

WHAT IT IS – WHAT IT SHOULD BE

An Empirical Analysis of the Effect of Procedures and Substantive Arguments on
Adjudicative Tribunal Resource Allocation Decisions

A Case Study of 2003-2008 Decisions made by the Ontario Health Services Appeal and
Review Board (HSARB) regarding Out of Country Coverage for Non Emergency
Inpatient Health Services (OCCNEIHS)

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ABSTRACT

Our current understanding of tribunal resource allocation decision-making is via judicial review of tribunal decisions and/or the capacity, independence and appointment process of tribunal members. This analysis of tribunals provides incomplete information.

This qualitative five year case study asked the three following questions:

Research Question #1:

Do procedures statistically affect the resource allocation decisions of the Board? If so, what elements of the procedures create this statistical effect?

The author analyzed the quantitative research results relative to the A4R theory's four procedural conditions of transparency and concluded that the A4R theory it bwas not 'fine grain' enough to identify the complexity of the tribunal resource allocation decision making. Quantitative analysis revealed that Board decisions were influenced by elements of the Board's procedure. In particular, the author's statistical analysis found that the Board's procedures statistically did affect resource allocation decisions by disadvantaging self- represented parties and, for a certain year, parties not participating in the tribunal's hearing orally/in person.

Research Question #2:

What substantive arguments affect the resource allocation decisions of the Board?

This study confirmed that submissions by the parties – the patient and OHIP - affected resource allocation decisions. However, within these substantive arguments the research found that patients and administrative requirements played a key role in determining out of country coverage of nonemergency inpatient health services (OCCNEIHS). The research also identified that more patients requesting OCCNEIHS argued for treatment to be considered acceptable than argued that treatment domestically would be delayed. The research also identified that there was an absence of arguments regarding the economic implications of OCCNEIHS.

Research Question #3

What Should Be the Revised Resource Allocation Decision Making Mechanism?

It is recommended that any non-neutral procedures be further examined and potentially eliminated. It was also recognized that significant expert consensus on multiple factors was required in order to make resource allocation decisions. As a result of this research, it is recommended that resource allocation decisions should be based on a multi factorial algorithm comprised of ongoing expert consensus, available publicly and utilized by OHIP for the determination of resource allocation. The Board's jurisdiction should be revised.

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I could not have done it without you

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Research Question #1

Do procedures statistically affect the resource allocation decisions of the Board?

If so, what elements of the procedures create this statistical affect?

Research Question #2

What substantive arguments affect the resource allocation decisions of the Board?

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Chapter 1

INTRODUCTION

Why allocate resources? Scarcity. Scarcity assumes more people want a given resource than is available. When more people want a resource than is available, difficult choices have to be made. So how do we – as a society – decide how to allocate a limited resource? What is the decision making process? Do certain factors influence the decision making process? What is the theoretical, actual and revised resource allocation decision making process? This thesis attempts to answer these questions

Adjudicative administrative tribunals¹ are one mechanism for making decisions regarding the allocation of resources. Tribunals in Ontario are a quasi-judicial decision making mechanism which provide parties - who have been denied a government resource by a government agency – a forum to appeal the resource allocation decision. Tribunals are important because the vast majority of Ontario residents will not access the judicial system for resource allocation decision making but may access the quasi-judicial system of tribunals. As such, tribunals have a larger impact on the residents of Ontario than the courts. However, very little is known about Canadian tribunals – and Ontario tribunals in particular - and the factors which influence tribunal resource allocation decision making. Our current understanding of tribunal resource allocation decision making has taken place – in the author’s opinion – in the following two waves.

¹ Hereinafter “tribunals”.

The first wave of attempting to understand tribunal decision making was the result of the legal analysis of judicial review. While courts typically defer substantive decision making to the tribunal, they review the tribunal's decision in accordance with procedural requirements according to the law. The courts have also provided tribunals with direction concerning what the courts consider appropriate procedural elements. As such, the court's oversight and direction to a tribunal through judicial review has been an important factor in understanding tribunals.

The second wave of attempting to understand tribunals and the factors which may influence their resource allocation decision making came from the examination of tribunal members themselves – typically in terms of the members' expertise, independence, potential bias and appointment processes.

Both the first wave and the second wave - in the author's opinion – provide important but preliminary information on tribunal procedures. However, judicial review and tribunal member attributes do not provide a holistic view of resource allocation decision making by tribunals. This limited view of tribunal decision making about resource allocation is not only providing an incomplete picture of tribunal decision making but is also a missed opportunity to proactively address problems before they come before the tribunal. A more comprehensive empirical analysis of actual tribunal decision making is required.

In this thesis, the author seeks to develop a novel third wave in understanding tribunal resource allocation decision making. The premise of the third wave is that a tribunal's

decision cannot be understood in isolation from the tribunal's procedures, the submissions by the parties, an understanding of who is appearing before the tribunal and why they are submitting a request.² These elements cannot be separated from the decision arrived at by the tribunal and must be viewed together in order to understand tribunal decision making. In this respect, unlike the first wave of judicial review for tribunal compliance with court sanctioned procedures or the second wave of tribunal membership attributes, this thesis looks at the interplay between patient profiles, procedures, substantive arguments and the ultimate tribunal decisions.

An example of the interplay between profiles, process and substantive argument could be seen in a basketball game. In a basketball game, the focus is not just on the referee's capacity to referee, his/her appointment as a referee or the independence he/she has to call certain plays. The focus is not on a sports networks' review of the referee's decisions. The interest in basketball is on the game played between the teams. It is important to know who is on the home team and who is on the visitor team. Assuming the home team is a constant professional basketball team, observers may wish to know who is on the visitor team. The seven foot tall home team of professional basketball players may be playing a competitive game against another seven foot tall professional basketball team from a rival city. The home team may also be playing against a first grade school team that is three feet tall and never played a competitive game. In this respect, knowing

² In this study, one party is constant while the other party is constantly changing. The party that is constantly changing – in this study it is the patient - activates the hearing before the tribunal. It is also the patient who is affected by the tribunal's decision. However, it is not known who the patients are, where they reside, why they come before the tribunal and what remedy the patient of the tribunal. In order to provide a more fulsome context, the author analyzed each of the decisions in this case study in order to create a 'patient profile' for the study period. The patient profile data are outline in Chapter 7.

who the parties are gives the observer a sense of the game which is about to be played – or in the case of parties before the tribunal, a sense of the hearing that is about to take place.

In terms of process, the basketball teams are required by the rules to play within a basketball court. They do not play outside the court line and into the stands. The players also do not bring a ping pong table onto the court and try to play ping pong while the basketball game is underway. The rules of the game are assumed to be understood. If the rules of the game are not abided by, it may be because a player does not understand the rules or they may understand the rules but wish to make a point contrary to the rules. Applied to a tribunal hearing, the tribunal has a jurisdiction within which a hearing takes place. The parties cannot expand the jurisdiction of the tribunal (e.g. play in the stands) or bring into the tribunal those elements which are not within the jurisdiction (e.g. a ping pong table). A party before the tribunal may truly not understand the jurisdiction of the tribunal, may want to make a point or may not have another suitable forum in which to bring forth concerns.

Also in terms of process, the basketball league does not purposely disadvantage the teams – such as putting rocks on one side of the basketball court thus disadvantaging one of the teams. Instead, the basketball league tries to ensure that the basketball court is a level playing field for both teams so the teams can concentrate on playing the game rather than navigating the rocks. The venue may inadvertently disadvantage a team if the game is continually played on one team's home court or if the venue lights are too bright for one

team to play to their potential. Applied to a tribunal hearing, the tribunal's procedures are intended to create a level playing field with no intentional barriers (e.g. the rocks on one half of the court) upon which the game can be actually played. While not intended, the tribunal's procedures may inadvertently disadvantage one of the parties if self represented or unable to attend the hearing in person.

In terms of substantive issues, it is helpful to know whether a particular team plays well in the first part of the game but not in the second part of the game or if the team has a particular technical skill in one area of play but not in another. Applied to the tribunal, it is helpful to know if a party excels in one part of the substantive argument before the tribunal but not in another substantive argument.

Overall, it is important for the observer not just to know who won the basketball game/granted a resource but rather to know who the teams/parties were, if they played within the court/jurisdiction, where they were inadvertently disadvantaged by the venue/procedures to the point of losing the game/not attaining the resource requested and where in the process a party won the game/what substantive argument(s) attained the resource requested.

Continuing with the basketball example, most players and teams are assessed over an extended time period. In this respect, trends can be observed both within one player and between teams. This assessment over time is important in order to determine if a particular game reflects a trend or if it reflects an outcome that occurred by chance and is

not a trend. Applied to the tribunal, it is important to understand if the elements of patient profile, procedures, substantive arguments and the Board decision occurred by chance or if the elements reflect a trend. To date, most legal research is based on case analysis. The academic discussion, outlined in Chapter 3, identifies that case analysis is insufficient and empirical research is required. However, there is little legal research on multiple cases over an extended period of time which is analyzed statistically to distinguish between chance occurrences and trends. This thesis seeks to analyse multiple cases over an extended period of time and to statistically analyse the data in order to determine if the results were due to chance occurrences or if the results reflected a trend or trends.

Empirical Research

In order to understand the effect of procedural elements and the substantive arguments on tribunal resource allocation decisions and how this compared to theoretical models, a case study of a tribunal was undertaken. In this respect, one section of a regulation – section 28.4(2) of Regulation 552³ of the Health Insurance Act,⁴ which deals with the funding of health care outside of Canada, was critically analyzed over a five year period. When the government denies publicly funded health insurance for health care requested outside of Canada, the government's decision can be appealed to the Health Services Appeal and Review Board (HSARB). It should be noted that the statutes and regulation related to HSARB do not require HSARB to act primarily as a health service resource allocation decision making body. However, that is the effect of what it does, and in the course of fulfilling its legislative mandate, HSARB does operate though a resource

³ R.R.O. 1990, [hereinafter “Regulation 552”].

⁴ R.S.O. 1990, c.H.6, [hereinafter “the HIA”].

allocation lens. This resource allocation lens can be seen throughout the approximately 400 decisions regarding s.28.4(2). The decisions were empirically analysed with respect to the following: the characteristics of the parties before the tribunal, the procedural elements of the tribunal hearing, the substantive arguments of the parties before the tribunal and the effect these latter two elements had on the tribunal's ultimate decision to grant or deny resource allocation. The resource being allocated was public financing of health care outside of Canada.

The five year period was selected for a number of reasons. First, the study time period represented a period of relative stability. One provincial government party was in power during this period suggesting little philosophical or political change to out of country health care policy and/or legislation during this period. Second, the leadership of the HSARB as a tribunal and the office secretariat remained constant during the period. Third, the position of the appellate courts in Ontario was not finalized during this period, resulting in an absence of changes to social policy or the legislation.⁵ This relative stability on multiple fronts allowed for a focus on actual tribunal resource allocation decision making rather than a focus on changes to the legislation and regulatory framework or structural changes to the decision making mechanism. It was also assumed, at the beginning of this thesis research, that HSARB decisions during the study period would be easily accessible electronically. This latter point turned out not to be the case.

⁵ One major case decision from the Ontario Divisional Court was released in 2007 - *Flora v. Ontario Health Insurance Plan*, 2007 CanLII 339 (ON S.C.D.C.). However, this decision was on appeal to the Ontario Court of Appeal. The Ontario Court of Appeal's decision was released in July of 2008 - [Flora v. Ontario Health Insurance Plan](#), 2008 ONCA 538 (CanLII) after the thesis study period ending March 2008. While on appeal, major changes to the HSARB resource allocation process or the provincial legislation did not take place.

It should be noted that this study deliberately did not empirically research Board members' capacity, independence, potential bias or appointment process. This decision was made because of methodological challenges. This study attempted to objectively quantify variables for analysis. However, details regarding the Board members' appointment process, duration of appointment, availability, preference or expertise to hear certain cases and the capacity, independence or potential bias of the scheduler were not available from the data source. For example – in terms of the appointment process -- nominations for Board member appointments are submitted to a legislative committee comprised of all political parties. Each political party is required to approve an appointment. Appointed Board members serve for a non-tenured, part time period of two to three years. The two to three year part time appointment was not the same for all appointees in the study, such that some appointees may be nearing the end of their appointment while other appointees are just beginning their appointment. Once appointed, the Board members submit their availability to a scheduler who formulates panels of three appointees to collectively hear and deliberate on a case. None of the above information – along with Board members' capacity, independence and potential bias -- was available through this study's data source of Board decisions.

Resource allocation decision making, as previously discussed, has typically focused on the neutrality of the decision maker. There is a long standing debate within the Alternative Dispute Resolution (ADR) academic literature regarding the neutrality of mediators and the affect on the process and outcome of disputes between parties. More

recently, this debate has shifted to include the role of the decision making system.

Lawrence Susskind⁶ argues that mediators should not be neutral during the process or outcome of mediation. Mediators need to play an active role in the process of mediation by guaranteeing full participation and a balanced exchange between capable parties as well as being accountable for the negotiated outcomes.

Josh Stulberg⁷ argues that mediators need to exhibit neutrality regarding the outcome but not in the process to arrive at the outcome. If a mediator assumes responsibility for the fairness of the agreement between the parties then the mediator is abandoning a neutral stance and creates an unwarranted role expansion. He states that the mediator is not equipped or entitled to assume the role of social conscience or social critic.

Bernie Mayer⁸ states that the focus on the neutrality of the mediator is misleading as the fairness of an outcome is largely reliant on the system structure rather than the mediator's behavior. In fact, he states that it is the role of the system not the role or obligation of the mediator to provide a socially responsible process. In this respect, the design, safeguards and management of the system, the training of people who work within the system and the ability to address system problems needs to be considered. Mayer states that a mediator can still be neutral and yet intervene when the system has not allowed for

⁶ Lawrence Susskind, "Environmental Mediation and the Accountability Problem" (1981) 6 VT. L. REV. 1.

⁷ Joseph B. Stulberg, "The Theory and Practice of Mediation: A Reply to Professor Susskind" (1981) 6 VT. L. REV. 85.

⁸ Bernie Mayer, "Core Values of Dispute Resolution: Is Neutrality Necessary?" 95 Marq. L. Rev. 805 2011-2012.

participants to have an effective voice, including having the right parties at the table and/or have ignored important issues.

This thesis aligns with the scholarship of Mayer by focusing on the system as opposed to focusing on the decision maker. Of particular interest is Mayer's comment regarding the need to consider system problems. The consideration of system problems can only be undertaken if the system problems are identified. An empirical review undertaken in this thesis of Board processes, substantive legal arguments and outcome decisions over multiple years is designed to help identify system problems which may subsequently be addressed.

It must be stressed that the empirical quantitative research that was undertaken in this study examined preliminary correlations not causation relationships. In other words, the study cannot report that one factor caused another factor. The study can only say that there was a correlation between the factors. As a correlation, the factors must be more closely examined in order to determine the meaning behind this result. It is highly recommended that further qualitative research be undertaken to further explore the correlations.

In terms of research questions, this study focused on analyzing the association of the Board's procedures and the parties' substantive arguments on Board decisions. In terms of procedures, the prevailing assumption is that procedures do not influence the resource allocation decision but rather create a 'level playing field' upon which the parties can

make their substantive arguments. This assumption was questioned in this thesis. In this respect, the thesis asks the following question: Research Question #1:

Do procedures create a statistically significant effect on resource allocation decisions of the Board? If so, what elements of the procedures create this statistical effect?⁹

The quantitative results of the Board's procedures were analyzed relative to the leading process theory – Accountability for Reasonableness (A4R) - in order to determine if the theory of resource allocation decision making reflected the actual practice of resource allocation decision making. If the actual practice did not reflect the A4R theory, expecting the A4R theory to explain tribunal decision making is questionable.

This thesis also critically examined why some Applicant/Patients are granted resources while others are not. As such, this thesis asks:

Research Question #2:

What substantive arguments affect resource allocation decisions of the Board?¹⁰

Based on the research results of actual tribunal decision outlining procedures, the substantive arguments taking place before the Board and an analysis of the literature, this author proposes a revised resource allocation decision making mechanism in order to answer the following question:

⁹ Chapter 8 – What It Is Now: Procedures: Quantitative Research Results

¹⁰ Chapter 9 – What It Is Now: Substantive Arguments: Quantitative Research Results

Research Question #3

What Should Be the Revised Resource Allocation Decision Making Mechanism?¹¹

The revised resource allocation decision making mechanism should increase the likelihood of decision acceptance by ensuring a fair, transparent neutral process for determining resource allocation and taking into consideration a multiple of factors that affect substantive arguments.

Outline of this Thesis

This thesis is laid out in the following manner: Chapter 2 outlines the legislative context within which the Board operates. Chapter 2 is important because the analysis of this study relative to the A4E theory became largely dependent on the legislative framework rather than on the study's data. In this respect, at least two of the four A4R theory criteria are established in legislation as opposed to quantitative data. For example, the A4R requirement for the 'appeals' condition and the 'enforcement' condition were found in the statutes rather than within the Board's decision.

Chapters 3, 4 and 5 review the literature regarding resource allocation mechanisms. Chapters 3, 4 and 5 review the literature in terms of the lack of empirical research, the judicial and quasi-judicial systems of decision making and the existing procedures and substantive theories regarding decision making. More specifically, Chapter 3 reviews the

¹¹ Chapter 11 – What It Should Be: Revised Resource Allocation Decision Making Mechanism

literature regarding the academic discussion of the overall lack of empirical research in legal studies. This chapter specifically examines the dearth of tribunal empirical research and lack of academic discussion and debate on the topic. Chapter 3 also critically analyses the existing qualitative and quantitative tribunal research. The existing qualitative and quantitative research on tribunals was analyzed in an effort to inform the author of existing research methodologies and potential variables for analysis. This methodological review formed the basis of this thesis' research design. Chapter 4 reviews the academic debate regarding the use of judicial and quasi-judicial as decision making mechanisms. In particular, Chapter 4 reviews the debate regarding the role of the courts in health care decision making, their overview of tribunals via judicial review and their deferral of difficult resource allocation decisions to tribunals. Chapter 5 reviews the academic literature on substantive and procedural decision making theories with specific reference to the A4R theory.

Chapters 6, 7, 8, and 9 outline the study's methodology and the results. For example, Chapter 7 examines who is coming before the Board, why they are coming before the Board and what treatment and facilities they are requesting. Chapter 8 analyses the first research question -- whether the Board's procedures statistically affect resource allocation decisions. If procedures are associated statistically with resource allocation decisions, the study analyzes what elements of the procedures create this statistical effect. Chapter 9 analyses the second question - what submissions by the parties affect resource allocation decisions.

Chapter 10 analyses the study results relative to the academic discussion regarding the lack of empirical research and relative to the A4R theory. Chapter 11 answers the third research question by outlining a revised resource allocation decision making mechanism – based on the results of Chapter 7-10. Chapter 12 summarizes the study's conclusions.

Chapter 13 presents a final thought regarding the potential to use the OCCNEIHS situation to pilot test and study alternative health care delivery models. Chapter 14 is an Epilogue which outlines some legislative development since the end of the study period.

Chapter 2

Legislative Framework

1. Introduction

2. Legal Framework

- a. Canadian Constitution - Division of Powers
- b. Human Rights Code
- c. Canada Health Act
- d. Ontario Health Insurance
- e. Health Services Appeal and Review Board
 - i. Statute, Regulation, Jurisdiction and Composition
 - ii. The Board's Procedures

Dates (file/hearing/decision);

Format (oral/written/teleconference/combo);

Self-representation/lawyer

Interpreter

Review by HSARB

iii. Substantive Arguments of the Parties

Insured Services

Excluded Services

Out of Country Coverage – ‘test’ criteria under s.28.4(2)

Generally Acceptable

Identical / Equivalent

Delay

Prior Approval Requirement for OCCNEIHS: s.28.4(5)

3. Conclusion

Chapter 2

Legislative Framework

Introduction

The purpose of this chapter is to provide an overview of the existing Canadian health care legislative system within which HSARB is situated. It is within this system and legal constraints that Board decisions regarding the out of country coverage of health care services are made. Chapter 2 is important because the analysis of this study's results relative a leading theory, Accountability of Reasonableness,¹² was largely dependent on the legislative framework rather than on the study's quantitative data. For example, at least two of the four A4R theory criteria – the appeals condition and the enforcement condition -- are established in legislation as opposed to the quantitative data. Chapter 2 is also important because it provides the legislated definitions and criteria for the Board's procedures (Research Question #1) and the substantive legal arguments of the parties before the Board (Research Question #2).

Summary of Ontario's Out of Country Coverage

In order to provide a context for this research, it is important to understand how health care services are provided to Ontario residents. Health care services are provided to Ontario residents in three major situations in three main geographic areas.

The three major situations include – an emergency, a non-emergency outpatient situation and a non-emergency inpatient situation. Emergency situations involve a serious or life

¹² Hereinafter “A4R”.

threatening event for the patient where immediate action must be taken - such as a heart attack or a severe car accident. Non-emergency outpatient situations involve a health care situation that is not considered serious enough to require admission into the hospital or health facility. Non-emergency inpatient situations involve events where the patient is admitted into the hospital or health facility for a serious health care issue. However, while the health care issue is considered serious enough for admission to the hospital, it is not considered serious enough to qualify as an emergency situation.

In addition to the three major situations in which health care services are provided, Ontario residents are able to receive health care in three main geographic locations: (1) within Ontario, (2) outside Ontario but within Canada and (3) outside Canada. It should be noted that any form of health care services outside Canada is – theoretically -- available to Ontario residents. The question is who pays for health care service outside Canada. If the patient pays for the health care services outside Canada through a private health insurance plan or out-of-pocket – often referred to as ‘medical tourism’ -- the Ontario government and the publicly insured health plan are not involved and have no say in what services are or are not to be funded. However, if the Ontario government is asked to use public funds to pay for out of country health care, then Ontario legislation – specifically the HIA- is invoked.

