all health care units, either private or public.[115]

Furthermore, if the Ombudsman appears, based on our reflection, to be a valuable institution for instilling more accountability in the health care sector, it should still work in tandem with other institutions and tools, such as the Auditor General, the courts, and boards of directors in health care institutions to develop a broader culture, almost a reflex, of accountability from health care decision-makers. The benefits of a strong culture of accountability, which should be part of a renewed model of health care governance, are worth all the effort put into improving such a model.

114. See C.M. Flood & K.M. May, *supra* note 12.
115. *Ibid.*; S. Mackenney & L. Fallberg, eds. *Protecting patients' rights? A comparative study of the ombudsman in healthcare*, Oxon (UK): Radcliff Medical Press, 2004.