The Ontario government’s public insurance program that administers the HIA is called the Ontario Health Insurance Plan – or as commonly referred to – OHIP. The criteria by which OHIP determines which health care services provided outside Canada are publicly

insured are set out in the HIA and Regulation 552. Under Regulation 552, section 28 determines whether health care provided outside of Canada will be paid for by OHIP. Specifically, section 28.4(2) contains the regulatory criteria – or the ‘test’ - to determine whether non-emergency inpatient health services provided on an inpatient basis outside of Canada are or are not publicly insured by OHIP. Out of country coverage for non-emergency inpatient health services will be referred to as OCCNEIHS for the purpose of this thesis. In terms of the process to receive OCCNEIHS, the patient – based on approval from their physician - appeals to OHIP to approve and thus fund an OCCNEIHS. OHIP may grant, deny or partially grant the requested OCCNEIHS based on the test in section 28.4(2). Where OHIP has denied or partially denied the requested OCCNEIHS, the patient may appeal the request to HSARB.¹³ Based on the submissions of the parties at a hearing, HSARB issues a written decision stating whether or not the health care service is financially covered by the provincial publicly insured health plan. The patient and/or OHIP may appeal the HSARB decision to the Ontario Divisional Court,¹⁴ then the Ontario Court of Appeal and ultimately with leave to the Supreme Court of Canada (SCC).

2. Legal Framework

The Board’s decision regarding an OCCNEIHS takes place within a larger legislative framework. The legislated framework reviewed included the Canadian Constitution, the Ontario Human Rights Code, the Canada Health Act, the Ontario Health Insurance Act,

¹³ HIA Supra Note 4 at s.20.

¹⁴ Ibid at s.24.

the Ministry of Health Appeal and Review Boards Act. Thus, the Board must determine resource allocation based on the parties' submissions within these legal constraints.

a. Canadian Constitution: Division of Powers

It is important to understand the overall constitutional context within which HSARB operates. The overriding statute that affects all laws within Canada is the Canadian Constitution¹⁵ of 1867. The Constitution has played an important role in the federal government and the provincial government with respect to the Ontario health care system. The Constitution divided the governance powers of the federal and provincial governments under section 91 and section 92. According to section 91 of the Constitution, the federal government has jurisdiction to deal with national issues that affect all Canada such as taxation (s.3), census and statistics (s.6) and marine hospitals (s.11). The federal government also has jurisdiction over Canadian issues outside Canadian borders such as trade and commerce (s.2). Thus, the federal government has Constitutional powers for some matters across Canada as well as issues outside or coming into or out of Canada. Provincial jurisdiction is outlined in s.92 of the Constitution. In addition to provincial jurisdiction over property and civil rights (s.13) in the province and matters of a local nature (s.16), section 92(7) has been interpreted to assign the bulk of the jurisdiction over health to the provinces.¹⁶ As such, the delivery of health care is interpreted to be largely a provincial responsibility.

¹⁵ Constitution Act, 1867 (U.K.), 30&31 Vict., c. 3.

¹⁶ Section 92(7) states that provinces have jurisdiction over health care delivery:

The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.

In 1982, the Canadian Charter¹⁷ was enacted. While the Constitution applies to the provincial and federal governments, the Charter applies to the government relative to its residents in that it protects individual rights and freedoms from unjustified governmental actions.¹⁸ The Charter does not explicitly protect a right to health care but the Supreme Court of Canada (SCC) has stated that when the government puts in place a system to provide health care, that scheme must comply with the Charter.¹⁹

In 2002, the Ontario legislature clarified that the Board did not have constitutional jurisdiction to inquire into or make a decision concerning the constitutional validity of a provision of an Act or regulation. Thus, the Board's enabling legislation, the Ministry of Health Appeal and Review Boards Act,²⁰ expressly prohibits the Board from having authority to inquire into or decide questions concerning the constitutional validity.

Section 6(3) of that MOHARBA states:

Limit on jurisdiction

6(3) Despite subsection (2), the Board shall not inquire into or make a decision concerning the constitutional validity of a provision of an Act or a regulation.²¹

¹⁷ Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c.11 [hereinafter "the Charter"]

¹⁸ Nola M. Ries, "Charter Challenges" in Jocelyn Downie et al. eds, Canadian Health Law and Policy 3rd ed (LexisNexis Canada Inc., 2007) 541.

¹⁹ *Chaoulli v. Quebec (Attorney General)*, [2005] S.C.J. No. 33, 1 S.C.R. 791 (S.C.C.) [hereinafter "Chaoulli"] at para 104 per McLachlin C.J.C. and Major J..

²⁰ S.O. 1998, Chapter 18, Schedule H [hereinafter "MOHARBA"].

²¹ *Ibid.*

Prior to this amendment, the Board did interpret the legislation to include jurisdiction to determine constitutionality.²² However, given the 2002 legislative prohibition and the subsequent five year study period of 2003/04 to 2007/08, the Board would have operated under a jurisdiction which excluded Constitutional jurisdiction. The Board itself has recently recognized the argument that it should have Charter review powers but clearly stated that this scope is beyond its jurisdiction.²³

b. Ontario Human Rights Code

While the Board does not have jurisdiction over constitutional questions, it does have jurisdiction to apply the Ontario Human Rights Code²⁴. The application of the Code to a tribunal's statutory mandate was clarified on April 21, 2006 in the decision of Tranchemontagne.²⁵ In that decision, the majority of the SCC held that administrative tribunals must apply the Code and consider whether any aspects of the tribunal's legislation are inconsistent with the Code when rendering their decisions. The majority of

²² L.H. v. General Manager of OHIP, September 19, 2001 – unreported decision

²³ In EH v. Ontario (Health Insurance Plan), 2011 CanLII 67509 (ON HSARB), <<http://canlii.ca/t/fnlpj>> retrieved on 2012-02-13 the Appellant had made a number of submissions as to why the Board ought to proceed with a hearing on the Charter issues. The Board stated at para 10-11:

“One such submission, to which there may be considerable merit, is that a Charter challenge made to legislation before the Board is considerably more expeditious, less time consuming and less expensive to the parties than proceeding before a Court. The Appellant also submits that disadvantaged individuals would have a greater opportunity to participate in Charter challenges whether before this Board or other administrative tribunals than they would in a court proceeding.

11. As sympathetic as this Board may be to the Appellant’s submissions, the fact remains that Section 6(3) of MHARBA presents an insurmountable hurdle for the Appellant to overcome. This section does not allow the Board to even “inquire” into the constitutional validity of an Act or Regulation, which is the very inquiry the Appellant asks the Board to make. The Appellant has given no authority that deals with any other Board’s jurisdiction regarding constitutional inquiries in the face of such a prohibition. On any principle of statutory construction or interpretation, the Board is foreclosed from granting the relief requested by the Appellant in paragraph 20.D of her submissions. The question whether the legislature’s erection of the hurdle faced by the Appellant was constitutional will have to be answered in another forum.”

²⁴ R.S.O.. 1990, c. H.19 [hereinafter ‘the Code’].

²⁵ Tranchemontagne v. Ontario (Director, Disability Support Program), [2006] 1 SCR 513 [hereinafter “Tranchemontagne”].

the SCC also stated that tribunals that are properly seized with human rights complaints cannot decline to exercise their jurisdiction, in favour of referring the complainant to a human rights commission, unless the legislature has granted the tribunal the power to do so. The SCC stated:

The importance of the Code is not merely an assertion of this Court. The Ontario legislature has seen fit to bind itself and all its agents through the Code: s. 47(1). Further, it has given the Code primacy over all other legislative enactments: s. 47(2). As a result of this primacy clause, where provisions of the Code conflict with provisions in another provincial law, it is the provisions of the Code that are to apply.²⁶

As such, the Code is a statute with quasi-constitutional status, which the Ontario Legislature has given primacy over all other provincial legislation – including the HIA and Regulation 552.²⁷

The Board itself recognized its right to apply the Code in D.G. v. Ontario (Health Insurance Plan):²⁸

²⁶ Ibid at para 34.

²⁷ The importance of Dunsmuir v. New Brunswick, [2008] 1 S.C.R. 190 and Canada (Citizenship and Immigration) v. Khosa, 2009 SCC 12 (2009) should be noted – i.e. where a reasonableness standard of review applies, reviewing courts cannot substitute their own view of a preferable decision, but must determine whether the tribunal's outcome falls within the range of possible, acceptable outcomes supported by the evidence.

²⁸ 2009 CanLII 85052 (ON HSARB), <<http://canlii.ca/t/2c035>> retrieved on 2013-02-24 [hereinafter D.G. v. Ontario].

In the Appellant's Appeal, the Appellant states that the policy which does not provide for insured PSA screening tests is wrong and flagrantly discriminatory to males. Accordingly, the Appellant's application raises a matter of alleged discrimination which may be contrary to the Human Rights Code of Ontario. Although this Appeal Board does not have jurisdiction to determine the constitutional validity of the statute (Ministry of Health Appeal and Review Board Act, Section 6(3)), this Appeal Board does have jurisdiction to consider whether a matter before this Appeal Board may be a violation of the Ontario Human Rights Code, since the recent Decision of the Supreme Court of Canada in *Tranchemontagne v. Ontario (Director, Disability Support Program)*, 2006 SCC 14 (CanLII), [2006] 1 S.C.R. 513. More specifically, the Appeal Board may have jurisdiction to consider whether or not the exclusion of screening tests for prostate cancer in asymptomatic men and the failure to fund them is discriminatory under the Human Rights Code.

The Appeal Board raised this matter with both the Appellant and the Respondent, and provided the Appellant with a number of options, including adjourning this Hearing in order to be in a position to provide evidence and argument on the matter of the alleged discrimination under the Human Rights Code, or obtain advice with respect to his rights in that regard, or proceed with the hearing in the absence of advancing such a submission before this Appeal Board. The Appeal Board notes that its jurisdiction is concurrent with that of the Ontario Human Rights Tribunal.

The Appellant chose to proceed with the hearing, and makes no argument with respect to whether the insurability of PSA screening tests was discriminatory against men. The Appeal Board proceeded with this matter on that basis.²⁹

It is a challenge to understand how the Board must apply the Code – a quasi-constitutional statute – yet the Board does not have the jurisdiction to deal with constitutional matters. This is a topic for another discussion.

c. Canada Health Act

In Canada, the Canada Health Act,³⁰ instituted in 1986, is the legal foundation for the distinguishing characteristic of the Canadian single payer health care system of uniform and universal access to a comprehensive range of publicly insured physician and hospital services.³¹ To date, the CHA only has one Regulation, which outlines the prohibition of extra-billing and user fees.³²

The federal government uses its jurisdiction for taxation under section 91(3) of the Constitution to assist in the funding of the Canada-wide publicly funded health care system. The CHA is the umbrella legislation governing the conditions provinces must

²⁹ Ibid.

³⁰ R.S.C. 1985, c. C-6 [hereinafter ‘the CHA’].

³¹ William Lahey, “Medicare and the Law: Contours of an Evolving Relationship” in Jocelyn Downie et al. eds, Canadian Health Law and Policy, 3d (LexisNexis Canada Inc., 2007) 1 [hereinafter “Lahey”] at 2.

³² CHA, Supra Note 30 Extra-billing and User Charges Information Regulations SOR/86-259.

meet to qualify for full cash transfers of federal taxation funds to the provincial health care programs.³³ Tax funding takes place through the Canada Health Transfer (CHT).³⁴

According to section 3 of the CHA, the objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

The purpose³⁵ of the CHA is to establish criteria and conditions for provincial insured health services in order to receive federal taxation funds/full cash contributions. The CHA outlines, among other elements, the principles which underlie the publicly funded Canadian health care system and act as the criteria for the ‘full cash contributions’ from the federal government to the provinces. These five principles – in addition to user fees and extra billing being banned³⁶ -- are outlined in section 7. Section 7 states that the five

³³ It should also be noted that the federal government has extensive jurisdiction under other federal legislation governing health issues across Canada and across borders. Statutes outlining such federal jurisdiction include: the Department of Health Act, to protect against disease, to engage in health surveillance activities and to conduct research; the Canadian Institutes of Health Research Act which provides federal jurisdiction over the Canadian Institutes for Health Research, a major funding body which supports health research regarding individual and population health; and the International Health Regulations which seeks to prevent, protect, control and respond to the international spread of disease while avoiding unnecessary interference with international traffic and trade.

³⁴ The CHT came into effect on April 1, 2004. Prior to that time, starting in 1996, block funding was provided under the Canada Health and Social Transfer (CHST)
<http://www.parl.gc.ca/Content/LOP/ResearchPublications/2011-02-e.htm>,
<http://www.fin.gc.ca/fedprov/fihc-ifass-eng.asp>

³⁵ Section 4 states: The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

³⁶ [Extra-billing](#)

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists. 1984, c. 6, s. 18.

User charges

principles are public administration, comprehensiveness, universality, portability and accessibility.³⁷ ³⁸ The federal government does not contribute revenue to all provincial health care – the federal government only contributes to provincial health care that is paid for by the provincial government and not by individual out of pocket payments or by a private insurance plan, and that falls within the statutory definition of publicly ‘insured health service’.³⁹ Under the Canada Health Act, “insured health services” refers to hospital services, physician services and surgical-dental service. The provinces may choose to add additional health care services and practitioners to the provincially funded health care plan – but this is not required by the federal Canada Health Act.⁴⁰ ⁴¹

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province. Canada Health Act R.S., 1985, c. C-6.

³⁷ CHA, Supra Note 27 Program criteria – section 7 states: In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters: (a) public administration;(b) comprehensiveness;(c) universality;(d) portability; and (e) accessibility.

³⁸ Lahey states at page 37 that health care services outside of Canada must be paid for at the rate that would have applied if the services had been provided within the province in question. This author cannot find the citation within the CHA for this direction. As such, the CHA does not appear to require this action. Rather, the payment by the province appears to be a provincial decision rather than a requirement under the CHA.

³⁹ Insured health services are defined in section 2 of the CHA as: "insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation.

⁴⁰ The Canada Health Act, in section 2, also defines hospital services and physician services. “Physician services” is defined as ‘medically required’ services delivered by a person lawfully entitled to practice medicine in the place in which the practice is carried on by that person:

“Physician services” means any medically required services rendered by medical practitioners.⁴⁰ ⁴⁰ “Hospital services” are ‘medically necessary’ services provided both to in-patients or out-patients at a hospital.

“hospital services” means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, ...⁴⁰ ⁴⁰

⁴¹ This author notes that physician services under the CHA are referred to as ‘medically required’ services and hospital services are referred to as ‘medically necessary’ services. The HIA, as we shall see, defines physician services as ‘medically necessary’ and hospital services as ‘medically required’. Hence, there is a definitional discrepancy between the federal and provincial definition of ‘medically necessary’ as well as ‘medically required’. This is a fundamental definition difference. The scope of service inclusion for

It is important to note that within Canada, the vast majority of health care providers, including doctors, are either self employed professionals in private practice or employees of institutions or firms controlled and operated by independent corporate bodies.⁴² In the case of physicians, the benefit of this autonomy allows physicians to treat patients according to their own skill and judgment and not managerial direction. The downside of this autonomy complicates managerial direction, particularly for the health care system as a whole.⁴³ So while provincial governments are responsible for regulating the quality of health services and whether or not a health service is publicly funded, they are not responsible for the clinical judgment of autonomously practicing doctors. A doctor is able to use his/her clinical judgment regarding needed health care services for a given patient. According to Lahey, physician generated demand for health care services is a leading preoccupation in health care policy.⁴⁴ Given that the government funds medically necessary health care provided by such professionals as physicians, the government might attempt to reduce its costs by limiting health care budgets and the services that can be provided by doctors. This budget and service limitation has contributed to the public's perception and/or experience of long wait times to access health care deemed by the physician to be medically necessary.

d. Ontario Health Insurance Act:

'medically required' services and 'medically necessary' services is not defined in the CHA/federal or in the HIA/provincial statutes and regulations.

⁴² Lahey, Supra Note 31 at 13.

⁴³ Ibid at 13.

⁴⁴ Ibid at 19.

In Ontario, the provincial government pays for insured health care services for Ontario residents via the publicly funded Ontario Health Insurance Plan (OHIP).⁴⁵ ⁴⁶ OHIP's funding sources are based on both provincial taxation revenue and federal taxation revenue, discussed earlier. OHIP is governed by the HIA. The Minister of Health is ultimately responsible for the administration and operation of OHIP as it relates to the CHA.⁴⁷ As of 2006, both the Ontario Minister of Finance and the Ontario Minister of Health and Long Term Care "may" negotiate federal government contributions/cash contributions regarding 'insured' health services provided by a hospital or health facility.⁴⁸ ⁴⁹ The provincial and federal taxation revenue which pays for health care is not unlimited, yet it is anticipated that more Ontarians will continue to seek publicly insured health care - including out-of-country health care. The increased demand is likely due to advances in medical technology coupled with an increasingly mobile and aging

⁴⁵ The determination of Ontario based medically required and medically necessary health care services is beyond the scope of this thesis.

⁴⁶ It is unclear to the author at this time, what percentage of the Ontario government's annual budget is and has been spent on out-of-country health services – both for those cases coming before the Board as well as cases settled outside of Board Hearings. It is also not clear how much of the budget is spent on out-of-country health service administration and litigation. It is not clear how much is spent on the actual out of country health service and the impact – medically and fiscally – from subsequent related health care follow up in Ontario. These questions, although important, are not answered in this thesis as they were beyond the scope of the Board's decisions.

⁴⁷ HIA Supra Note 4 at s. 2(1), (2).

⁴⁸ Ibid at s.3(1), (2).

⁴⁹ This author notes that as of 2006, the Ontario Finance Minister began to represent the Ontario Government and to become involved in financial agreements with the federal government regarding insured services. Prior to 2006, it appears that only the Ontario Minister of Health represented the Ontario Government in financial agreements with the federal government. With these two Ontario government representatives – the Minister of Finance and the Minister of Health – it is unclear who has the final decision making authority regarding financial cost contribution from the federal government. Given the increased role of the Ontario Finance Minister as of 2006 to represent the Ontario Government in discussions with the federal government regarding insured health services, it is speculated by this author that financial discussions regarding insured health services began to take on legislative importance. The increased prominence of the Minister of Finance in OHIP legislation may indicate a more important role of fiscal and economic matters in the determination of insured services. However, the increased role of the Minister of Finance – in addition to the Minister of Health - in insured service negotiations with the federal government regarding cash contributions means that there are two political stakeholders from Ontario who may or may not be in agreement as to what constitutes 'medically necessary' and 'medically required' publically insured health care.

population. Recent research suggests that an aging demographic has an increased health care utilization.⁵⁰ If there is an increased utilization of the health care system then it is likely there would be an increase in the government expenditure on health care services and/or a decrease in the number of publicly insured health services. Ideally, the demand for publicly insured health care aligns with the purpose of the insurance.⁵¹ How decisions are made about what is covered by public insurance is at the heart of the system.⁵² Difficult decisions must be made regarding what is and is not covered by OHIP. Currently, in Ontario, the government and representatives from the Ontario Medical Association negotiate ‘behind closed doors’ what health care services will be insured by OHIP.⁵³

It has been said that the process derives political legitimacy from the participation of governments and clinical legitimacy from the participation of medical associations. But these sources of legitimacy are likely to be undermined by the

⁵⁰ Jason Nie, Li Tracy Wang, Shawn C, Rahim Moineddin, Ross Upshur, Health care service utilization among the elderly: findings from the Study to Understand the Chronic Condition Experience of the Elderly and the Disabled (SUCCEED project), 2008, 14:6 December, Journal of Evaluation in Clinical Practice, 1044-1049

⁵¹ Purpose of insurance

10. The Ontario Health Insurance Plan is continued for the purpose of providing for insurance against the costs of insured services on a non-profit basis on uniform terms and conditions available to all residents of Ontario, in accordance with this Act, and providing other health benefits related thereto. R.S.O. 1990, c. H.6, s. 10.

⁵² Lahey, Supra Note 31 at 39.

⁵³ The process of determining insurance coverage does include government decision makers and clinical decision makers. However, it is unclear if this process of determining insurance coverage is based on medically necessary and medically required health care or if the process is based on the government’s interest in cost controls and the clinicians’ interest in reimbursement for their services or both. Either way, the process is not transparent and the substantive arguments for inclusion and exclusion of insured health care unclear.

primary focus of the process on physician incomes and by the pervasive concern of governments for cost-containment as an overriding policy objective.⁵⁴

e. Health Services Appeal and Review Board

As will be outlined below, the academic literature has discussed the role of the courts and the use of the Charter in health care decision making. In Ontario, there is a statutory right for insured persons to appeal government health care decisions regarding denied insured services to the Board, and the statutory right to appeal Board decisions to the Divisional Court. However, the Board's actual procedures and the substantive arguments of the parties and their association with Board decisions are under researched. It is not known on a quantitative research basis if procedures involved in Board hearings have an effect on the Board's outcome decision to grant or deny the request for health care services out of country. It is also unknown statistically why the Board grants out of country health care coverage in some cases and denies coverage in others. A closer examination is required of the Board's statutes, regulation, jurisdiction, composition, procedures, substantive legal arguments presented by the parties and the outcome decision given by the Board. This section of Chapter 2 examines what is known about the Board from legislation and released Board decisions.

i. Statutes, Regulation, Jurisdiction and Composition

HSARB was created in 1998 by the amalgamation of five tribunals.⁵⁵ The Board's enabling legislation is the Ministry of Health Appeal and Review Boards Act

⁵⁴ Lahey, Supra Note 31 at 39.

(MOHARB). While HSARB is the appeal mechanism for multiple pieces of legislation,⁵⁶ the majority of the Board's work is with respect to one piece of legislation --the HIA.

Under the HIA, the Minister of Health has the authority to create an advisory panel comprised of physicians to advise on the interpretation of insured services within the Schedule of Benefits. An opinion from this advisory panel is required within 30 days of a request from the Minister of Health or a physician.⁵⁷ The HIA also authorizes the Minister to create a Medical Advisory Committee⁵⁸ whose duties are to be defined by the Minister.⁵⁹

⁵⁵ The Health Services Appeal Board, the Health Facilities Appeal Board, the Health Protection Board, the Nursing Homes Review Board and the Health Protection Board

⁵⁶ MOHARBA, Supra Note 20 at section 6.(1) The Board's duties are to conduct the hearings and reviews and to perform the duties that are assigned to it under the following Acts:

1. The Ambulance Act.
2. Repealed: 2007, c. 8, s. 216.
3. The Healing Arts Radiation Protection Act.
4. The Commitment to the Future of Medicare Act, 2004.
5. The Health Facilities Special Orders Act.
6. The Health Insurance Act.
7. The Health Protection and Promotion Act.
8. The Home Care and Community Services Act, 1994.
9. The Immunization of School Pupils Act.
10. The Independent Health Facilities Act.
11. The Laboratory and Specimen Collection Centre Licensing Act.
12. The Long-Term Care Homes Act, 2007.
13. Repealed: 2007, c. 8, s. 216.
14. The Private Hospitals Act. 1998, c. 18, Sched. H, s. 6 (1); 2006, c. 19, Sched. L, s. 8; 2007, c. 8, s. 216.

⁵⁷ HIA Supra Note 4 at s.5.

⁵⁸ Ibid at s.7.

⁵⁹ Ibid s.7(9)

Duties

The Medical Eligibility Committee shall perform such duties as are assigned to it under the Act or by the Minister. 1996, c. 1, Sched. H, s. 6.

The General Manager of OHIP has the authority to grant or deny enrolment in OHIP, to confirm if a health service is an insured service under OHIP and to fund this service.

Under the HIA, the jurisdiction of the Board is to hear appeals from ‘insured persons’ who have been refused health care coverage and/or the reimbursement of claims by the General Manager of OHIP.⁶⁰ Based on the Hearing, the Board can determine if the requested out of country health service is or is not an “insured service” under OHIP. The Board can direct OHIP to take action or amend an OHIP decision as the Board sees fit as long as it is in accordance with the HIA.⁶¹

The HIA specifies that facts presented as evidence at a Board Hearing must be based “exclusively on evidence admissible or matter that may be noticed under section 15 and 16 of the Statutory Powers and Procedures Act”.⁶² ⁶³ Under the Board’s Rules of Practice and Procedure, it is at the Board’s discretion whether to admit oral or written evidence that is subject matter of the Hearing – at the Hearing if it is admissible in court but does not have to be proven under oath.⁶⁴

⁶⁰ Ibid at s.20(1).

⁶¹ Ibid at s.21(1)

Powers of Appeal Board

21. (1) If a person requires a hearing, the Appeal Board shall appoint a time for and hold the hearing and may, by order, direct the General Manager to take such action as the Appeal Board considers the General Manager should take in accordance with this Act and the regulations. 2002, c. 18, Sched. I, s. 8 (12).

Same

(1.0.1) For the purposes of making an order under subsection (1), the Appeal Board may amend a direction of the General Manager or a practitioner review committee and shall do so in accordance with this Act and the regulations. 2002, c. 18, Sched. I, s. 8 (12); 2007, c. 10, Sched. G, s. 16 (1).

⁶² Ibid at s.23(4).

⁶³ R.S.O. 1990, c. S.22&23 [hereinafter “SPPA”].

⁶⁴ Rules of Practice and Procedure, Rule 16

In addition, the SPPA, the MOHARBA, the HIA and its regulations do not give the Board the authority to consider compassionate reasons as evidence of the need to grant out of country coverage. The Board is also not authorized to grant monetary damages.⁶⁵

A final decision of the Board can be appealed to the Ontario Divisional Court along with a transcript of the proceeding.⁶⁶ Divisional Court can review the Board's decision on questions of law or fact or both. The Court can also exercise all the powers of the Board including endorsing the Board's direction to OHIP, substituting its own opinion and requiring a rehearing by the Board.⁶⁷

The Board is comprised of at least 12 members appointed by Orders in Council and with the approval of the Minister of Health.⁶⁸ No more than three members can be medical

⁶⁵ Except, under Rule 16 of its Rules of Practice and Procedures, where a party has acted unreasonable, frivolously, vexatious or in bad faith in the course of defending or prosecuting an action

⁶⁶ Appeal to Divisional Court

[24.\(1\)](#) Any party to the proceedings before the Appeal Board under this Act may appeal from its decision or order to the Divisional Court in accordance with the rules of court. R.S.O. 1990, c. H.6, s. 24 (1); 1998, c. 18, Sched. G, s. 54 (6).

Record to be filed in court

[\(2\)](#) Where any party appeals from a decision or order of the Appeal Board, the Appeal Board shall forthwith file in the Divisional Court the record of the proceedings before it in which the decision was made, which, together with the transcript of evidence if it is not part of the Appeal Board's record, shall constitute the record in the appeal.

⁶⁷ Powers of court on appeal

[\(4\)](#) An appeal under this section may be made on questions of law or fact or both and the court may affirm or may rescind the decision of the Appeal Board and may exercise all powers of the Appeal Board to direct the General Manager to take any action which the Appeal Board may direct the General Manager to take and as the court considers proper and for such purposes the court may substitute its opinion for that of the General Manager or of the Appeal Board, or the court may refer the matter back to the Appeal Board for rehearing, in whole or in part, in accordance with such directions as the court considers proper. R.S.O. 1990, c. H.6, s. 24 (2-4).

⁶⁸ MOHARBA Supra note 20 at s.7(1).

practitioners.⁶⁹ A Hearing can take place in front of an odd number of Board members.⁷⁰

In this study, all Hearing decisions analysed took place before the typical panel composition of three members. The Chair of the Board is responsible for the selection and assignment of Board members to any given Hearing.⁷¹

ii) The Board's Procedures

At the court level – as opposed to the tribunal level -- it has been argued that common law requirements for fair procedures in court may, ironically, interfere with the goal of a straightforward, understandable appeal process by imposing complex procedural requirements, and thus impede access to justice.⁷² Alternatively, “speedy, informal and inexpensive dispute resolutions backed by specialized expertise”⁷³ may facilitate access to justice. Several factors are thought to facilitate access to justice at the tribunal level. Pitfield – who has researched the Board’s activities -- states that, in addition to factors such as perceptions of bias and lack of transparency, the accessibility of procedures and cost can act as significant deterrents in accessing the Board.⁷⁴ Pitfield defined ‘accessibility of procedures’ as the provision of information about the Hearing. This would include the application of legislation, the provision of assistance to applicants wishing to prepare an appeal, as well as the need for legal counsel for unrepresented parties. In terms of cost, Pitfield states that the “costs” of the appeal process at the Board – which include the cost of hiring legal services, documentary and/or testimonial

⁶⁹ Ibid s.7(3).

⁷⁰ Ibid s.13(3).

⁷¹ Ibid s.13(2).

⁷² Caroline Pitfield, 2003 LLM Thesis, University of Toronto “Critical Evaluation of HSARB: Giving Patients a Louder Voice in the Health Care System”, 123-5 [hereinafter “Pitfield”] at 123-125.

⁷³ Judith McCormack, “Nimble Justice: Revitalizing Administrative Tribunals in a Climate of Rapid Change” (1995), 59 Sask. L. Re. 385, online QL (AMPA) [hereinafter “McCormack”] at 5 of QL version.

⁷⁴ Pitfield, Supra Note 72 at 123.

evidence, along with the cost of traveling to Toronto for oral hearings -- have more effect on the applicant than on the defendant OHIP.⁷⁵

This section of Chapter 2 examines the procedures of the Board from a legislative and operational perspective. The enabling legislation, MOHARBA, as well as the HIA and its Regulations do not specify any requirements regarding procedural protections for a Hearing before the Board.⁷⁶ However, several procedures were identified by the author based on a review of decisions. These include: the date of the Hearing; the date of the decision; the format of the Hearing (oral/written/teleconference/combination of formats); whether the parties were self-represented or represented by legal counsel; if an interpreter was present; and whether the Hearing was de novo or a review of a previous Board decision. These procedures elements are listed in more detail below.

Dates (file/hearing/decision);

Pitfield identified the Board's 'timeliness' as a major impediment to access to health care services in terms of the delays between the notice of an appeal and the hearing itself, and the delays in rendering a decision. She also identified that issues coming before the Board

⁷⁵ Ibid at134.

⁷⁶ Section 23(4) of the HIA does reference the SPPA regarding the admissibility of evidence at a hearing (SPPA s.15) and the notice of facts and opinions (SPPA s16).

Findings of fact

23(4) The findings of fact of the Appeal Board pursuant to a hearing shall be based exclusively on evidence admissible or matters that may be noticed under section 15 or 16 of the *Statutory Powers Procedure Act*. R.S.O. 1990, c. H.6, s. 23 (4).

were of increasing complexity.⁷⁷ This increasing complexity may or may not affect the “timeliness” of Board procedures.

According to the SPPA, the Board is authorized to establish timelines for its procedure and to review all or part of its decision.^{78 79}

Format (oral/written/teleconference/combination);

Hearings before the Board can take place in several formats. A Hearing can be held orally, in writing or by teleconference call. A Hearing can also use a combination of these formats such as a written submission by the patient/applicant and a teleconference or in person appearance by OHIP before the panel. At the Hearing, the applicant – typically the patient or the patient’s advocate – under oath presents his/her evidence to the panel as to why he/she should be granted health care service funded by OHIP and why they are appealing OHIP’s decision denying the service -- based on the HIA and Regulation 552. Evidence may include testimony, an approval form provided by OHIP and completed by the applicant’s physician and witness’ statements supporting the applicant. OHIP’s designate then presents OHIP’s evidence to support its decision to deny funding for the service to the applicant based on the HIA and Regulation 552. Once OHIP has presented its case, the applicant may question the OHIP representative to clarify its presentation and to make final remarks. Once both sides have presented their evidence, the panel thanks

⁷⁷ Pitfield, Supra Note 72 at 137-140.

⁷⁸ SPPA, Supra Note 63 at s.16.2.

Time frames

[16.2](#) A tribunal shall establish guidelines setting out the usual time frame for completing proceedings that come before the tribunal and for completing the procedural steps within those proceedings. 1999, c. 12, Sched. B, s. 16 (6).

⁷⁹ A Reviewed decision cannot again be reviewed by the Board Rule 21.09(6)

the parties and ends the hearing. Further evidence or advocacy is not accepted by the panel once the hearing has ended. The appeal is ended once a written decision is released by the Board.

Self-representation/Lawyer

The MOHARBA, HIA and its Regulations do not require the applicant to have a lawyer nor does the Board or government provide a lawyer or legal assistance to the applicant.

Interpreter

There is no requirement under the MOHARBA or the HIA to provide interpretation services to the parties appearing before the Board. The Board does provide interpretation services free of charge to parties if requested prior to the Hearing.

Review of Its Own HSARB Decision

The Board has the jurisdiction to review and reconsider a panel's decision.⁸⁰ Once reconsidered by the Board, the decision cannot again be reviewed by the Board.⁸¹ The review of a panel's decision can be the result of a request by a party or by the Board itself.⁸² The Board will determine if it reviews a decision based on a number of factors such as a material error, public interest, new evidence, reliance on or effect of decision, consent of the opposing party to the review and the availability of additional appeal venues.

iii) Substantive Arguments of the Parties

If OHIP has denied out of country health care funding coverage, it tends to be based on one of two conditions under the HIA: whether the applicant qualifies as an 'insured person' and/or if the health care service is an 'insured service' under the HIA, Regulation 552 and the Schedule of Benefits negotiated between the Ministry of Health and the Ontario Medical Association. For the purpose of this thesis, the assumption will be made that the applicant qualifies as an 'insured person'. The focus of this thesis will be on the determination by the Board of what constitutes an 'insured service'.

Insured Services

⁸⁰ SPPA, Supra Note 63 at s.21.2(1)

A tribunal may, if it considers it advisable and if its rules made under section 25.1 deal with the matter, review all or part of its own decision or order, and may confirm, vary, suspend or cancel the decision or order. 1997, c. 23, s. 13 (20).

⁸¹ Rule 21.09(6).

⁸² Rule 21.03.

Under the HIA, an insured person is entitled to receive insured services.⁸³ Insured services include: prescribed services of hospitals and health facilities,⁸⁴ medically necessary services provided by a physician,⁸⁵ and health care services provided by prescribed practitioners⁸⁶ – all under conditions and limitations that may be prescribed. “Prescribed is defined as “prescribed by the Regulations”.⁸⁷ Cabinet can make regulations regarding what is and is not an insured service and the payment scheme for the insured services.⁸⁸ Regulation 552 governs insured services and specifically the services provided by Ontario physicians if those physician services are specified in the schedule of benefits⁸⁹ and hospital services. An OHIP determination that a service is not an ‘insured service’ can be appealed to the Board. Typically, a service is not an insured service because it is an excluded service under the HIA Regulation 552 s.24(1) or, in the case of out of country services, it has not met the “test” outlined in s.28. The details of ‘excluded services’ and out of country coverage are outlined below.

Excluded Services

Excluded services are listed in the HIA Regulation 552 s.24(1). For the purpose of this thesis, treatment that is generally accepted in Ontario as being ‘experimental’ is one of the services excluded from coverage listed in s.24(1). This section is analysed in more detail later in this thesis. The experimental exclusion from coverage states:

⁸³ HIA Supra Note 4 at s.12(1).

⁸⁴ Ibid at s.12(1)1.

⁸⁵ Ibid at s.12(1)2.

⁸⁶ Ibid at s.12(1)3.

⁸⁷ Ibid at s.1.

⁸⁸ Ibid at s.45(1)(e).

⁸⁹ Regulation 552 Supra Note 3 at s.37.1(1).

EXCLUSIONS

24 (1) The following services rendered by physicians or practitioners are not insured services and are not part of insured services unless, in the case of services rendered by physicians, they are specifically listed as an insured service or as part of an insured service in the schedule of benefits or, in the case of services rendered by optometrists, they are specifically listed as an insured service or as part of an insured service in the schedule of optometry benefits:

...

17. Treatment for a medical condition that is generally accepted within Ontario as experimental.

...

Treatment that is considered to be “experimental” is not funded by OHIP whether the treatment is available domestically or out of country.

Out of Country Coverage – the criteria ‘test’ under s.28.4(2)

In Ontario⁹⁰, an insured person may receive coverage for out-of-country health care services under two conditions. The first condition is if emergency treatment is required⁹¹

⁹⁰ The CHA s.11(1)(b) obliges all provinces to provide “payment amounts for the cost of insured health services provided to insured persons while temporarily absent from the province.”

⁹¹ S.28.3 states in part 28.3 (1) In-patient services rendered outside Canada in an eligible hospital or health facility are prescribed as insured services if,

- (a) the services are medically necessary;
- (b) it is medically necessary that the services be provided on an in-patient basis;
- (c) in Ontario, the insured person would ordinarily have been admitted as an in-patient of a public hospital to receive the services; and
- (d) the services are rendered in connection with an illness, disease, condition or injury that,

⁹² as a result of an acute, unexpected event which arose while out of Canada and requires immediate treatment. The second condition is if the health care service was a non-emergency situation but received prior approval from OHIP. Non-emergency health care can take place on an outpatient basis or an inpatient basis. For the purpose of this thesis, the focus will be on non-emergency inpatient out-of-country health care services (OCCNEIHS) under s.28.4(2) which during the period 2003/04-2007/08 stated:

s.28.4(2) Services that are part of a treatment and that are rendered outside Canada

at a hospital or health facility are prescribed as insured services if,

(a) the treatment is generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person; and

(b) either,

(i) that kind of treatment that is not performed in Ontario by an identical or equivalent procedure, or

-
- (i) is acute and unexpected,
 - (ii) arose outside Canada, and
 - (iii) requires immediate treatment. O. Reg. 31/92, s. 3; O. Reg. 596/93, s. 2.

(2) In subsection (1),

“eligible hospital or health facility” means,

- (a) a hospital licensed or approved as a hospital by the government in whose jurisdiction the hospital is situated in which complex medical and complex surgical procedures are routinely performed, or
- (b) a health facility licensed by the government in whose jurisdiction the health facility is situated in which complex medical and complex surgical procedures are routinely performed. O. Reg. 31/92, s. 3.

⁹² Regulation 552 s.28.2 deals with emergency outpatient hospital services; s.23.3 deals with emergency inpatient hospital services. Section 29 deals with physician services

(ii) that kind of treatment is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage.⁹³

Under the s.28.4(2) “test”, the Board must determine if the out of country health care treatment is generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person in question.⁹⁴ In addition, the s.28.4(2) test requires either that the treatment is not performed in Ontario by an identical or equivalent procedure⁹⁵ ⁹⁶ or if the treatment is performed in Ontario but travel outside the country to receive the treatment is required to avoid a delay that would result in the insured person’s death or significantly irreversible tissue damage.⁹⁷ ⁹⁸ The s.28.4(2) ‘test’ does not provide the Board with jurisdiction to assess economic factors such as service cost estimates, cost effectiveness and/or cost benefit analysis on an individual or societal basis. The s.28.4(2)

⁹³ Regulation 552, Supra Note 3 at s.28.4(2)(a)(b)(i)(ii).

⁹⁴ For the purpose of this thesis, ‘out of country health care treatment is generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person in question’ is also referred to as ‘generally acceptable’ or ‘GA’.

⁹⁵ For the purpose of this thesis, ‘identical or equivalent’ is also referred to as ‘I/E’.

⁹⁶ “OHIP is in a better position than individual physicians to know what treatments are available in the province. Before a patient is allowed to go out of the country for treatment, OHIP must be satisfied that the treatment is not, in fact, performed in Ontario. Consulting with OHIP is the only effective way to make that determination.” Sandra Blad v. General Manager OHIP, unreported decision, December 18, 1998

⁹⁷ For the purpose of this thesis, ‘delay that would result in the insured person’s death’ is referred to as ‘delay-death’ and ‘delay that would result in the insured person’s significantly irreversible tissue damage’ is referred to as ‘delay-MSITD’.

⁹⁸ This author points out that Ontario’s HIA Regulation 552 s.28.4(2) test does not require the health care service to be available from another Canadian province before it is considered out of country for compliance with s.28.4(2) – the criteria is only if the health care service is not available in Ontario. Thus, section.28.4(2) allows for the review of out of country health care services for potential public funding before a review of Canadian provincial health care service options. As such, a non-domestic service is examined before a domestic service. This is of interest to the author as the CHA requires that all provinces – in order to receive ‘cash contributions’ from the federal government - operate under the five principles discussed earlier – including the principle of ‘portability’ of health care services across Canada. The federal CHA does not make reference to the portability of health insurance across Canadian borders. Thus, it is unclear to the author how s.28.4(2) meshes with the CHA ‘portability’ requirement.

test also does not include any criteria regarding the compassionate circumstances of the patient requesting the out of country treatment. As discussed earlier, the Board does not have jurisdiction to assess whether a provision in legislation is or is not constitutional.

Prior Approval Requirement for OCCNEIHS: Section 28.4(5)

The request for the OCCNEIHS must be submitted by a practicing Ontario physician on behalf of the insured patient. The physician must confirm that the OCCNEIHS requested is generally acceptable for persons in the same medical circumstance as the patient. The submitting physician must confirm that an identical or equivalent procedure to the requested OCCNEIHS is not performed in Ontario or that a delay in receiving the identical or equivalent provided in Ontario would lead to the patient's death or MSITD. Based on the physician's submission, OHIP will approve or deny funding for the insured service. Under section 28.4(2), if the OCNEIHS is to be approved, the requested health care service must be approved by OHIP prior to its receipt.

Section 28.4(5) states:

Prior Approval

The following are conditions of payment of amounts for services prescribed in this Section:

1. An application for approval of payment must be submitted to the General Manager by a physician who practices medicine in Ontario on behalf of the insured person and the application must contain a written confirmation from that physician that, in the

- opinion of the physician, one of the conditions set out in clause 2(2)(b)⁹⁹ is satisfied.
2. The General Manager must give written approval of the payment of the amount under this section before the services for which approval has been sought are rendered.
 3. The services must be received within the time limit set out in the approval described in paragraph 2.
 4. If the services are covered by a preferred provider arrangement, they must be received from a preferred provider.

It is important to recognize that the Board struggled with the issue of whether or not OHIP had the discretion to fund OCCNEIHS that had not been approved by the General Manager of OHIP prior to being received by the patient. In October of 2008, the Ontario Divisional Court heard an appeal from a Board decision which upheld OHIP's decision not to fund OCCNEIHS which had not received prior approval. In January of 2009, the Ontario Divisional Court released its decision -- C.C.W. v. Ontario Health Insurance Plan.¹⁰⁰ The court ruled that the HIA Regulation 552 s.28.4(2) did not provide OHIP with the discretion to retroactively approve OCCNEIHS.¹⁰¹ It is also important to note that the court hearing (2008) and ruling (2009) came after the thesis study period (2003/04-

⁹⁹ Regulation 552, Supra Note 3 at s.28.4(2)(b) refers to 'either' identical or equivalent procedures or a delay causing death or MSITD

¹⁰⁰ 2009 CanLII 712 (ON SCDC), [hereinafter 'C.C.W.] <<http://canlii.ca/t/224j3>> retrieved on 2013-02-22

¹⁰¹ Ibid at para 57 "Neither the Act nor the regulations expressly confer a discretion on the General Manager to give retroactive prior approval for out-of-country medical treatment or to waive the requirement for prior approval." However, the Court did find that the Board should have considered the urgency of the situation, objective of s.28.4(2) and the implied power of OHIP to grant retroactive approval in certain cases = para 108 "The Board reached an unreasonable decision in failing to find that the General Manager has the implied power to give retroactive approval in urgent situations in order to meet the objectives of s. 28.4 of Regulation 552."

2007/08). As will be seen in the analysis of Board decisions made during the study period, the interpretation of OHIP's discretion to grant retroactive approval and reimbursement was variable.

3. Conclusion

The purpose of this chapter was to provide an overview of the existing Canadian health care legislative system within which HSARB is situated. It is within this system and legal constraints that Board decisions regarding the out of country coverage of health care services are made. The overview highlights the complexity and extensive interaction between various statutes. The overview also highlights the legislative definitions as well as the lack of HSARB's specific procedural protections required under the MOHARBA and the HIA. As well, the overview outlines the substantive test for OCCNEIHS outlined in regulations.

Chapter 2 is also important because this thesis analyses the study's results relative to the A4R theory and found that consistency with the A4R theory largely depended on the legislative framework outlined here rather than on the study's quantitative data. In this respect, the legislation complied with the A4R theory rather than the legislation's actual operation.

Chapter 3

Literature Review: Part I

Need for Empirical Research

Need for Empirical Quantitative Research

Existing Empirical Research on Tribunals

Existing Qualitative Research on Tribunals

Existing Quantitative Research on Tribunal

Conclusion

Chapter 3

Literature Review: Part I

Need for Empirical Research

This Chapter outlines the academic discussion regarding the lack of Canadian empirical research in the legal academic field and on tribunals specifically. Not only is administrative law an under researched area of law, the lack of empirical research regarding administrative law poses a significant risk to evaluating the work of the tribunal and to the reputation of this legal academic field. The lack of research may be the result of many factors including research capacity, complexity, difficulty, institutional support and lack of prestige. This Chapter also reviews the limited existing qualitative and quantitative tribunal research.

Need For Empirical Quantitative Research

Empirical Legal Studies is a growing field of legal study which emphasizes the use of empirical research approaches similar to other social science disciplines such as economics, political science, sociology, and psychology. ‘Empirical research’ is defined as the use of statistical techniques and analysis – including the systematic coding of judicial opinions that facilitate descriptions of or inferences to a larger sample or population as well as replication by other scholars.^{102 103} Despite the availability of

¹⁰² Michael Heise, “The Importance of Being Empirical” 26 Pepp. L. Rev. 807 [hereinafter “Heise”] at 810 – Heise states that this narrow definition of empirical research is clearly distinct from traditional theoretical and doctrinal counterparts – at 833 Heise argues that “[w]here empirical questions lurk, data warrant at least as much respect as that accorded opinions and words”.

¹⁰³ Peter H. Schuck “Why Don’t Law Professors Do More Empirical Research?” 39 J. Legal Edu. 323 [hereinafter ‘Schuck’] at 323- 24.

empirical research tools, the current legal scholarship remains dominated by theory and doctrine.¹⁰⁴ Heise states:

“Our legal literature would be enriched if more academics, particularly law professors, became more engaged in empirical legal research and produced more of it ... Empirical work sheds important light on old legal issues and identifies and speaks to the issues that the more traditional theoretical and doctrinal genres cannot reach. ...”¹⁰⁵

The dearth of empirical research by legal academics may be the result of several factors including: the lack of research being conducted outside of law libraries; most law professors who generate much of the legal scholarship yet lack training in the area of empirical research; the lack of prestige; the lack of internal and external incentives to conduct empirical research; the risk of exposure to falsification through replication of results and the fact that anecdotal evidence is often easier to collect than empirical research.¹⁰⁶ Lowery and Evans argue that legal research does not focus on basic research, and, in addition to a lack of institutional support, there is a failure to teach methods and paradigms and expand research arsenals for scholarly work. This lack of rigor in research methods creates a ‘crisis of confidence of sorts concerning research that clearly exists in the field’.¹⁰⁷ Doctoral work is particularly challenged. The doctoral contribution to

¹⁰⁴ Heise, *Supra* Note 102 at 834.

¹⁰⁵ *Ibid* at 834.

¹⁰⁶ *Ibid* at 809.

¹⁰⁷ Daniel Lowery and Karen G. Evans, “The Iron Cage of Methodology: The Vicious Circle of Means Limiting Ends Limiting Means” (2004) Vol 36 No 3 Administration and Society 306 [hereinafter “Lowery”] at 308.

knowledge and theory development has been minimal and doctoral research in the field¹⁰⁸ is “distinguished by its poor quality”.¹⁰⁹ The authors challenge the field to explore ways of introducing rigorous empirical methods into curriculum and research.^{110 111}

The urging for legal academic empirical research is not new. The development of good theories is made even more difficult without the benefit of good data¹¹² and the lack of an empirical footing poses a threat to legal theory’s persuasiveness and influence.¹¹³ In terms of quantitative research, a study by Arthurs et al,¹¹⁴ stated that developing and applying statistical data in legal research was undertaken frequently by only 3% of Canadian law professors, occasionally by 15% and not at all by 58%. Empirical research methodologies were employed in less than 10% of the law review articles published in each of five selected years of the study.¹¹⁵ Arthurs et al conclude “... that lists of research projects undertaken by these institutions rarely indicate any empirical, interdisciplinary, comparative or historical aspects.”¹¹⁶ The Nuffield Report of 2006 points out similarities to the Arthurs 1983 study. The Nuffield Report of 2006 found that, despite the achievements and potential of empirical legal research, UK universities had a current

¹⁰⁸ Lowery, *Supra Note 107* is referring to scholarly research in Public Administration

¹⁰⁹ *Ibid* at 308.

¹¹⁰ *Ibid* at 307.

¹¹¹ *Ibid* at 307.

¹¹² Derek C. Bok, “A Flawed System of Law Practice” (1983) 33 J. Legal Educ. 570 [hereinafter “Bok”] at 581.

¹¹³ Richard A. Posner, “Against Constitutional Theory” (1998) 73 N.Y.U.L. Rev. 1 [hereinafter “Posner”] at 3.

¹¹⁴ H.W. Arthurs, *Law and learning: Report to the Social Sciences and Humanities Research Council of Canada by the Consultative Group on Research and Education in Law* (Ottawa: Social Sciences and Humanities Research Council of Canada, April 1983) [hereinafter “Arthurs 1983”] Table 1.

¹¹⁵ Arthurs 1983 *Supra* Table 4.

¹¹⁶ *Ibid* at 83.

capacity crisis to undertake empirical legal research and that this crisis would grow worse.¹¹⁷

Need for Empirical Research of Tribunals

In addition to the dearth of empirical research by legal academics generally, there is also a dearth of Canadian empirical research of tribunals. For example, there is a disturbing absence of debate in the academic literature regarding the actual administrative tribunal procedures experienced by litigants, the substantive legal arguments and the association with the outcome resource allocation decisions by tribunals. The lack of information and debate is important because more citizens have resource allocation decisions determined by tribunals than by courts.¹¹⁸ Administrative law – and a tribunal specifically -- is concerned with everyday practice of administrative justice, not just judicial review of administrative decision-making.¹¹⁹ Even more disturbing is the absence of thorough empirical research regarding the actual functioning of tribunals and the evaluation of this actual functioning related to its ideal functioning. Preliminary qualitative and quantitative empirical research, as cited below, offer insights into tribunal functions. More importantly, the cited tribunal research provides insights into study methodology challenges and the importance of sound methodology upon which conclusions should be based.

¹¹⁷ The Nuffield Foundation, Nuffield Inquiry Law in the Real World: Improving Our Understanding of How Law Works, Final Report and Recommendations, The Nuffield Inquiry on Empirical Legal Research, (London, 2006), online http://www.ucl.ac.uk/laws/socio-legal/empirical/docs/inquiry_report.pdf at 39.

¹¹⁸ Cooper v. Canada (Human Rights Commission), [1996] 3 S.C.R. 854 at 899-900.

¹¹⁹ Lorne Sossin, “Access to Administrative Justice and Other Worries” in Colleen M. Flood et al, eds, Administrative Law in Context (Toronto: Emond Montgomery Publications Limited, 2008) 391-409 [hereinafter “Sossin”].

According to Sossin and Hoffman, tribunals are key in allocating scarce resources yet their decision making process and content is under researched. Empirical research to evaluate the accountability of tribunals ‘is one of the least scrutinized areas of administrative law’.¹²⁰ The authors state that an assessment of health-related adjudicative tribunals has never before been comprehensively undertaken.¹²¹

“The dearth of externally-focused empirical evaluation is not only a missed opportunity, in our view, but may also pose a significant risk. ... Without this data, the Boards may lack the baseline measurements needed to track changes over time, evaluate the performance of decision-makers and staff, and engage in longer term strategy planning. ... For academics, it is an under-scrutinized sphere of administrative law and health system functioning that is both ripe for research and, potentially, reform.”¹²²

The authors recommend the need for evidence and data driven strategies in order to evaluate and achieve a tribunal’s intended purpose.¹²³ They argue that the current research focuses on theory, doctrine, and procedures - not substantive decision making that could be assessed through empirical research.

¹²⁰Lorne Sossin, and Stephen Hoffman, “Empirically evaluating the impact of adjudicative tribunals in the health sector: context, challenges and opportunities” (2010) 28 Windsor Y.B. Access Justice 343-360 [hereinafter “Sossin and Hoffman”].

¹²¹Ibid at 345.

¹²²Ibid at 353.

¹²³Ibid at 117.

“Once a system of empirical observation is in place, potential evaluators can establish benchmarks according to which they can track and assess performance. Such comparative points of measurement can be drawn from thoughtful consideration, aspiration goals of leaders, expert judgment on what is possible, data from similar tribunals in other jurisdictions (i.e. comparative analysis), or previous empirical observations from the same tribunal (i.e. interrupted time-series analysis).”¹²⁴

.....

The two tribunal paradigms – process and substance – which present a unique challenge for empirical evaluation as simple evaluation cannot be effectively utilized. However, the fact that evaluation is not easy does not detract from its importance.¹²⁵

The authors make a final comment on the role of empirical research in legal academia. While empirical research is not new to the health sector, it is rare in the context of administrative justice. The authors state that the lack of empirical research may be due to the complexity of the health system, methodological complications (simple research design cannot isolate cause-effect relationships, lack of clear criteria and goals, few past examples to emulate) and legal barriers. The lack of empirical research may also be due to a lack of competence, capacity and academic prestige in the legal field to conduct such empirical research.

¹²⁴ Ibid at 359.

¹²⁵ Ibid.

“Finally, as recently highlighted by the Nuffield Inquiry on Empirical Legal Research, the legal academy also suffers from a dearth of empirical competence and capacity to conduct such studies. ... Empirical legal methodologies are also not generally recognized to be as prestigious within the academic community as traditional doctrinal investigations. The pervasive culture of deference to experts and authority must further diminish the perceived value of objective empirical work and weaken any apparent need for more rigorous research that is higher on the hierarchy of evidence. Again, the focus on elements of process (e.g. bias and independence) rather than impact (e.g. judicial decisions) as indicators of quality and performance must also deter legal scholars from conducting work in this area such that target outcomes are less likely to be assessed.”¹²⁶

Existing Qualitative Research on Tribunals

Two graduate theses undertook qualitative research on tribunals. The Jacobs 2009 doctoral thesis qualitatively analysed three Canadian tribunals regarding the factors influencing daily independent tribunal decision making.¹²⁷ Specifically, Jacobs examined the internal commission relationships and their link to external bodies within the daily workings of tribunal decision-making via 30 interviews, focus groups and nine months observing daily operations of three commission (the Office of the Information and Privacy Commission in Ontario, the Quebec Commission d'accès à l'information in Quebec City, federal Privacy Commissioner's office in Ottawa). The study did not

¹²⁶ Ibid at 357.

¹²⁷ Laverne Jacobs 2009 PhD Thesis, York University “Fashioning Administrative Independence at the “Tribunal” Level: An Ethnographic Study of Access to Information and Privacy Commissions in Canada”. [hereinafter “Jacobs”].

examine structural guarantees of independence (financial security, security of tenure, and the appointment and removal process) and did not reveal confidential information about actual individual cases. Jacobs concluded that¹²⁸ "when it comes to empirical studies compiling and examining what it is that tribunals do, there is a dearth of Canadian administrative law theory and information available."¹²⁹ However, Jacobs stated: "the realities of tribunal existence are not that neatly packaged "¹³⁰ and factors affecting tribunal independence did not 'jump out'. Nevertheless, the tribunals' institutional culture was found to be an important factor.¹³¹ This thesis provided an interesting examination of the factors affecting the independence of tribunal decision making and the 'dearth' of Canadian administrative law theory generally.

Brenda Gamble's 2002 doctoral thesis 'What's In, What's Out – Stakeholder views on the Boundaries of Medicare' for the University of Toronto's Institute of Medical Sciences Department¹³² did not examine tribunals but rather undertook a qualitative study of decision makers' views on what health care services should be publicly funded. The views of "policy elites" from key stakeholder groups across Canada were solicited. The

¹²⁸ Ibid. The theses comments are based on the SCC decision of Ocean Port Ltd. V. British Columbia (General Manager, Liquor Control and Licensing Branch) [2001] 2 S.C.R. 781 and her review of the academic literature as well as her doctoral thesis research. According to Jacobs, this was a landmark decision with respect to the judicial statement that the amount of independence a tribunal should have is determined by the will of the Legislature. Jacobs states that, based on a SCC decision, scholars have been invited to determine the factors that affect the independence of various decision making bodies. However, according to Jacobs, this decision has not been taken up as not much has been said or done on the development of models of independence and impartiality that are true to the work of tribunals.

¹²⁹ Ibid at 7.

¹³⁰ Ibid at 343.

¹³¹ As a result of the dearth of theoretical application of models to the actual practice of tribunals, Jacobs develops three new theoretical model regarding administrative independence; independence informed by judicial dictates; independence informed by cultural understandings; independence informed by fundamental values of fairness.

¹³² Hereinafter "Gamble".

general public was not included in assessing the views.¹³³ The study concluded that ‘policy elites’ wanted to continue ‘needs based’ health care provided by hospitals and doctors. The policy choices that were made earlier influenced the ‘policy elites’ on what should be funded by Medicare and any change would be based on the government’s ability to mediate the scope of conflict within existing institutional frameworks. This qualitative study is interesting methodologically because in determining what health care services should be insured, it excluded submissions from the general public and it did not include the criteria for determining who were ‘policy elites’.

Existing Quantitative Research on Tribunals

In his doctoral thesis for the Faculty of Law at the University of Toronto published in 1999, Chipman¹³⁴ undertook an empirical quantitative research analysis of 669¹³⁵ ‘reported’ decisions¹³⁶ on multiple types of appeals over an eight year period of one tribunal - the Ontario Municipal Board. Chipman sought to determine whether the

¹³³ A self administered 12 page questionnaire was mailed out in January to April 2002 to 4,934 “provider” groups of which 2,523 were returned completed. In March to April of 2002 a web based version on the questionnaire – which only included one question – was sent to 5,200 members of the Canadian Federation of Independent Businesses. Of the 5,200 web based questionnaire, 1,240 were returned completed.

¹³⁴ John Chipman 1999 SJD Thesis ,University of Toronto “Policy-Making by Administrative Tribunals: A study of the manner in which the Ontario Municipal Board has applied provincial land use policies and has developed and applied its own planning policies”[Hereinafter “Chipman”].

¹³⁵ Ibid. - 348 cases for the time period 1971-1978 and 321 cases for the time period 1987-1994

¹³⁶ Ibid - Methodologically, there was considerable provincial policy change over time which affected the tribunal. It was not feasible to analyse all decisions. (Chipman at 340) Each year looked at 75-80 decisions regarding planning appeals, referrals, assessment appeals and ‘other matters’. The 75-80 decisions was less than the total number handed down by the tribunal but were decisions where the tribunal made a specific statement about its views on the matter in question. (Chipman at 341) Chipman coded the data based on: identifiers, type of application, land use type, supporters and opponents, professional support or opposition, expressions of provincial policy, potential areas of policy development, importance of policy to Board’s decision and the actual Board decision.

tribunal applied provincial planning policy and/or developed and applied its own planning policy in many areas where the provincial policy was silent.¹³⁷ ¹³⁸

According to Chipman, Ontario tribunals have been the subject of rich, but often generalized and theoretical literature. Yet despite their importance, there has been little published empirical scholarly analysis of the manner in which such agencies actually engage in their day-to-day activities.¹³⁹

“Court decisions, particularly those of the more senior courts, are closely studied, but the vast range of administrative decision-making, which probably touches more persons closely than do judicial decisions, remains largely anonymous and unaddressed.”¹⁴⁰

...

“Given their significant role, it is valuable to have a clear understanding of the considerations they (tribunals) bring to bear in making decisions on matters under their jurisdiction.”¹⁴¹

Chipman concluded, based on his empirical quantitative research, the tribunal in his study did not perform according to the theoretical models:

¹³⁷ Chipman was also examining the relationship between tribunals and government and the degree of tribunal independence in carrying out their mandate.

¹³⁸ Chipman, Supra Note 134 at 338.

¹³⁹ Ibid at 4. -“There is no lack of “how to be successful before the Board” presentation materials, often of high quality, prepared by lawyers, planners and other professionals who appear before it, but this is of necessity of a limited and practically-focused nature, and is no substitute for analysis which attempts to place the Board’s decision-making in a more analytical context, to get behind what it does to examine how and why it does it.”

¹⁴⁰ Ibid at 1.

¹⁴¹ Ibid at 3.

“The OMB has not behaved as the literature of regulatory theory might have led us to expect. … The reality of regulatory activity, as the commentators fully recognize, can be far more complex and ambiguous, and the analysis of the Board’s decision-making certainly reveals a pattern far removed from the theoretical norm.”¹⁴²

This quantitative research is of interest as it examines actual tribunal decisions and undertakes statistical assessment of the coded results. Based on this quantitative study, Chipman concludes that the tribunal did not perform according to theoretical models. This is the first quantitative study of tribunals that identified the discrepancy between administrative law theory and administrative law practice.

Karen Fernandez’s 2009 York University, Master of Arts thesis, entitled Democracy, Power and Decision-Making¹⁴³ continues Chipman’s study of the OMB. She examined 31 OMB decisions in the downtown Toronto core for the 8 1/2 year period of 2000 to 2008. Fernandez sought to determine who benefits from the process given the way the OMB operates and how OMB decisions come to reflect the consistent nature of the Board’s own developed policies.¹⁴⁴ Given the methodology for this study, the author

¹⁴² Ibid at 319.

¹⁴³ Hereinafter “Fernandez”.

¹⁴⁴ Fernandez comments that while other studies had looked at the role of citizen participation, the role of expert testimony and the effects of the appeals on the built environment, she wanted to investigate the decisions of the OMB in an attempt to determine the role that it has come to play in approving developments that are to alter the look of the city significantly” in relation to the adoption of the New Official Plan and the planning for the downtown area.

interprets the study results with caution¹⁴⁵ but acknowledges the important development of indicators such as approval rates, decision outcomes, number of decisions with sufficient reasons for analysis, position taken by the Board, and policies referred to in the final decision.

Caroline Pitfield, in her 2003 LLM thesis at the University of Toronto entitled ‘Critical Evaluation of HSARB: Giving Patients a Louder Voice in the Health Care System’,¹⁴⁶ examined public participation at the policy making level and the legal mechanisms to challenge government decisions. Specifically, Pitfield sought to ‘evaluate’ whether HSARB, as a specialized appeal mechanism, provided patients with an accessible and effective way to challenge government decisions about the availability of ‘insured’ health care both within and outside of Canada. She wanted to explore “how good a job the Board is doing as an appeal mechanism for those with complaints about access to health care services” particularly as compared to the Courts and given the relative dearth of review as to whether the tribunal could provide an alternate decision making mechanism with the values of procedural fairness, reasonableness and Charter principles like dignity and equality.¹⁴⁷ Pitfield examined HSARB’s statute, regulation, rules, annual report and ‘unreported’ decisions available in hardcopy from the HSARB office.¹⁴⁸

¹⁴⁵ Comment - For the eight and a half years of January 2000 to August 2008, approximately 4-5 cases appears to have been selected per year – but this is unclear. While 36 qualified for the study only 31 were used – it is unclear what the exclusion criteria were for the 5 cases. The study only looked at a small geographic area (downtown Toronto – Bloor to Queens Quay and Parliament to Bathurst) so the results can only be generalized to that area. The study claims to look at “trends in decision making regarding planning in the downtown area” (p66) but it is unclear if trends can be extrapolated from this sample size of 31 decisions and 8 ½ years of coverage.

¹⁴⁶ Pitfield, Supra Note 72.

¹⁴⁷ Ibid at 61.

¹⁴⁸ Ibid at 7 “... information on the Board is relatively difficult to access ... unreported decisions were only available in hardcopy at the Board’s Toronto office.”.

Pitfield concluded that HSARB had the potential to provide patients with an accessible and effective way to challenge government decisions about health care availability but had yet to fulfil its potential and needed to be more accessible and responsive. With respect to the presence or absence of legal assistance provided by MOHARBA and the HIA, Pitfield states:

“Those with lawyers (or with legal knowledge themselves) are better equipped to formulate effective arguments, to do the proper research, and to use judicial procedures to their advantage – examine and cross-examine witnesses, to bring motions and to make objections, based on the Board’s Rule of Practice, for instance. They are also more likely to introduce legal arguments, or use statutory interpretations, which can be effective ways of challenging OHIP’s insistence that a claim does not fall within the statutory scheme. Such advantages are in addition to the obvious impact that legal knowledge, and familiarity with legal procedures and relevant legislation, will have on the potential success of the appeal in the first place.

The need to hire a lawyer to defend one’s interests successfully in civil, and particularly [sp] criminal proceedings, has been recognized by parties in such disputes for years. There is also a constitutional right to legal counsel when interests of sufficient importance – like liberty and security of the person – are in jeopardy ...

Entitlements to health care services are not considered serious enough to warrant state-funded counsel for those involved in Board proceedings. Still, appellants may feel that they are significant enough to justify hiring a lawyer, particularly given the potential complexity of the Board’s proceedings and in the absence of much information or assistance with respect to how they work.”¹⁴⁹

With respect to the Board, Pitfield concluded ‘there is a problem’ as the ‘accessibility of procedures’ are complex, difficult to understand, and may require the assistance of a lawyer or some form of legal assistance.

Pitfield also noted that there was a gap between the parties’ expectations of HSARB and the Board’s limited jurisdictional powers.¹⁵⁰ Pitfield argues for increasing HSARB’s discretion, allowing HSARB to be more compassionate and extending its powers, providing assistance to unrepresented litigants, reinstating Charter jurisdiction, and increasing the Board’s expertise regarding medical necessity. Despite numerous methodological challenges,¹⁵¹ this thesis provides important insights into the distinction between procedural aspects of a hearing and the substantive legal arguments before the tribunal.

¹⁴⁹ Ibid at 129-130.

¹⁵⁰ Ibid at 100.

¹⁵¹ It is unclear what time period was studied, how many cases were studied and what the inclusion and exclusion criteria was used. It is unclear what is the definition and indicators for “accessibility” and “effectiveness” i.e. are defined relative to the patients’ expectations or relative to the tribunal’s mandate or the courts decree. There were no key informant or interview assessment with patients, OHIP or members of the tribunal to qualitatively assess “accessibility” and “effectiveness”. It is unclear whether this is a comparison between the ‘Courts’ and an administrative tribunal or just an analysis of the tribunal. It is unclear if a ‘specialized appeal mechanism’ differed from an ‘appeal mechanism’ and ‘administrative tribunals’¹⁵¹ In the absence of qualitative data, a documentary review was undertaken by Pitfield of HSARB related statutes, regulations, rules, annual reports and unreported decisions.

Pitfield and Flood evaluated HSARB's out-of-country appeal process in terms of the need for an accessible, equitable, quick and effective process for an appeal mechanism within a publicly funded health care system.¹⁵² The authors reviewed HSARB's mandate, composition, definitions, regulatory provisions, and decisions. The study raised very interesting insights – particularly regarding the low success rates of appeals. However, the study is methodologically unclear with respect to time frames and the definition of medical necessity.¹⁵³ It is also unclear if the study is based on Pitfield's LLM thesis or if it is a new study. If the methodology is unclear, the insights from the study are to be considered cautiously. However, the study was interesting in its exploration of substantive legal arguments before the tribunal.

Conclusion

The purpose of this chapter is to outline the academic discussion regarding the lack of empirical research in the legal field and specifically the lack of empirical research on Canadian tribunals. Adjudicative administrative tribunals are important because more citizens have resource allocation decisions determined by tribunals than by courts. However, our understanding of how tribunals make resource allocation decisions comes largely through the academic analysis of judicial reviews undertaken by the courts, where

¹⁵² Caroline Pitfield and Colleen M. Flood, "Section 7 'Safety Valve': Appealing Wait Times Within a One-Tier System" in Colleen Flood et al ed., *Access to Care Access to Justice* (University of Toronto Press Incorporated, 2005) 477 [hereinafter "Pitfield and Flood"].

¹⁵³ The methodology of the study – particularly with respect to the time period covered by the decisions - is unclear. For example, the article states 121 cases heard in 2002. The authors cite a 1995 case with respect to s.28.4(2) dealing with delay. The authors also make reference to a 1999-2000 time period and then to a 2001 case heard in 2003 with respect to the release of a decision. The study also makes reference to Applicant's understanding of 'medical necessity' but it is unclear how many Applicants have this understanding and if the understanding crosses all years.

the courts are emphasising fair procedures protections. Administrative law is an under researched area of law. This lack of administrative law research poses a significant risk to evaluating the work of the tribunal and to the reputation of this legal academic field. Of the empirical legal research on tribunals that does exist, there are several methodological flaws and shortcomings which limit the interpretation and generalizability of the findings.

Chapter 4

Literature Review: Part II

Judicial and Tribunal Decision Making Mechanisms

1. Introduction
2. Courts as Decision Making Mechanism
3. Judicial Review
4. Tribunals as Decision Making Mechanisms
5. Judicial and Political Deferral to Tribunals
6. Conclusion

Chapter 4

Literature Review: Part II

Judicial and Tribunal Decision Making Mechanisms

1. Introduction

The purpose of this chapter is to provide an overview of the judicial and adjudicative tribunal decision making mechanisms within which HSARB is situated. This chapter outlines the debate about the increased or decreased role of the courts in health care decision making and their oversight role of adjudicative tribunals through the use of judicial review. The increased or decreased use of the courts as decision makers about health care resource allocation is considered within the context of another academic discussion regarding whether the court is deferring difficult resource allocations to tribunals.

2. Courts as Decision Making Mechanism

Why is a discussion of health care resource allocation decision making by the courts of importance to this thesis, which focuses on tribunal procedural factors, the substantive legal arguments of the parties and tribunal decision? The answer stems from the fact that the courts can provide, among other things, direction to tribunals with respect to the tribunal's jurisdiction, procedural fairness, the appropriate standard of review and the interpretation of legislation.

Our traditional understanding of the courts and their health care resource allocation decision making arises out of a review of the caselaw and the academic analysis of that caselaw. In academic analysis, the use of the courts to allocate resources is discussed and debated. The debate centres on whether there is an increased or decreased use of the courts, why courts are being used as resource allocation mechanisms, whether the courts are suitable resource allocators and how the judiciary sees its role relative to tribunals.¹⁵⁴ There is also academic discussion about the role of government, the courts and tribunals in consciously deferring health care resource allocation decisions to each other as a means of dealing with or avoiding difficult health care allocation decisions.

Hadorn argues that there is a progressive attempt by litigants to use the court as a forum for health care resource allocation – even if in reality litigation is a rare event. This may be due to assumptions that the courts have the capacity to deal with complex resource allocation issues and/or deal with constitutional rights. Litigation on questions of resource allocation may be the result not only of issue complexity but of decision consistency, individual judicial consideration, decision making capacity of institutions and political aversion to sensitive resource allocations.¹⁵⁵

Syrett argues that courtroom litigation is still rare. Litigation may be an evolving social and political trend, coupled with the increasing public visibility of strategies of

¹⁵⁴ With respect to the latter point, the courts themselves may have different opinions about their role in health care resource allocation.

¹⁵⁵ D. Hadorn, “Emerging parallels in the American health care and legal-judicial systems.” (1992) Am J. Law Med.18:79-95 [hereinafter “Hadorn”].

rationing.¹⁵⁶ According to Syrett, key factors in the UK in the use of the courts for health care resource allocation is the attitude of the judiciary towards health care resource allocation claims as well as institutional and constitutional competence of the courts to adjudicate upon issues arising from allocation decision-making in healthcare. The consequence of these assumptions is that judges have tended to adopt a restrained and deferential approach toward such matters when argued before them.¹⁵⁷ This judicial position has dissuaded many would-be litigants, who are likely to perceive other channels (such as the political process) as offering greater prospects of success.¹⁵⁸ Syrett states that courtroom litigation regarding resource allocation is not the best arena in which to engage in deliberations on the need for rationing and the principles which should underpin such choices.¹⁵⁹ The deferential approach of the judiciary to the government for direction regarding health care resource allocation may be problematic. Syrett argues that the government is unlikely to lead because “of the propensity of politicians to engage in strategies of ‘blame avoidance’ on questions of healthcare rationing. There is scope for other institutions within civil society to seize the initiative in generating wider deliberations on such issues. ... the courts regard their role as primarily reactive to the

¹⁵⁶ K. Syrett, “Rationing in the Courts: England” in Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective (Cambridge: Cambridge University Press, 2007) [hereinafter “Syrett”] at 159-178.

¹⁵⁷ For example, Syrett examined the extent the U.K. courts to engage in questions of health care resource allocation in order to reach some conclusions about the openness of courts to employ public health law principles and values in decision-making regarding healthcare rationing. He concluded that English courts – the judges themselves - are generally more reluctant to prospects of evolution of a judicial role re decision on allocation of healthcare.

¹⁵⁸ Syrett, Supra Note 156 at 161.

¹⁵⁹ Ibid at 159.

wider health policy context.”¹⁶⁰ However, despite the problems, judicial involvement in health care resource allocation cannot be casually dismissed. Syrett states:

“... courts may make a telling and useful contribution to the process of decision-making on the allocation of resource, although their capacity to do so will, of course, be contingent upon their readiness to adjust their restrained, deferential approach in the interest of fulfilling the sort of instrumental, facilitative role ... ”¹⁶¹

Alternately, Mariner argues that in the USA there is an increased use of the courts as health care resource allocation forums. This increase, it is argued, is a result of proposals to reduce national expenditures for health care under Medicare and other programs.¹⁶²

These cost containment concerns have raised questions about the limits on legislative power to distribute health care benefits. Mariner argues that the American legislative power to distribute health care via the constitutional guarantee of equal protection analysis has been a weak, rigid and imprecise source of protection for the sick. As a result, there is a role for the courts to ensure a heightened scrutiny and flexible approach to reviewing claims. Mariner concludes that American judges may be seeking a greater role in health care resource allocation – a role she supports. However, when courts do

¹⁶⁰ Ibid at 178.

¹⁶¹ Ibid at 161.

¹⁶² WK Mariner “Access to health care and equal protection of the law: the need for a new heightened scrutiny” (1986) Am J Law Med. 12(3-4):345-80. Review. PubMed PMID: 3330409 [hereinafter “Mariner”].

adopt the role of resource allocators, it is unclear if the courts offer an explicit or implicit recognition of the financial impact of resource allocation decisions.¹⁶³

Use of the Charter as a Decision Making Mechanism

Whereas the Canadian Constitution outlines the jurisdiction of the federal and provincial governments, the Charter of Rights and Freedoms outlines the rights of individuals relative to governmental actions.

There is a debate whether the Charter is being used as a resource allocator of health care and if this use is appropriate. Sheldrick argues that the Canadian courts have increasingly been used to allocate health care resources under the Canadian Charter of Rights and

Freedoms and under the court's authority to judicially review administrative law

decisions.¹⁶⁴ Charter challenges are resorted to because of the absence of effective alternatives to challenge decisions regarding access to government funded health care.¹⁶⁵

Alternatively, Greschner argued that there are few Charter challenges because of the relative comprehensiveness of the publicly funded system in Canada. She argues that the basic principles articulated in the Canada Health Act mirror values of equality and protection of human dignity under the Charter.¹⁶⁶

¹⁶³ Mariner, *Supra Note 159*.

¹⁶⁴ Byron Sheldrick, "Judicial Review and the Allocation of Health Care Resources in Canada and the United Kingdom" (2003) 5 *Journal of Comparative Policy Analysis: Research and Practice* 149 [hereinafter "Sheldrick"] at 163.

¹⁶⁵ Martha Jackman, "Charter Review as a Health Care Accountability Mechanism in Canada" (2010) *Health Law Journal*, Vol 18:1-29 [hereinafter "Jackman"].

¹⁶⁶ D. Greschner, "How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Cost?" Discussion Paper No. 20 (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 19.

Both Flood et al.¹⁶⁷ and Sheldrick argue that Charter challenges as a mechanism for resource allocation decision making are costly and time consuming and may produce policy outcomes that are undesirable from the perspective of both the state and the user groups,¹⁶⁸ and litigants have not necessarily seen judicial decisions as an effective form of decision making.¹⁶⁹

Sheldrick's position counters Flood's argument that the courts may be the best means to protect welfare entitlements and rights.¹⁷⁰ However, there is a distinction between the recognition of a health right and the enforcement of that right. Flood and May argue that where patient health care rights exist, the issue of enforcing those rights needs to be examined.¹⁷¹ Jackman, alternatively, argues that there is no judicial recognition of a constitutional right to publicly funded health care based on need in Canada.¹⁷² Flood and May argue that patients need accessible, inexpensive means to deal with their rights in health care.¹⁷³ The ability to bring forth patient concerns about resource constraints to a review body may also help shed light on inappropriate resource allocation decisions and spur change.¹⁷⁴

¹⁶⁷ Colleen M. Flood, Mark Stabile & Carolyn Tuohy, "What is In and Out of Medicare? Who Decides? In Colleen M. Flood, ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 15 at 29 [hereinafter "Flood et al"].

¹⁶⁸ Sheldrick, Supra Note 164 at 163.

¹⁶⁹ Flood et al., Supra Note 167 at 29.

¹⁷⁰ Sheldrick, Supra Note 164.

¹⁷¹ Colleen M. Flood and Kathryn May, "A Patient Charter of Rights: How to Avoid a Toothless Tiger and Achieve System Improvement" Final Draft fro the Canadian Medical Association Journal, 23 January 2012 [hereinafter "Flood and May"].

¹⁷² Jackman, Supra Note 165.

¹⁷³ Flood and May, Supra Note 171.

¹⁷⁴ Ibid.

“The evidentiary burden, costs and delays associated with ordinary litigation make it an impractical means of enforcing patients’ rights. Moreover, patients cannot readily bring litigation against the system actors such as governments for resource allocation decisions. If a patient charter of rights is to be meaningful it must provide patients with an inexpensive, readily accessible, independent means through which to file a complaint and have it quickly resolved.”¹⁷⁵

In terms of resource allocation, Jackman argues that the Charter has enormous potential as a health care accountability mechanism.¹⁷⁶ Jackman argues that there is a judicial reluctance to use the Charter in rationing public funds for health care services.

Canadian residents have utilized the Charter as a mechanism to question the government’s decision whether to fund or not fund a health care service. In Auton,^{177 178} a Charter argument regarding the violation of the equality provision – s.15 – was brought against the British Columbia government for its decision not to fund behavioural therapy for children with autism. The SCC ruled, in a deferential opinion, that there was no violation as the scope of Medicare was a matter for the legislature and not the courts as long as the government maintained equality of constitutionally protected access. As there was not a s.15 violation, the SCC did not consider cost arguments as s.1 justification.

¹⁷⁵ Ibid.

¹⁷⁶ Jackman, Supra Note 165 at 26.

¹⁷⁷ Auton (Guardian ad litem of) v. British Columbia (Attorney General), [2004] S.C.J. No. 71.

¹⁷⁸ Eldridge v. British Columbia (Attorney General) [1997] 3 S.C.R. 624 (S.C.C.) also used s.15 to challenge resource allocation re. the provision of deaf interpreters as an insured benefit – the SCC agreed with the claimants that the government had violated s.15.

According to Lahey, the decision by the SCC left the responsibility for allocating resource to the governments and legislatures.¹⁷⁹

Alternatively, in Chaoulli,¹⁸⁰ resource allocation decisions were not left to the governments and legislatures. In Chaoulli, the Supreme Court ruled that Quebec's legislated prohibition on private medical insurance in the face of long wait times violated the Quebec Charter. However, only a minority of the judges found that the Quebec law violated section 7 of the Canadian Charter.¹⁸¹

¹⁷⁹ Lahey, Supra Note 31 at 53.

¹⁸⁰ Chaoulli, Supra Note 19.

¹⁸¹ This author must comment here on the Chaoulli case as it does relate to empirical results and analysis found in this study. The Chaoulli case is an example where the opinion of the patient regarding a medical procedure/hip surgery is different from his own physician. In this thesis study, when there is a difference of opinion between the patient and their own physician this difference is termed a 'discrepancy within team patient'. The discrepancy within team patient may take many forms but typically relates the general acceptability of a given health care service for the patient and/or a delay encountered by the patient. In order to understand the health care issues experienced in the Chaoulli case, one must read the original trial decision released in 2000. The patient's hip problems appear to begin in June of 1994 and both hips are operated on two years later as of September 4, 1996. The trial decision lists the following health care issues and services over three years: the unemployed patient was treated for depression in 1993 and was also treated for a heart attack by three specialists. He received a recommendation for heart surgery in January of 1994 and had the surgery in March of 1994. The patient's hip problems began in June of 1994. He was examined by a doctor in June of 1994 and then referred by his family physician to a specialist (Dr. F.) who saw him in January 10th of 1995. On January 11, 1995, Dr. F. gave his recommendation to the patient but the patient wanted a second opinion. At a February 28, 1995 appointment, Dr. F. told the patient he was not an ideal candidate for hip surgery. On March 27, 1995 the patient went to the emergency room. On April 11, 1995, Dr. F. saw the patient. On May 18, 1995, the patient received an operation on his left hip. From July 1995 to December 1995, the patient consulted a 'number of people'. In January of 1996, the patient fell on his shoulder. In April of 1996, the patient was operated on for a hernia. In February the patient met with Dr. F. who determined the patient's right hip required an operation. On September 4, 1996, the patient received an operation on his right hip. In the author's opinion, this is a significant number of health care services provided to the patient some of which the patient does not appear to experience a delay accessing care. In addition, the issue before the court with respect to the delay receiving hip surgery through the public health care system appears to be resolved within approximately two years.

The trial court also appears to question the validity that the patient's complaint results from the public health service. The trial court stated:

Mr Zeliotis initiated a media campaign denouncing the delays in the health system. The truth is that, bearing in mind his personal medical obstacles, the fact that he was already suffering from depression, his indecision and his complaints which in many respects were unwarranted, it is hard to conclude that the delays that occurred resulted from lack of access to public health services, and in fact even the complaints made about the delays by Mr. Zeliotis may be questioned ...

Lahey states that:

‘... the right of Canadians to health care is in the process of transitioning from a right that is defined by governments through their legislative and administrative processes to a right that Canadians will be able, to some still uncertain extent, demand from governments through the adjudicative process. Whatever else this may mean, it certainly means a new kind of accountability that requires governments to explain the rationale for their legislative and policy choices to the overseeing courts.¹⁸²

Lahey goes on to state that use of the judiciary to make resource allocation decisions may unavoidably focus on the rights of an individual rather than the interests of the collective. However, this individual focus ‘cannot be altogether bad’ given the lack of participation of affected individuals and ‘black-box’ decisions of bureaucrats.¹⁸³

The Charter raises two questions with respect to this thesis – 1) are tribunals themselves subject to the Charter and 2) are tribunals able to review Charter questions submitted by the parties. For example, are parties before a tribunal able to clarify whether they have a

It is possible to sympathize with Mr. Zeliotis, to understand the pain and anguish he felt, but one cannot conclude that the problems and delays he speaks of were solely caused by problems of access to Quebec health services. At the same time, the Court acknowledges that despite the fact that his medical file is not entirely conclusive he has an ‘interest’ in the broad sense in bringing the instant proceedings. So far as he was concerned, he had real problems getting an operation and this caused him suffering. He felt he would have had better access if there were a private system. We cannot say this is true, but it is his opinion and he is entitled to it.”

In this author’s opinion, the Chaoulli case highlights the importance of understanding the patient’s original submission at trial and the trial court’s decision based on this submission.

¹⁸² Lahey, *Supra Note 28* at 57.

¹⁸³ *Ibid* at 58.

Charter right to a given health care service when the government denies provision of that service.

With respect to whether tribunals are subject to the Charter, the 2001 Supreme Court of Canada decision in *Ocean Port Hotel Ltd. v British Columbia (General Manager, Liquor Control and Licensing Board)*¹⁸⁴, held that administrative tribunals as agencies are within the operations of the executive branch of the government and are thus – like the government itself – subject to the Charter. The question whether tribunals are able to review Charter questions was resolved in the 2010 Supreme Court of Canada decision in *R. v. Conway*¹⁸⁵ which held that administrative tribunals are courts of competent jurisdiction to hear Charter issues and grant general remedies - if Charter jurisdiction has not been excluded by statute.¹⁸⁶

3. Judicial Review

A quasi-judicial / tribunal decision can be judicially reviewed by the courts based on 1) an alleged breach of procedural fairness or bias and/or 2) the tribunal's inappropriate utilization of its specific standard of review. If a tribunal's decision does not comply with

¹⁸⁴ [2001], 2 S.C.R. 781, online QL (SCJ) [hereinafter “Ocean Port”] at para 32.

¹⁸⁵ 2010 SCC 22, [2010] 1 SCR 76 [hereinafter “Conway”].

¹⁸⁶ Ibid - Conway at para 22 states: “[t]he result of this question will flow from whether the tribunal has the power to decide questions of law. If it does, and if Charter jurisdiction has not been excluded by statute, the tribunal will have the jurisdiction to grant Charter remedies in relation to Charter issues arising in the course of carrying out its statutory mandate (Cuddy Chicks trilogy; Martin). A tribunal which has the jurisdiction to grant Charter remedies is a court of competent jurisdiction.”

procedures or substantive review relative to the standard of review, the court can quash, set aside or remit the matter back to the tribunal.

Procedural Review of Tribunal Decisions

Administrative tribunals, such as the Board, are required to follow procedures that are fair, particularly when Board discretion is involved.¹⁸⁷ The court judicially reviews a tribunal's decision primarily in terms of the procedures the tribunal followed in arriving at the decision - as opposed to a judicial review of the tribunal's substantive outcome of the decision itself. As such, tribunals will endeavour to follow procedures that are endorsed by the courts in an effort to create a fair environment for both parties in which the tribunal will come to an outcome decision. The tribunal will also endeavour to follow procedures to avoid its outcome decision being overturned by the courts for failure to follow fair procedures.

Decisions that are policy decisions, such as those made by the legislature or minister as opposed to outcomes affecting an individual, do not typically require following the procedural protections.¹⁸⁸ The government has maintained that it is entitled to make health policy decisions and has refused to extend the duty of fairness.¹⁸⁹

The duty of fairness and the factors to be considered are established in caselaw. In Baker, the duty of fairness was held to require full and fair consideration of the issues and

¹⁸⁷ Baker v. Canada (Ministry of Citizenship and Immigration) [1999] 2 S.C.R. No. 39, online QL [hereinafter ‘Baker’]

¹⁸⁸ Ibid at para 60

¹⁸⁹ Pitfield, Supra Note 72 at 29.

‘meaningful opportunity to present various types of evidence relevant to their case and have it fully and fairly considered.’¹⁹⁰ The Supreme Court in Baker also stated that the right to participate, as an element of the duty of procedural fairness, ensured that:

“..administrative decisions are made using a fair and open procedure, appropriate to the decision being made and its statutory, institutional and social context, with an opportunity for those affected to put forth their views and evidence fully and to have them considered by the decision-maker.”¹⁹¹

Baker also established factors which must be considered in the duty of fairness. These include five factors for general procedural fairness - the nature of the decision and the process involved in making it, the nature of the statutory scheme, the importance of the decision to the individual affected, the legitimate expectations of the parties, and the procedure chosen by the tribunal. Specific procedural fairness factors include - notice that the decision will be made, disclosure of the info on which the tribunal will base its decision, the opportunity to participate or make views known, full hearings similar to that which occurs in courts, opportunity to give evidence and cross examine, right to counsel, and oral or written reasons for its decisions.¹⁹²

¹⁹⁰ Baker, Supra Note 187 at para 32.

¹⁹¹ Ibid at para 22.

¹⁹² Ibid .

According to Huscroft, the duty of fairness requires two things – (1) the right to be heard and (2) the right to an independent and impartial hearing.¹⁹³ “Hearings” do not necessarily have to be oral hearings as the modern state could not function if oral hearings were required for every administrative decision.¹⁹⁴ It has also been argued that additional factors may influence an applicant’s access to fair hearings. For example, access to justice factors may include such things as the access to adequate legal representation¹⁹⁵ and physical access to administrative justice.¹⁹⁶

Pitfield argues that any shortcomings with respect to determinations of fact are not surprising as they are the natural result of administrative law’s focus on procedure. Pitfield argues that ‘[w]hat matters are how the process looks and not necessarily how well it works.’ In her view, tribunals have chosen the fairness of process over the accuracy of factual determinations and questions whether judicial procedures are actually fair and effective.¹⁹⁷

It is expected by this author that procedures are neutral and allow the substantive legal argument with respect to the legislation to be the only determining factor(s) for the tribunal decision. But what if the due procedural protections, so strongly entrenched in administrative law, influence the outcome decision as much or more than the substantive legal argument(s)? This is a core question for this thesis - whether these procedures are

¹⁹³ Grant Huscroft, “The Duty of Fairness: From Nicholson to Baker and Beyond” in Colleen M. Flood et al, eds. *Administrative Law in Context* (Toronto: Emond Montgomery Publications Limited, 2008) 117. [hereinafter “Huscroft”].

¹⁹⁴ *Ibid* at 118.

¹⁹⁵ Sossin, *Supra Note 119* at 402.

¹⁹⁶ *Ibid* at 396.

¹⁹⁷ Pitfield, *Supra Note 72* at 98.

neutral or whether they – in addition to substantive legal arguments - influence the outcome tribunal decision. Subsequent chapters in this thesis analyse, for example, whether the procedures of the Hearing format and legal representation at the Hearing affect the decision regarding resource allocation.

Substantive Review of Tribunal Decisions

A ‘substantive review’ of tribunal decisions by the courts is not a review of the procedures used by the tribunal but an actual review of the tribunal’s decision relative to the tribunals’ jurisdictional mandate, the standard of review and evidence. In essence, administrative law principles ensure decision-makers act within the bounds of their legal authority.¹⁹⁸ While it is argued that the courts appear to have a deferential approach to decision-makers, including the decisions of tribunals,¹⁹⁹ if the tribunal’s decision is not legally appropriate relative to its statutory authority, the courts can overturn the tribunal decision.

For example, in *Stein v. Quebec (Regie de l’Assurance-Maladie)*,²⁰⁰ the Quebec Superior Court overturned the Tribunal’s decision to uphold the government’s denial of out of country colon cancer surgery reimbursement. In that case, Stein was told by his physician that the liver metastases should be removed as soon as possible. Stein, after being rescheduled for surgery several times, sought surgery out of country via a procedure that was considered by the tribunal to be ‘experimental’ in Canada. The Quebec Superior

¹⁹⁸ Nola Reis, Charter Challenges” in Jocelyn Downie et al ed., Canadian Health Law and Policy 3rd edition (Canada, Lexis Nexis, 2007) at 538 at 556.

¹⁹⁹ Pitfield, Supra Note 72 at 29.

²⁰⁰ [1999] Q.J. No. 2724, [1999] R.J.Q. 2416 (Que. S.C.). [hereinafter “Stein”].

Court found the Tribunal's decision irrational, unreasonable and contrary to the purpose of the Quebec Health Act and ordered reimbursement.²⁰¹ According to Lahey, "Stein indicates an emerging willingness in the courts to demand that health care policy-makers more tightly connect their decisions to an understanding (and a justification) of the consequences of those decisions for real flesh and blood citizens."²⁰²

When a court substantively reviews a tribunal decision, it is reviewed according to a standard. Until 2008, the standard of review varied for tribunals from correctness, reasonable simpliciter to patent unreasonableness. The court provided guidance to tribunals regarding the standard of review in the 2008 SCC decision of *Dunsmuir v. New Brunswick*²⁰³ which established correctness and reasonableness as the two standards of review. In the case of *Flora v. Ontario Health Insurance Plan*,²⁰⁴ the Ontario Court of Appeal held HSARB's Standard of Review as one of reasonableness. In *C.C.W. v. Ontario Health Insurance Plan*, the court confirmed that the Standard of Review for HSARB out of country cases was that of reasonableness²⁰⁵ and deference was owed to HSARB in the interpretation of its own statute.²⁰⁶

²⁰¹ *Ibid* at para 32.

²⁰² Lahey, *Supra Note 31* at 52.

²⁰³ 2008 SCC 9 (CanLII) [hereinafter 'Dunsmuir']..

²⁰⁴ 2008 ONCA 538 (CanLII) [hereinafter "Floira"] at para 92 "I end my analysis of the reasonableness of the Board's decision where I began. Under the formulation of the reasonableness standard articulated in Dunsmuir, deference is owed to the Board's decision if it falls within a range of acceptable outcomes that are defensible on the facts and the law and if the justification for the decision is sound, transparent and intelligible. I have no hesitation in concluding that the Board's decision satisfies these requirements. I turn next to Mr. Flora's Charter s. 7 claim."

²⁰⁵ C.C.W., *Supra Note 100* at para 46.

²⁰⁶ However, no deference was given to the Tribunal regarding the government's/OHIP's to retroactively give prior approval to out of country applications. The court also confirmed the Tribunal had no jurisdiction of deal with constitutional issues.

The courts have been helpful in establishing the standard of review for tribunals and HSARB specifically. However, the judicially reviewed tribunal decisions only reflect a small percentage of all tribunal decisions. The small percentage of cases on appeal to the courts may not represent the cases that come before a tribunal. Of the tribunal cases not appealed to the courts, little research has been done to analyze the procedures and the substantive legal arguments presented by the parties and the resulting tribunal decision.

4. Tribunals as Decision Making Mechanisms

Charter challenges before the courts review government decision making relative to legal rights and norms. Administrative Law is about ensuring that governmental power is used in an accountable, fair way relative to ordinary citizens.²⁰⁷ To different extents, both constitutional law and administrative law deal with the legality of government powers.²⁰⁸

Administrative tribunals are important because more citizens have resource allocation decisions determined by tribunals than by courts.²⁰⁹ Tribunals are concerned with everyday practice of administrative justice not just the judicial review of administrative decision-making.²¹⁰

²⁰⁷ Colleen M. Flood, “An Introduction to (the Effervescence of) Administrative Law in Colleen M. Flood et al, eds. *Administrative Law in Context* (Toronto: Emond Montgomery Publications Limited, 2008) 9. [Hereinafter “Flood”].

²⁰⁸ *Ibid* at 9.

²⁰⁹ *Cooper v. Canada (Human Rights Commission)*, [1996] 3 S.C.R. 854 at 899-900.

²¹⁰ Sossin, *Supra* Note 119.

Tribunals have evolved over the last quarter century from the old approach to governing which was one of “command and control” whereby administrative bodies imposed the regulation and sanctioned any non-conforming behaviour to ‘new’ governance.²¹¹ Under the new governance model, the ideal is that the government uses a mixture of tools to accomplish the government’s goals including the concept of a ‘regulatory pyramid’ of escalating strategies as a means of flexibility in enforcing regulatory regimes.^{212 213}

Our theoretical understanding of how tribunals make resource allocation decisions comes largely from the judicial review by courts of individual tribunal decisions. The understanding of tribunal procedures and substantive legal arguments through the eyes of the court in judicial review is not the only way to understand how tribunals operate:

“...for many years excessive emphasis has been placed on judicial review of administrative tribunals. Indeed, in the beginning years of the subject, and for too long, there was, in my view, far too much attention paid to legal controls of administrative action, as reflected, for example, in the views of A.V. Dicey and Lord Hewart of Bury, and not enough attention to what might be called a realistic approach to the subject”²¹⁴

²¹¹ W.A. Bogart, “The Tools of the Administrative State and the Regulatory Mix” in Colleen M. Flood et al, eds. *Administrative Law in Context* (Toronto: Emond Montgomery Publications Limited, 2008) 26

²¹² I. Ayres & J. Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate* (New York: Oxford University Press, 1992).

²¹³ J. Braithwaite, *Restorative Justice and Responsive Regulation* (New York: Oxford University Press, 2002).

²¹⁴ Frank Iacobucci, “Preface” in Colleen M. Flood et al, eds. *Administrative Law in Context* (Toronto: Emond Montgomery Publications Limited, 2008) xxiii.

5. Judicial and Political Deference to Tribunals

In the academic discussion regarding the use of the courts as a mechanism to allocate resources, the issue of judicial deferral to the legislature and administrative tribunals arises again and again. Ham states that political leaders are reluctant to allocate health care resources at the macro level as they will have to accept responsibility for unpopular choices. The retreat from explicit resource allocation decision making can be interpreted as a political blame avoidance strategy to avoid unpopular decisions and shift these to tribunals, health authorities and physicians.²¹⁵ Ham states:

“In these circumstances, there is a tendency for policy makers to avoid blame either by ducking tough choices or by devolving responsibility to others. Rationing by guidelines rather than exclusions is one manifestation of this, in that it leaves ultimate responsibility for deciding who should be given access to health care resources to agencies such as sickness funds and health authorities at the meso level and to physicians at the micro level.”²¹⁶

According to Flood, the larger debate around tribunal decision making regarding resource allocation has to do with whether the government defers politically sensitive issues to the courts and/or administrative tribunals as a way of avoiding unpopular decisions.^{217 218} The courts are deferential to the government and both the government and the courts avoid

²¹⁵ Chris Ham, Glenn Robert, *Reasonable Rationing: International Experience of Priority Setting in Health Care*, (Maidenhead: Open University Press, 2003). [hereinafter “Ham 2003”] at 14.

²¹⁶ *Ibid* at 8.

²¹⁷ Flood, *Supra Note 208* at 9.

²¹⁸ R. Abella, “Canadian Administrative Tribunals: Towards Judicialization or Dejudicialization” (1988) 2 *Can. J. Admin. L & Prac.* 1 at 2.

substantive resource allocation decisions by engaging administrative tribunals. According to Flood, the legislature makes a conscious decision to devolve difficult decisions regarding resource allocation away from the legislature and the courts and into the hands of administrative tribunals.²¹⁹ Flood states:

“Through statutes, legislatures give these tribunals and boards power over others. Their reasons for doing so are as varied as the types of delegated decision-makers in existence. Sometimes there is a desire to employ particular expertise that is not available within a government department; sometimes there is a need for an independent and impartial decision maker so that decisions are not seen to be dictated by political processes; and sometimes, which is of greater concern, governments may try to bury or deflect attention from inadequate funding for programs or tough resource allocation decisions by devolving decision making to administrative agencies with court-like powers.

Judicialization can be appealing to governments, who “clothe what are essentially economic or social decisions with a sort of protective colouring that may bolster the tribunal’s credibility, or at least make it a little less vulnerable to criticism.”²²⁰

...Whatever the reason for establishment of a board or tribunal, it is very important to realize that the legislature – almost always at the behest of the government – makes a conscious choice to devolve decision-making away from the legislature and not to the courts but to an administrative body.²²¹

²¹⁹ Flood, Supra Note 208 at 8.

²²⁰ Ibid at 8.

²²¹ Ibid.

6. Conclusion

The purpose of this chapter is to provide an overview of the debates regarding the judicial and adjudicative tribunal decision making mechanisms within which HSARB is situated.

It is debated whether tribunals provide an accessible, inexpensive mechanism for resource allocation decisions or whether they are just a mechanism for government and the courts to defer or shift difficult and/or unpopular decisions.

Chapter 5

Literature Review

Part III: Process and Substantive Theories

1. Introduction
2. Part A Theories - Access / Procedures
3. Part B Theories - Substantive Mechanisms
 - a. Review Panels
 - b. Physicians
 - c. Multiple Stakeholders
 - d. Corporations
4. Part C - Other Theories - Factors Contributing to Resource Allocation Decisions
 - a. Economic Theory
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5. Conclusion

Chapter 5

Literature Review

Part III: Process and Substantive Theories

1. Introduction

The purpose of this chapter is to review the major health care resource allocation decision making scholarship and to identify the current debates in the academic discussions. This review will be used as the basis to develop a context within which to analyse tribunal decision making factors – specifically the study of HSARB resource allocation decisions. This thesis does not review the scholarship on decision making capacity, appointment process of decision makers, the independence of decision makers or governance and regulation theory. These are valid ways to study resource allocation decision making. However, this thesis quantitatively focuses on actual procedural factors faced by the litigants and the effect these factors have on the decision outcome. The thesis also critically examines the substantive regulatory ‘test’ in order to determine which factors actually influence resource allocation decisions. Thus, the literature review not only seeks to outline the various procedural and substantive decision making theories but to also establish, based on the existing empirical research, if the theories and the practical application of resource allocation decision making are aligned. If the theory and practice are not aligned, it is anticipated that the literature review will establish where the disconnect is taking place.

The literature, while providing an outline of the procedural and substantive theories, did not summarize common themes. This needed to be derived by the author from a review of numerous theories. An exhaustive review of the literature did not provide a quantitative analysis or examination of whether the theory and the practical application of resource allocation decision making were aligned. In essence, the lack of quantitative research literature regarding the alignment of theories to practice made the congruity of tribunal resource allocation decisions and any applicable theory difficult to understand.

This chapter is structured as follows: Part A examines access/procedural theories. Part B reviews substantive theories regarding who makes resource allocation decisions - technical review panels, physicians, multiple stakeholders and corporations. Part C examines 'other factors' which may contribute to resource allocation decision making – such as economic theory and the 'levels' of decision making.

The next chapter will analyse, based on a study of HSARB decisions, what is actually taking place regarding resource allocation decision making. Subsequent chapters will analyse the theories relative to the actual procedural and substantive factors affecting the tribunal resource allocation decisions.

2. Part A - Access / Procedural Theories

The interest in health care resource allocation decision making arose because of difficulty obtaining agreement on the principles / substantive approaches that should guide decision

making.²²² ²²³ There was a need to ensure the decisions themselves were reached in a legitimate and fair way rather than focusing solely on substantive elements because procedural theory in health care resource allocation has been influenced by a number of theorists including the writings of Daniels and Sabin on the A4R, Nelson,²²⁴ Calabresi and Bobbitt²²⁵ and Orentlicher's²²⁶ and Chris Ham's²²⁷ concern about transparent decision making. In essence, there is a theoretical debate regarding the transparency of procedures and whether procedural transparency is critical for the acceptance of a resource allocation outcome. There is limited academic qualitative research on the application of health care resource allocation decisions and there does not appear to be any quantitative research on the application of procedural resource allocation decision making theory to health tribunals.

One prominent procedural theory, developed in the late 1990s by Daniels and Sabin, is entitled the theory of Accountability for Reasonableness (A4R). In essence, the theory states that due to a lack of consensus over substantive distributive justice principles for health care, society must rely on fair deliberative procedures that yield a range of acceptable answers. In other words, Daniels and Sabin state that decision makers can only legitimately allocate health care resources for consumption by individuals and

²²² Daniels, N. Sabin, J.E. (1997). Limits to health care: fair procedures, democratic deliberation, and the legitimacy problem for insurers. *Philosophy and Public Affairs* 26(4): 303-50 [hereinafter "A4R"].

²²³ N. Daniels, J.E. Sabin, *Setting Limits Fairly*, (New York: Oxford University Press, 2008) [hereinafter "Setting Limits Fairly"].

²²⁴ Richard J. Nelson III, "Rationing health care in Britain and the United States" *Journal of Health & Biomedical Law* 7.2 (Fall 2011) 175 [hereinafter "Nelson"].

²²⁵ Calabresi G., Bobbitt, P., *Tragic Choices*, W.W. Norton & Co. (New York: 1978), at 17-22 [hereinafter "Calabresi and Bobbitt"].

²²⁶ David Orentlicher, "Rationing Health Care: It's a Matter of the Health Care System's Structure" 19 *Annals Health L.* 449 2009-2010.[hereinafter "Orentlicher"].

²²⁷ Ham, Supra Note 215.

society if the allocation process itself is accepted by society. In this respect, the outcome decision regarding the health care resource allocation may not be agreed upon, but the process for achieving the outcome is considered acceptable to individuals and society and thus the outcome decision is accepted. A key aspect of this procedural theory is the need to have a transparent decision making process. The ‘A4R’ theory requires four conditions of transparency: publicity, relevance, appeals and enforcement. Under the publicity condition, decisions by decision makers must be publicly accessible. Under the relevance condition, the rationale for decisions must rest on the evidence that fair-minded parties agree is relevant. Under the appeals condition, a mechanism for challenging a decision and/or a dispute resolution mechanism must be made available. Under the enforcement condition, regulation of the process must be in effect to ensure the conditions of publicity, relevance and appeals.

In 2008, Daniels and Sabin released a book entitled *Setting Limits Fairly* which asks the question ‘how can a society or health plan meet population health care needs fairly under resource limitations?’ The authors recast their 1998 question regarding how to decide about resource allocation decision making. The authors asked under what conditions society should grant authority to individuals or institutions to set limits to health care? The authors concluded – as they did in 1998 - that limits can only be acceptable as legitimate and fair if they are established through a fair limit-setting process – according to the theory of A4R – such that stakeholders accept the outcome as fair and legitimate. Given the lack of consensus about approaches to rationing, society must rely on fair

deliberative procedures that yield a range of acceptable answers.²²⁸ Procedural fairness must, according to the authors, enable public deliberation and democratic oversight for health care limits. The authors state that legitimacy to decide is a fundamental problem of ethics and health policy regardless of financing, delivery systems or different countries and that no democratic society has achieved consensus on distributive justice principles for health care.^{229 230}

The necessity for transparency in resource allocation decision making as outlined by Daniels and Sabin is challenged by a number of academics. For example, in order to discuss procedural fairness accurately, transparency itself must be further broken down – something which is not done in the A4R theory. Nelson examined two types of transparent resource allocation decision making - explicit resource allocation and implicit resource allocation.²³¹ Explicit resource allocation involves transparent decision making that acknowledges cost related concerns as the justification for limiting access to particular treatment. Implicit rationing involves decisions to limit access to care where

²²⁸ The authors are from medicine and philosophy and do not appear to be aware of administrative law or the legal principals of procedural fairness. Their A4R theory looks very much like the long standing principle of procedural fairness. In their own language and paradigms, they may be using legal principals in medical decisions.

²²⁹ Setting Limits Fairly, Supra Note 223 at 5.

“... [c]omplaints about the health care system are rarely formulated in terms of legitimacy. ... In many national health insurance or service systems, the complaints are often about underfunding and bureaucratic insensitivity to patient needs. ... In countries with universal coverage systems, awareness of legitimacy is focused less on who exercises authority and more on how that authority should be exercised.”

²³⁰ Ibid at 4.

One view is the sickest patients should receive health care resources. Another view is that society should maximize the total benefits its health care expenditures provide regardless of who benefits.

“In the absence of a broadly accepted consensus on principles for fair distribution, the problem of fair allocation becomes one of procedural fairness. ... When we lack consensus on principles that tell us what is fair, or even when we have general principles but are burdened by reasonable disagreements about how they apply, we may nevertheless find a process or procedure that most can accept as fair to those who are affected by such decisions. That fair process then determines for us what counts as a fair outcome.”

²³¹ Nelson, Supra Note 224.

cost considerations are not articulated in a transparent process but are nonetheless a factor. In essence, both types of transparent resource allocation – explicit and implicit – acknowledge factors – such as cost – differently in terms of transparency and its effect on the outcome decision.

The American academics, Calabresi and Bobbitt state that explicit public, transparent resource allocation decisions - that resulted in suffering and/or death -could exacerbate social tensions.²³² As a result, society tries to conceal any conflict of values in order to avoid this social tension and appearing to make a ‘tragic choice’.²³³ In other words, transparent resource allocation decisions may have a negative effect on society rather than allowing for acceptance by society.²³⁴ Interestingly in 2001, the UK academic Chris Ham,²³⁵ advocates for the development of resource allocation guidelines in a fair and open procedure so that decisions based on these guidelines are defensible. In other words, the transparency of resource allocation decision making does not appear to be sufficient without accompanying guidelines.

In 2003 Chris Ham, stated the challenge of rationing health care services needed a systematic approach:

²³² Calabresi and Bobbitt, Supra Note 225.

²³³ Calabresi and Bobbitt, in their 1978 book coined the term ‘tragic choices’ to describe difficult choices which had to be made regarding the allocation of scarce health care resources. They identified four methods of resource allocation – markets, political processes, lotteries and custom – similar to Trebilcock’s models of market, lotteries, queuing, voting and merit based allocations discussed later.

²³⁴ Orentlicher also states that it is not clear that society will tolerate transparent resource allocation decision making processes.

²³⁵ Chris Ham and A Coulter, “Explicit and Implicit Rationing taking responsibility and avoiding blame for health choices” (2001) J Health Serv Res Policy 6 163-9 [hereinafter “Ham 2001”].

“In an era of ever-increasing medical possibilities, publicly financed health care systems face the challenge of determining what services should be covered for the insured population. This challenge, usually referred to as health care rationing or priority setting, words we shall use interchangeably, has led governments in a number of countries to take a more systematic approach to the determination of service coverage than has usually been the case in the past.”²³⁶

Ham advocated for resource allocation guidelines along side of exclusions and the responsibility for rationing takes place at many different points in the system - as opposed to one decision making point.²³⁷

Need for Quantitative Research

There appears to be little empirical research regarding the application of resource allocation decision making procedural theory to actual decision making. Two qualitative research initiatives looking at theory’s application to practice have been done by Ham and Giacomini.

In his book, *Reasonable Rationing: International Experience of Priority Setting in Health Care*,²³⁸ Ham investigated – based on case studies of five countries - the extent which actual resource allocation decisions met Daniels and Sabin’s four conditions (publicity,

²³⁶ Ham 2003, Supra Note 215 at 4.

²³⁷ Ibid.

²³⁸ Ibid.

relevance, appeals and enforcement) in the A4R theory.²³⁹ Researchers for the Canadian component of the case study stated that the rationale for priority setting is seldom available to anyone other than decision makers. As a result, patients and the media are not aware of the difficulties faced by decision makers and are not able to engage in discussions around priorities. The researchers were also not aware of an appeal process for a second opinion.²⁴⁰

In the detailed reports of all five country studies, it was established that in decision making about priorities at the macro level, there are gaps in cost and benefit information:

“Those responsible for priority setting therefore have to confront the need to make decisions in conditions of incomplete information and likely conflicts between objectives.”²⁴¹

Even if more accurate information was available it would still have to be interpreted by policy makers in the process of determining priorities. Ham states:

²³⁹ The five countries included: New Zealand, Canada, the United Kingdom, Norway and the Netherlands regarding health technologies. The following seven questions were asked of each country:

1. What procedures are used to determine whether health technologies should be funded?
2. What is the role of different institutions in these procedures?
3. What kind of evidence do these institutions expect/require/consider in making funding decisions?
4. What standard of proof do they expect to be demonstrated in agreeing funding?
5. What appeal mechanisms are available for reviewing decisions?
6. What does experience in your country say about the debate between those who argue for stronger institutions and those who argue for better information to support priority setting?
7. To what extent does experience in your country meet the tests of accountability for reasonableness?

²⁴⁰ The authors appear unaware of the HSARB

²⁴¹ Ham 2003, Supra Note 215 at 7.

“One clear conclusion from experiences so far is the sheer messiness of health care decision making and the inherently political nature of priority setting. The allocation of scarce resources between competing demands is at once an economic challenge and a political puzzle. ..”²⁴²

From the work undertaken by Ham, it appears that there is evidence of a partial retreat from explicit rationing at the macro level. Instead of explicit rationing at the macro level, the focus on the meso level of health authorities and micro level of physicians of rationing could be interpreted as a political blame avoidance strategy in order to avoid unpopular decisions and shift these unpopular decisions to tribunals, health authorities and physicians.

“In these circumstances, there is a tendency for policy makers to seek to avoid blame either by ducking tough choices or by devolving responsibility to others. Rationing by guidelines rather than exclusions is one manifestation of this, in that it leaves ultimate responsibility for deciding who should be given access to health care resources to agencies such as sickness funds and health authorities at the meso level and to physicians at the micro level.”²⁴³

In their study of twenty four Canadian health policy documents from January 1998 to January 2005, the authors – Giacomini, Kenny and DeJean - express concern about how

²⁴² Ibid at 8.

²⁴³ Ibid

process theories, which assist with procedural fairness, are reflected in policy²⁴⁴. The authors found that the reviewed health policy documents cite health care frameworks but the frameworks are not well defined, described, or evaluated, vary substantially and provide little consistency. For example, the variability articulated in the terms “equity” and “accountability” suggested to the authors that policy makers currently develop ethical principles for their frameworks based on their own understandings and not based upon standard definitions. As such, the authors state that the development or reliance on an ethics framework as a feature of health policy should proceed with caution.

In summary, the focus on procedures is the result of difficulty obtaining agreement on the theoretical underpinning that should guide substantive resource allocation decisions. The scholarship in the area of procedural theories focuses on pros and cons of legitimate, transparent resource allocation decisions in order to yield a range of acceptable answers. However, there is very limited qualitative research available and limited academic commentary regarding application of procedural theory of health care resource allocation decisions. There also does not appear to be any quantitative research on the application of procedural resource allocation decision making theory at the tribunal level.

3. Part B - Substantive Theories

a. Review Panels

There is limited empirical research on the application of resource allocation decision making theory by tribunals in Canada. The limited Canadian empirical research that does

²⁴⁴ M. Giacomini, N Kenny and D DeJean, “Ethics frameworks in Canadian health policies: Foundation, scaffolding, or window dressing?” (2009) *Health Policy*, 89 (1), 58-71.

exist is not referred to by American academic discussion about health care resource allocation decisions. Instead, the American academic discussion is based on theory not empirical research. The academic theory discusses the creation of independent reviews by specialized technical panels²⁴⁵ and independent and impartial governing boards.²⁴⁶ These specialized technical panels would determine resource allocation. The debate is regarding the scope of jurisdiction of these theoretical bodies.

Ruger argues that consumers alone, physicians or health experts, strict algorithms or cost-benefit calculations, shared decision making within an informed consent model, fair procedures or third parties such as insurers should not make health care decisions. Health care decisions must involve an integrated mix of stakeholders:²⁴⁷

“Shared health governance extends beyond the individual patient-doctor relationship to the institutions that oversee the health sector. For example, patients must be protected from physicians who have financial incentives to provide inappropriate and costly care, of who unfairly deny, or fail to recommend, appropriate medical care; or who practice bedside rationing. In the former case, peer review should motivate physicians to conform to established standards. In the latter, appeals procedures should protect individuals from unfair denial of care. An independent and impartial

²⁴⁵ William Sage, “Managed Care’s Crime: Medical Necessity, Therapeutic Benefit, and The Goals Of Administrative Process In Health Insurance” 53 Duke L. J. 597 [hereinafter “Sage”]

²⁴⁶ Jennifer Ruger, “Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law” (2006) Cornell Journal of Law and Public Policy Vol. 15:2. 101-187 [hereinafter “Ruger”]

²⁴⁷ Ibid at 107.

governing board should periodically review coverage and quality decisions, hear and rule on patient and physician appeals, and require guidelines to be adjusted. The board should also oversee and critically review quality of care and other information, including physician credentials and abilities. Many states currently have consumer grievance and appeal procedures, while Medicare has a federal external review system.”²⁴⁸

In terms of economic theory, Peacock states that resource allocation panels are important to the process of resource allocation decision making. Peacock states that resource allocation decisions must consider the outcomes and trade-offs of their decisions and that doctors must accept the key concepts that underpin programme budgeting and marginal analysis and other economic approaches to priority setting.²⁴⁹

Sage argues for expert, independent review of disputes in order to screen and control ineffective, costly litigation regarding health care resource allocation decision.²⁵⁰ Such an ‘administrative adjudication mechanism’ would allow the use courts only to be used for unsettled issues. In this respect, independent review panels represent an extension of health care regulation rather than litigation management.²⁵¹

²⁴⁸ Ruger, *Supra Note 246* at 108.

²⁴⁹ Stuart Peacock et al, ”Using economics to set pragmatic and ethical priorities” (2006), *BMJ* 25; 332 (7539): 482–485

²⁵⁰ Sage acknowledges the longstanding problem in the regulation of professions generally: how to hold experts accountable to non experts.

²⁵¹ William M. Sage, “Unfinished Business: How Litigation Relates to Health Care Regulation”, (2003) 28 *J. Health Pol. & L.* 387, 397 (2003).

The independent review panels, according to Sage, offer a standard process for resolving socially contentious entitlement issues that builds public values, strengthens therapeutic relationships by reducing adversarial tensions, building patients' trust in their health plans and providers, and rewarding compassionate behavior.²⁵² Among other things, Sage suggests that independent review procedures should be different for insured individuals who are severely or chronically ill than for those who are only occasional users of health care services.

The academic discussion reviewed above points to the need for specialized technical review panels populated by a mix of stakeholders. The debate regarding specialized technical review panels is regarding the scope of their jurisdiction. The jurisdictional scope may include patient protection from: inappropriate and costly care, the denial of care, the failure to recommend care. The jurisdiction may also require compliance with guidelines, oversee the quality of care provided, and periodic review coverage. The panels might also consider health outcomes and trade-offs and control for ineffective and costly litigation as well as following different procedures for chronically ill patients versus occasional patients.

b. Physicians

Resource allocation decisions by physicians based on medical necessity is debated in the literature. The debate is about whether physicians, as a decision making mechanism, determine 'medical necessity' in the interest of the individual patient, the society at large or a combination of the individual and society – or – if physicians

²⁵² Sage, Supra Note 245 at 623.

should even be involved in these decisions. There is also discussion regarding the determination of medical necessity as a clinical, contract or corporate function and whether the term 'medical necessity' is a term of art rather than a clinical term.²⁵³ This debate considers whether or not utilitarian values – as represented by economic analysis, collective societal decisions versus individual physician decisions, and physician models of service delivery should be considered. Why is the role of physicians in decision making important to this thesis on tribunal resource allocation decision making? In the substantive argument before the HSARB/tribunal, physicians are required to determine if a procedure is medically necessary for a given patient and if a delay receiving that treatment would result in harm to the patient. In this respect, an understanding of the theory behind physician resource allocation decision making is important.

Physicians Decide

Ubel²⁵⁴ ²⁵⁵ argues that physicians should determine medical necessity and thus resource allocation for patients. Physicians, it is argued, are often asked to be "gatekeepers," determining their patients' access to medical therapies and technologies. At the same time, most physicians have been taught that they should act as patient advocates, pursuing patients' best interests regardless of cost. Ubel argues that healthcare rationing is appropriate in order to help control healthcare costs, and that rationing decisions made at

²⁵³ Ibid.

²⁵⁴ P.A. Ubel, "Physicians, thou shalt ration: the necessary role of bedside rationing in controlling healthcare costs" (2001) Health Pap.,2(2):10-21.[hereinafter "Ubel 2001"] PubMed PMID: 12811141

²⁵⁵ P.A. Ubel PA and Gold, "Recognizing bedside rationing: clear cases and tough calls" (1997) Ann Intern Med. 1;126(1):74-80. [hereinafter "Ubel 1997"] Review. PubMed PMID: 8992926.

the bedside by physicians must be part of the rationing system. A system that attempts to control costs by mandating an elaborate set of rules would be burdensome to physicians.

Physicians not to Decide

Barrett²⁵⁶, on the other hand, argues that Ubel's main conclusion that physician participation in bedside rationing is essential to controlling healthcare costs "is out of step with the current focus of thinking and policy debate within Canada and other countries with universal public healthcare systems." Barrett states that in the Canadian context, we collectively need to better understand the limits and choices in defining the "medicare commons," which occurs at the intersection of the overall level of funding, the range of comprehensiveness of services provided and the level of access that we are able to provide. In order to facilitate this understanding and collective responsibility, a deliberative, transparent process that engages patients and the public must be undertaken. Ultimately, Barrett argues, physicians must accept responsibility to use scarce resources prudently.

Veatch, like Barrett, opposes physicians allocating resources. He states that physicians who are bound by the Hippocratic Oath make poor allocators of health care resources because they are working for the benefit of their patient at the expense of all others.²⁵⁷

²⁵⁶ P.H. Barrett, "The tragedy of the Medicare commons?" (2001) Health Pap.;2(2):23-30PubMed PMID: 12811142

²⁵⁷ Robert M. Veatch, "A General Theory of Allocation," *Transplantation Ethics* (Washington, D.C.: Georgetown University Press, 2000), 287-310 [hereinafter "Veatch"].

“There are serious problems, however, with permitting allocations to be made on the basis of a clinician’s interpretation of these traditional medical professional values.... Clinicians will differ amongst themselves over how these conflicts should be resolved. Even if they could agree completely, it would not follow that lay people – the ones whose lives are at stake and the ones who created the pool of resources to be allocated – would concur with the ranking. ... Because these choices have nothing to do with medical knowledge, there is no reason why clinicians should be the ones making them? It is the general lay public that creates the money pool to support dialysis and creates the pool of cadaver organs to be allocated. They should be the ones making the moral choices relating to medical and non-medical goods and relating the pursuit of maximum benefit to maximum justice or fairness in allocation. Clinicians should remain free to give undivided loyalty to their patients. That is incompatible with asking them to be resource allocators.”²⁵⁸

Aaron argued against the determination of medical necessity and medical resource allocation by physicians. A key factor that Aaron identifies is the link between economic analysis of health care and the generally acceptable medical norms of providing health care:

“... In general, medical norms currently call for providing all care that promises net medical benefits. Under efficient health care rationing, some care will not be provided even if it is beneficial when benefits per dollar of

²⁵⁸ Ibid.

cost fall below some threshold. By definition, therefore, care that provides positive benefits below that threshold will not be offered. Because community tastes differ, some services that are deemed to generate sufficient benefits to justify provision in one community may be found not to provide sufficient benefits in another. Furthermore, judgments about medical benefits are often imprecise and probabilistic. Ethical challenges will arise from attempts to justify denial of care in one community that is available in others, or denial of care with a probability of success (or cost-effectiveness) only marginally lowers than that of another service that is available.”²⁵⁹

c. Multiple Stakeholders

Lauridsen²⁶⁰ presents a third argument. He acknowledges the inevitable need for rationing of healthcare has apparently presented the medical profession with the dilemma of choosing the lesser of two evils. He states that physicians appear to be obliged to adopt either an implausible version of traditional professional ethics or an equally problematic ethics of bedside rationing. The former requires unrestricted advocacy for patients but prompts distrust, moral hazard and unfairness. The latter commits physicians to rationing at the bedside; but it is bound to introduce unfair inequalities among patients and lack of political accountability towards citizens. However, Lauridsen argues that this dilemma is false, since a third intermediate alternative exists. This alternative makes it possible for physicians to be involved in rationing while at the same time being genuine advocates of

²⁵⁹ Henry J. Aaron, “Health Care Rationing: Inevitable but Impossible?” (2008) Georgetown Law Journal, Georgetown Law Journal, 96 Geo. L.J. 539 [hereinafter “Aaron”].

²⁶⁰ S. Lauridsen, “Administrative gatekeeping - a third way between unrestricted patient advocacy and bedside rationing” (2009) Bioethics Jun;23(5):311-20 PubMed PMID: 18410460.

their patients. According to this ideal, physicians are required to follow fair rules of rationing adopted at higher organizational levels within healthcare systems. At the same time, however, they are prohibited from including considerations of cost in their clinical decisions.

According to Hunter,²⁶¹ whether a physician should operate for the good of society, the good of their patient or somewhere in between - this is a “wicked issue”. Clinicians themselves are ambivalent on these matters. Many would prefer governments and politicians to make these decisions openly in publicly funded healthcare systems, since they determine how much of the overall budget is to be spent on healthcare. Others believe it to be the responsibility of clinicians to decide how health care resources should best be used in individual cases.

It is also argued that the physician’s role itself is unclear and as such makes the allocation of resources by physicians extremely unclear. According to Eike-Henner W. Kluge, until the role of the physician in resource allocation is more thoroughly assessed, there will be ongoing challenges in the formal decision making process.²⁶² Physicians act as gatekeepers – and conflict results. A physician has a fiduciary duty to their patient, a gatekeeper’s duty to government funded health care resources while being self employed business operators.^{263 264}

²⁶¹ D.J. Hunter “Rationing healthcare: the appeal of muddling through elegantly” (2001) *Health Pap.* 2(2):31-7; discussion 69-75. PubMed PMID: 12811143.

²⁶² Eike-Henner W. Kluge, “Resource Allocation in Healthcare: Implications of Models of Medicine as a Profession” (2007) *Medscape General Medicine* 9(1):57 [hereinafter “Kluge”].

²⁶³ *Ibid.*

Kluge argues that simply picking one model – either the Hippocratic, Social Service or Business Model - will not solve the problem. Rather, a reconceptualizing of the three mutually incompatible models for a “service-provider monopoly” is required.

d. Corporations

The debate over the role of physicians in health care resource allocation may represent the larger battleground of the clinical versus corporate control of health care. The battle

²⁶⁴ Kluge describes three existing yet mutually incompatible physician models which can influence how resources will be allocated. The models include: the Hippocratic Model, the Social Service Model or the Business Model. These roles and their underlying theories of resource allocation are inherently in conflict.

Under the Hippocratic Model, based on the Hippocratic Oath which sets out the nature and purpose of medicine, there is a fiduciary relationship between the physicians and patient. The physician must act in the best interest of the patient. The concept of balancing societal rights and economic rights is not part of this fiduciary relationship between the physician and patient.

Under the Social Service Model, the physician has a duty to do the best for the health status of members of society and “... construes medicine as one among several social enterprises of which the overall purpose is to advance the well-being of members of society.” Interestingly, Kluge makes the distinction between the obligation of medical profession and the individual physician:

“Equally as important, however, it means that the social service model must acknowledge that the individual physician is not identical to the medical profession, and therefore that although ethically defensible resource allocation policies may (and should) incorporate overall social considerations, they also have to acknowledge that individual physicians have a fiduciary obligation toward their individual patients.”

Under the Business Model, the physician - as a licensed service provider - retains a gatekeeping function as in the social service model. In the Business Model, the marketplace becomes the primary determinant of resource allocation rather than the health needs of the individual or society overall. The patient’s right to healthcare resources becomes defined in terms of the patient’s financial capacity. Economic measures of cost-benefit and cost-effectiveness are irrelevant in determining resource allocation unless they relate to the physician’s market competitiveness and the consumers ability to pay.

“... the patient becomes a service consumer or customer and the physician-patient relationship is defined in purely contractual terms. Fiduciary considerations become relevant only within the limits set by the contract and therefore are subject to terms that find their basis in contract law, not in the traditional ethics of the profession.”

may come to a head over the definition of the word “medical necessity”. Sage²⁶⁵ argues that current allocation theories oversimplify the economic and clinical effects and focus primarily on the determination of “medical necessity.” According to Sage, medical necessity is a term of art in health insurance contracts used to distinguish, at the margin, covered from non-covered services.²⁶⁶

“To many physicians, the phrase “not medically necessary” means “not clinically indicated”, which makes them question why a seemingly nonprofessional party such as a health plan has the right to challenge their professional opinion. To many health plans, it means “not covered even though not expressly excluded from coverage,” which gives them a degree of comfort issuing denials based on established insurance practice even though such decisions outrage physicians. Consequently, decisions involving medical necessity are frequently characterized by inconsistent administration, poor communication, distrust and, if disputes arise, relatively unprincipled, results-oriented judicial resolution.²⁶⁷

Sage argues that disputes about health care resource allocation portray the struggle between corporate interests and clinical judgment over health care decisions – and by extension, the legitimacy of allowing cost considerations to override clinical judgment. The concept of medical necessity (MN) is at the heart of insurance contracts. Sage argues that MN has a multitude of meanings and operates at a symbolic and substantive level,

²⁶⁵ Sage, Supra Note 245.

²⁶⁶ Ibid at 598-599.

²⁶⁷ Ibid at 601.

sometimes referring to entitled medical benefits and sometimes referring to ideology of political positioning.

According to Sage, a serious problem is that, because of its symbolic importance, health professionals and policymakers often regard “medical necessity” as a coverage standard unto itself, rather than entwined with a historically determined, legally stylized insurance document that itself operates within an increasingly complicated set of relationships among purchasers, health plans, and providers.²⁶⁸ Sage argues that not only is there a lack of empirical research in this area, the court’s involvement is questionable given their focus on the individual as opposed to the society at large:

“Absent empirical research, one must employ less precise tools to explain medical necessity. Reading judicial opinions in medical necessity disputes conveys several distinct impressions. First, there is relatively little law in these cases. This is true even though, unlike medical malpractice cases, their rationales are fully stated in published text instead of being hidden in a jury’s unexplained verdict regarding liability. Second, the facts of principal interest to courts concern clinical benefit to the specific patient bringing suit, not “population health,” “cost-effectiveness,” or the prudent use of pooled social resources—in other words, identified rather than statistical lives. Third, the time pressures created by disputes over preauthorization and the potential conflicts of interest that beset both

²⁶⁸ Ibid at 605.

insurers and providers in managed care seem to make courts apprehensive that the facts before them are incomplete or untrustworthy. Fourth, hallmarks of procedural fairness at early stages of the dispute—such as clear explanations regarding denials, timely access to internal appeal mechanisms with competent systems of gathering evidence, and unbiased external review—tend to reassure courts that coverage cases can be viewed as contractual matters and make courts less likely to reverse the health plan’s determination.”²⁶⁹

Sage ultimately concludes, despite the lack of empirical research, that the oversight for the allocation of resources should be based on a therapeutic (clinical judgment) rather than contract relationship (corporate interests).

4. Part C: Other Theories – Factors Contributing to Resource Allocation Decisions

a. Economic Theory

Economic theory is the study of decision making regarding the allocation of resources – particularly under conditions of scarcity.²⁷⁰ Costs are integral to priority setting and economic theory – but are highly controversial.²⁷¹ According to Ruger, economic analysis is part of utilitarian theory – which requires the allocation of resources in order

²⁶⁹ Ibid at 613.

²⁷⁰ M. Trebilcock, “The Lessons and Limits of Law and Economics” (1997) 23 Monash Law Review 124 [updated 2005] [hereinafter “Trebilcock”] at 37-42.

²⁷¹ Peacock., Supra Note 249.

to maximize the social utility.²⁷² ²⁷³ The economic analysis, as part of the decision process, typically looks at the cost of treatment relative to the society at large rather than the cost of treatment to the individual. As such, resource allocation favoring the good of society may be in conflict with resource allocation favoring the good of the individual.

It is important to note that not all academics agree that fiscal/cost issues should be incorporated into health care resource allocation decision making. Of the academics that advocate for the use of economic theory to be incorporated into decision making, there is not consensus on the extent of its use. For example, Robinson²⁷⁴ argues that the economists' approaches to priority setting (opportunity cost, marginal analysis and choice under scarcity) are based on the premise that it is possible to design a rational priority setting system that will produce legitimate changes in resource allocation. However, he argues that the economic models need to balance pragmatic and ethical considerations with economic rationality when making resource allocation decisions. Clinical autonomy must be balanced with financial responsibility:

²⁷² Ruger focuses on economic ‘measures’. According to Ruger, cost-utility analysis (CUA) is the primary method of evaluating health policy under a utilitarian ethic. CUA values health in terms of health preferences, desires or utilities. The quality adjusted life years (QALY) measures preferences and quality of life – the QALY, unlike other utility measures, operates on the premise that different individuals can health conditions can be compared on a single quantitative scale. Other economic measures include: cost-effectiveness analysis (CEA), cost-benefit analysis (CBA). The concern about economic analysis is that it will only account for aggregate welfare of society without considering benefits and burdens to society as well as the difficulty comparing interpersonal utility and comparing utility on a single quantitative scale. Ruger states that the Oregon Medical experiment is an illustration of the application of utilitarianism and cost-utility analysis – In that example, an algorithm counter intuitively ranked procedures i.e. tooth capping ahead of surgery for ectopic pregnancy and ranked nondisabled people ahead of disabled people because their health benefits were considered less.

²⁷³ Ruger, Supra Note 246.

²⁷⁴ R. Robinson, “Limits to rationality: economics, economists and priority setting” (1999) Health Policy. 49(1-2):13-26. Review. PubMed PMID: 10827288 [hereinafter “Robinson”].

“The results of priority setting will be implemented only if a decision making culture that considers costs, outcomes, and trade-offs between alternative uses of scarce resources has been established. Managers and doctors must accept the key concepts that underpin programme budgeting and marginal analysis and other economic approaches to priority setting. Successful application of priority setting methods requires a degree of integration between funding and priority setting mechanisms. If priority setting mechanisms conflict with funding mechanisms at local or regional levels, or with budget setting mechanisms within provider organizations, priority setting is unlikely to lead to changes in the allocation of resources.”²⁷⁵

While some academics argue that the use of economic analysis is key to the decision making process, the extent of its use and the value placed on financial considerations varies. For example, Callahan originally stated that for the greater good of society, government resources – such as Medicare in the USA – should focus on age-based rationing. The government should not pay for life-extending health care for persons who have lived out their ‘natural lifespan’. Rather, payment by the government for life-extending health care would be limited to those of an age not considered to be beyond a natural lifespan.²⁷⁶ This concept of rationing health care for the elderly was highly controversial.

²⁷⁵ Ibid.

²⁷⁶ Daniel Callahan, Setting Limits: Medical Goals in an Aging Society, with “A Response to My Critics” 135-135 (1995) [hereinafter “Callahan 1995”]

Callahan subsequently modified his position approximately two decades later in 2008.²⁷⁷

Callahan stated that under the best of circumstances, age should be irrelevant in the provision of health care. However, society's dilemma is how to ration health care in an era of growing Medicare cost, public pressure and expectations for more health care.

Callahan argues that a society must reflect on whether there is an obligation to keep the elderly alive as long as possible, regardless of the cost of doing so? Callahan argues that there is a duty to help young people to become old people, but not to help the old become still older indefinitely. Callahan argues that a more reasonable goal is maintaining a high quality of life within a finite lifespan.²⁷⁸

One may well ask what counts as “old” and what is a decently long lifespan? We can generally agree that the present Medicare and Social Security eligibility criteria of 65 years is quickly becoming outdated. My own answer is that someone is old when it can be said that he or she has had a “full life,” by which I mean enough time to do most (though not necessarily all) of the things that a life makes possible: education, family, work, and so on. As I have listened to people speak of a “full life,” often heard at funerals, I would say that by 75-80 most people have

²⁷⁷ Daniel Callahan, and Kenneth Prager, “Medical Care for the Elderly: Should Limits Be Set?” American Medical Association Journal of Ethics <http://virtualmentor.ama-assn.org/2008/06/oped1-0806.html> [accessed Feb 20 2013] [hereinafter “Callahan”].

²⁷⁸ Ibid.

lived a full life, and most of us do not feel it a tragedy that someone in that age group has died (as we do with the death of a child).²⁷⁹ ²⁸⁰

Similarly to Callahan's position, Emanuel²⁸¹ argues for a 'complete lives' approach, which prioritizes younger people who have not yet lived a complete life and will likely not do so without aid. Emanuel states that as an individual gets older in age, the probability of receiving a medical intervention should significantly decrease.

Several academics debate the issue of cost and state that other non-cost information must be considered. For example, Aaron argues that in resource allocation of health care, a variety of analytical, political, legal, and ethical challenges emerge, including the need to develop information on the expected medical benefit of various treatments for particular conditions and to place values on those benefits and methods of enforcing limits that can be enacted and sustained politically.²⁸² However, Trebilcock is of the view that imperfect information in the process of economic analysis is pervasive²⁸³ - almost no exchange is entered into with absolute perfect information by both parties.²⁸⁴ So, if the economic analysis information is imperfect, who makes decisions based on this imperfect information? Politicians, judges, medical experts? Trebilcock states that the incentive of elected officials is their political accountability

²⁷⁹ Callahan , Supra Note 276.

²⁸⁰ It is interesting to note that at the time of this 2008 article, Callahan was 77 years old - "There are some, like me at age 77, who continue to work, but the numbers drop off rapidly by 80 ..."

²⁸¹ G.P. Emanuel et al, "Principles for Allocation of Scarce Medical Interventions" (2009), 373 Lancet 423, at 428.

²⁸² Aaron, Supra Note 259.

²⁸³ Trebilcock, Supra note 270.

²⁸⁴ Ibid.

to constituencies and election, judges may be just as likely as politicians to adopt ‘efficiency-determined conceptions of the social welfare’ as notions of distributive justice,²⁸⁵ and medical experts have no advantage making social and procedural valuations.²⁸⁶

“Hence, the common law courts are viewed as maximizing a broad social welfare function, while politicians and their delegates (for example, bureaucrats and regulators) are viewed as captives of factional politics involving competition and conflict among distributional coalitions. On this view, the common law will tend to be concerned with efficiency, the political process with often cynically motivated redistributive or rent-seeking objectives.”²⁸⁷

Mehlman argues that the cost based resource allocation is to be compared not only to other cost options but to the cost of denying treatment.²⁸⁸ Mehlman states that central to cost saving is the concept of ‘statistical’ lives saved versus ‘identifiable’ lives saved at any cost. Saving ‘identifiable’ lives produces an emotional reaction and can be very compelling.

²⁸⁵ Trebilcock finds the Efficiency of the Common Law Thesis – that common law exhibits a general tendency towards the evolution of economically efficient rules - uncompelling.

²⁸⁶ Rather Trebilcock asks: Who should be on the committee that decides the resource allocation? Who should appoint them? What kinds of information or submissions should be solicited? What criteria would be used to evaluate the information? How would the veracity of the information be tested? Would a reasoned set what criteria? Or should we adopt a completely non-rationalistic (‘black box’) rather than rationalistic decision making process?”

²⁸⁷ Trebilcock, Supra Note 270.

²⁸⁸ M.J. Mehlman, “Rationing Expensive Lifesaving Medical Treatments” (1985) Wisc. L. Rev. 239

Ruger argues that both clinical and economic analyses are required for evidence-based decision making. In terms of economics, Ruger does include cost analysis, comparative pricing within a category of medical procedures and the importance of clinical case-by-case judgments by physicians while ensuring that the physician has the medical capacity and is not financially influenced outside medical criteria.

According to Williams, concern has increasingly been expressed at the low level of impact that economic evaluations have on the priority setting decisions they are designed to inform.²⁸⁹ While clinical evidence on the benefit and the costs being the main criterion used, Vuorenkoski et al argue that the criteria used for priority setting varied between studies, and also between decisions. The decisions seemed inevitably to be partly value-based in their nature, as the scientific or other exact evidence did not give a firm foundation on which the decisions could be solely based.²⁹⁰

On a global scale, there are different institutional perspectives on the use of economics in health care resource allocation decisions. The World Bank has done extensive work reviewing the literature on economic approaches to allocating health care.²⁹¹ The World Bank report on the economics of health care priority setting concludes that because of limitations in evaluation methodology, equity principles and practical constraints, the use

²⁸⁹ I. Williams and S. Bryan, “Understanding the limited impact of economic evaluation in health care resource allocation: a conceptual framework” (2007) Health Policy 80(1):135-43. Epub 2006 Apr 18. PubMed PMID: 16621124.

²⁹⁰ L. Vuorenkoski, H. Toivainen and E. Hemminki, “Decision-making in priority setting for medicines--a review of empirical studies” (2008) Health Policy, Apr; 86(1):1-9 PubMed PMID: 17950484.

²⁹¹ K. Hauck, P. Smith, and M. Goddard, “The Economics of Priority Setting for Health Care: A Literature Review” World Bank, Health, Nutrition and Population (HNP) Discussion Paper, September 2004. <http://siteresources.worldbank.org/Healthnutritionandpopulation/Resources/281627-1095698140167/Chapter3Final.pdf> [hereinafter “World Bank Report”].

of cost-effectiveness analysis in health care priority setting needs to be fundamentally rethought.²⁹² On the other hand, the World Health Organization-CHOICE program has developed complex cost effectiveness tools for countries to analyse the cost effectiveness of health care interventions to assist in decisions around allocating scarce health care resources.²⁹³

b. ‘Levels’ of Resource Allocation Decision Making

The literature also discusses the theory that there may also be ‘levels’ of resource allocation decision making. In other words, how a resource allocation decision is made depends on the level where the decision is made. Four key authors discuss ‘levels’ of decision making regarding resource allocation.

According to Sunstein,²⁹⁴ there are three levels of resource allocation decision making – general, mid level and low levels regarding resource allocation decision making. The level may affect the theory utilized for analysis. It is also often difficult to distinguish between general, mid and lower level principles. Sunstein states that academics often try to analyze the general principle of resource allocation relative to legal doctrines such as contract law and constitutional rights such as freedom of speech and equality.

²⁹² Ibid.

²⁹³ http://www.who.int/choice/toolkit/pop_mod/en/index.html

²⁹⁴ Cass Sunstein, “Incompletely Theorized Agreements” (1995) 108 Harvard. L. Rev. 1733, at 1739-40 [hereinafter “Sustein”].

Sunstein²⁹⁵ goes on to discuss the concept of “Incompletely Theorized Agreements” (ITA) which further provides a model for understanding collective resource allocation decisions. The concept behind ITA is that people can take different paths to common, often partial agreement. Sunstein states that it is rare for anyone to theorize any subject completely. There appears to be three levels of ITA – agreement on general principles, agreement on mid level principles and agreement on lower level principles – the latter is often seen in individual cases. Most often, people agree on a general principle but not on a particular case. ITA may also involve collective agreement on mid level principles but disagreement on both general theory and specific cases. There may also be agreement on mid level and lower level principles but not higher level principles. This sort of agreement is incompletely theorized in the sense that it is incompletely specified. Incompletely specified agreements permit acceptance of general goals when people are unclear about what the goals mean. This incompletely specified agreement hides social disagreement while allowing for both stability and flexibility.

Emanuel identifies three levels of resource allocation regarding government decisions – macro, intermediate and micro allocations. Macro-allocations to determine gross national product expenditures on the resource; intermediate determinations about basic health care packages for all; and micro allocations regarding a particular patient and a particular service. Emanuel states that all intermediate determinations, as opposed to macro and micro decisions, should be transparent.²⁹⁶ In terms of micro allocations, he states that the problem with overutilization of health care resources has been in part driven by a medical

²⁹⁵ Ibid.

²⁹⁶ Ezekiel J. Emanuel and Victor F. Fuchs, “The Perfect Storm of Utilization” (2008) 299 J. AM. MED. ASSOC. 2789, at 2789-90.

culture and training that encourages physicians to ignore costs in recommending treatments – particularly high volumes of office visits, hospitalizations, tests, procedures, prescriptions.

Instead of three ‘levels’ Orentlicher argues that allocation of resources is done either through a centralized or decentralized model. In a centralized model, a commission is established to develop guidelines for widespread use. The advantages of this model are the increased legitimization of a transparent process involving broad participation, the preservation of the physician-patient relationship and duty of loyalty, and the promotion of consistency and fairness among patients.²⁹⁷ In a decentralized model, resource allocation decisions are made on a case-by-case basis. The decentralized model was considered advantageous because of the unfeasibility of centralized decision making for most medical decisions. Orentlicher argues that a successful resource allocation model would combine both the centralized and decentralized models. Orentlicher concludes that centralized rationing alone is not feasible and physicians should make rationing decisions in a treatment context while government should make cost-effective decisions, thus limiting the resources available to physicians and eliminating any personal incentive physicians may have for high cost care.²⁹⁸

Like Sunstein, Ruger states that parties can agree at one level but not at another such that partial agreement and workable solutions are possible without requiring complete

²⁹⁷ Orentlicher cites examples of a centralized model which include the Oregon model for expanding the number of residents on Medicaid by reducing the scope of health service coverage. Other centralized models include the UK NICE model and the United Network for Organ Sharing (UNOS) which is a non-profit organization that distributes organs for transplant.

²⁹⁸ Orentlicher, Supra Note 226.

agreement. Ruger also argues, again like Sunstein, that there are three levels of resource allocation decision making. The three levels include: the Conceptual Level concerning values for human flourishing; the Policy Level concerning policies and laws such as the division of the total sectors budget belongs within the context of the political unit and should be evidence based.; and the Intervention Level which concerns specific patient cases²⁹⁹ in which physicians should have the authority to make evidence based resource allocation decisions.³⁰⁰ However, Ruger³⁰¹ argues that there is persistent disagreement and little guidance about the principles governing resource allocation. There also is a lack of guidance regarding the definition of what health care benefits³⁰² or the evaluation of outcomes.³⁰³

As a result, Ruger offers an alternative theoretical framework for health, ethics, policy and law that integrates both substantive criteria and procedural mechanisms. She states we are at a crossroads of

“...two dichotomous paradigmatic positions: consequentialism and proceduralism - which adherents often present as mutually exclusive. Consequentialists argue that we should assess health policy and laws by their consequences; proceduralists believe that fair processes will yield fair decisions. Thus far, neither end of the philosophical spectrum has promised or delivered a plausible solution, and

²⁹⁹ Ruger, Supra Note 246.

³⁰⁰ Ruger does not link the three levels of ITA (conceptual, policy, interventional) with the levels of budgeting (macro budget decisions and health policy budget decisions)

³⁰¹ Ruger, Supra Note 246

³⁰² Ibid at 103.

³⁰³ Ibid at 127.

attempts to incorporate both positions have been unsatisfactory. As a result, the field is at a standstill. Any movement forward involved elements of both the consequentialist and proceduralist frameworks. ...³⁰⁴³⁰⁵

Ruger states that “[i]f we are to develop a new paradigm of health ethics, policy and law, we must construct a framework that permits us to prioritize health goods and services amidst widespread disagreement.”³⁰⁶ Ruger outlines a new model to address these problems. The model includes the following key principles:

1. Humans flourish and health is required to flourish – a person’s ‘health capacity’ constitutes a person’s ability to be healthy and thus flourish
2. Value is placed on ‘basic’ or ‘central’ health capabilities such as the avoidance of premature death
3. A joint scientific and deliberative approach is needed to judge health care interventions – based on evidence based medicine, expert opinion of physicians and health experts, and input from individuals – physicians and

³⁰⁴ Ibid at 136.

³⁰⁵ According to Ruger, the current models fail to ensure just rationing for several reasons including:

1. Focus on health care not health
2. Focus on procedural fairness instead of substantive principles– democratic procedures for distributing health care are unclear with no moral theory for allocation
3. Economic models need further development
4. Role of preferences, both individual and societal, unclear in models
5. Need more focus on ‘accountability for reasonableness’ depending on different groups and values
6. The current models are ‘indeterminate’ – outcomes, needs, individuality, lack thresholds, all benefits are not equal, determining ‘whose’ preference i.e. citizens, medical experts, patients, payers, regulators, etc

³⁰⁶ Ruger, Supra Note 246 at 141.

- experts should have authority for substantive decisions about allocation decisions
4. Decisions are based on a shared concept of capacity for health functioning – when disagreements occur, ‘practical models of agreement or consensus facilitate workable solutions.’”
 5. Moral obligation to provide high quality care not just “equal access” to ‘decent minimums’ or ‘adequate care’
 6. Evaluation of health care must consider costs ‘because we live in a world of scarce resources’ – cost-effectiveness analysis (CEA) needs to be used to compare interventions within a single population - economic considerations need to follow and complement clinical considerations, not vice versa.

Ruger argues that both clinical and economic analyses are required for evidence-based decision making. In terms of economics, Ruger’s model does include cost analysis, comparative pricing within a category of medical procedures and the importance of clinical case-by-case judgments by physician while ensuring that the physician has the medical capacity and is not financial influenced outside of medical criteria.

5. Conclusion

The purpose of this literature review was not only to outline the various procedural and substantive decision making theories discussed in the literature but to also establish, based on the existing empirical research, if the theories and the practical application of resource allocation decision making were aligned. If the theory and practice are not aligned, it was anticipated that the literature review would establish where and why the

disconnect was taking place. The literature could then inform the quantitative research design of this thesis. Unfortunately, while there were numerous procedural and substantive theories in the literature, the empirical research regarding the application of these theories to actual tribunal decision making was minimal to non-existent.

The review of the literature did, however, raise several themes. First, health care resource allocation decisions are difficult but inevitable and decisions have to be made. Second, resource allocation decisions are often made on the basis of incomplete information by a variety of decision makers at various levels. Third, resource allocation decisions are made in a context of a number of transparent and non-transparent factors such as economic factors. Fourth, an accessible mechanism is needed to address resource allocation disputes. A fifth theme involves disagreement about how resource allocation decisions should be made – either based on agreed upon procedures and/or substantive legal guidelines / “test” requirements. Sixth, there is also disagreement regarding the objective for resource allocation decisions i.e. should the decision be based on what is best for society or what is best for the individual. Seventh, there is disagreement regarding the mechanism to make resource allocation decisions – the courts, administrative tribunals,³⁰⁷ technical review panels, physicians or corporations. Eighth, there appears to be confusion over the ‘right’ of individuals to a health care resource. Ninth – and most important for this thesis – there is a lack of quantitative empirical research regarding resource allocation decisions – particularly at the tribunal level and specifically by the Health Services Appeal and Review Board. Without existing quantitative empirical research,

³⁰⁷ The literature on the resource allocation decision making by tribunals, courts and the legislature is confusing. Academics appear to agree that the courts defer to the legislature. However, the legislature defers unpopular and/or difficult decisions to tribunals and courts oversee the tribunals. The courts judicially review decisions of tribunals. In essence, it appears to the author that the courts and the legislature are deferring to tribunals.

research questions and methodology needed to be developed in order to understand the reality of tribunal resource allocation decisions and what theories do and/should apply.

Chapter 6
Research Methodology

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1. Introduction
2. Case Selection
3. Sample Size of Case Selection
4. Timeframe for Case Selection
5. Research Matrix
6. Limitations of the Research

Chapter 6

Research Methodology

Introduction

Administrative tribunals speak through their decisions. HSARB is no exception. In its written reasons, HSARB outlines the case's context, the procedure that the Board followed, the substantive submissions of the parties and its decision whether or not a patient's request met legislated criteria.

In an effort to analyse factors which may affect the Board's health care resource allocation decision making, the author examined Board decisions regarding 28.4(2) Regulation 552 of the HIA for the fiscal 2003-2008 period relative to contextual, procedural and substantive resource allocation theories. By analyzing statistical associations within the Board decisions, certain trends evolved, some questions were answered and many others arose.

The challenge methodologically was to identify a significantly large caselaw data set (Appendix A), develop an objective research matrix (Appendix B), assess each individual case relative to the research matrix (Appendix C and Appendix D) and statistically analyze the results. As further discussed, certain trends emerged. However, as with many exploratory research protocols such as this, several unexpected trends were also identified. The following elements of the research methodology – case selection, sample size, timeframe, research matrix and limitations – are outlined in more detail below.

Case Selection

The case selection of Board decisions took place before the Board decisions were uploaded in August of 2010 to the CanLII website. Board Hearing decisions available from the Board's website that deal with Section 28.4(2) of Regulation 552 were analyzed for the fiscal five year period from 2003 to 2008. The search engine on the Board's website was used to identify all cases directly or indirectly dealing with s.28.4(2). "Directly dealing with s.28.4(2)" refers to all cases where the review of non-emergency inpatient health care service outside of Canada was the main issue. "Indirectly" refers to those cases where s.28.4(2) was not the main issue under review or where reference was made to s.28.4(2) but it was determined that s.28.4(2) was not applicable. For instance, in a case where an Ontario man requested health care in Quebec under s.28.4(2), the Board determined that s.28.4(2) was not relevant as Quebec is not outside of Canada.

Sample Size of Case Selection

It was initially difficult to determine the sample size of Section 28.4(2) cases to be reviewed. In the end approximately 400 HSARB decisions were analyzed. However, the HSARB decision database presents several research challenges:

First, the electronic database of HSARB decisions, which was accessible only through the HSARB website and not through standard electronic databases such as CanLII or Quicklaw,³⁰⁸ was still in basic form.³⁰⁹ The HSARB website database could not be

³⁰⁸ At the time, the Consent and Capacity Board Decisions were linked to legal research databases. Thus, the technology and administrative process existed to allow tribunal decisions to merge with existing legal research databases. It was anticipated at the time that this thesis would recommend further exploration of

searched by statute or regulation, section or successfully by key word. There is no headnote or annotation of the cases on the database.

Second, HSARB case decisions could only be searched by an exact citing of the initials in the style of cause. The HSARB initials may not correspond to the Court system style of cause. For example, in the recent case of Flora, the Court citation for the Flora case is Flora v. Ontario Health Insurance Plan, 2008 ONCA 538 (CanLII). The HSARB citation is A.F. v. The General Manager, the Ontario Health Insurance Plan, File # 6681 [decision released 11/21/2002]. The Flora case could not be located on the HSARB database if the word “Flora” or the initial “F” is searched. Of the HSARB database cases, four cases had the initials A.F. but only one of these four cases was the Flora case which was appealed to the Ontario Court of Appeal.

Third, appealed HSARB decisions were not listed as such on the HSARB case decision database. In this way, it is difficult to determine which cases were under review by HSARB, under appeal to the courts, had new decisions resulting from court appeals or stand as reported.

Fourth, searches through the HSARB case decision database were incomplete and produced only a fraction of the actual cases. For example, a search under the HIA for ‘out of country’ cases only produced 4 cases. A search under HIA for ‘Regulation 552 section

linking HSARB decisions to existing legal research databases. The addition of HSARB decisions to CanLII in August 2010 made this recommendation moot.

³⁰⁹ http://www.hsarb.on.ca/scripts/MOHSearchFile_Public.asp - this website is no longer active since the addition of HSARB decisions to CanLII in August 2010.

28.4' only produced 2 cases. Both searches did not identify the well known Flora case which deals with 'out of country' under 'Regulation 552 section 28.4'.

As a result, the HSARB case decision database was searched using the term "s.28.4(2)". Three hundred and eighty seven cases were identified for the fiscal period 2003-2008. All these 387 cases were read and analyzed. Of the 387 cases, only 314 were directly on point. The residual cases were either duplicates of a s.28.4(2) case, dealt with motions or orders for existing s.28.4(2) cases or were not applicable.

In summary, the limited search function, the incomplete retrieval of all relevant case decisions, the initialized HSARB citations, the difference between HSARB and Court citations, and the lack of noting up of HSARB decisions made it difficult to find HSARB section 28.4(2) cases and to follow cases appealed from HSARB to the Courts. As a result, a very broad net was cast to capture all s.28.4(2) cases. From this initial analysis of almost 400 cases, trends emerged and were further examined.

At the beginning of this thesis, one foreseeable recommendation was to revamp the HSARB case decision website to address the problems listed above and to integrate the HSARB case decisions to existing legal search engine e.g. CanLII³¹⁰ links to decisions of the Consent and Capacity Board along with other Tribunal decision databases. This in fact was done by the HSARB administrative office in August 2nd of 2010. This is a positive step. Also, given that the majority of Applicants before the Board are unrepresented, non-legally trained individuals, it will be recommended by this author that

³¹⁰ <<http://www.canlii.org/en/on/>>.

a non-legal research database which is user friendly for the general public be further explored.

Timeframe for Case Selection

The five year time period was selected for the case review of HSARB for several reasons. First, the legislation and decision making bodies – HSARB and the Court – were relatively stable in structure during this period. This relative stability allows for the thesis to focus on the theory, interpretation and application of the legislation rather than on changes to the legislation or structural changes to the decision making bodies. Second, the timeframe spans a period of one Ontario elected government (Ontario Liberals 2003 to the present). This also represents a time period of relative political stability. Third, it was assumed – perhaps incorrectly given the previous section’s review of the HSARB database – that the legal research technology would allow for accessing case decisions for the period of 2002 and later. It should be noted that several important Hearings took place before the Board before 2003 and subsequent Court decisions were issued after 2008. In specific cases, the timeframe will be expanded to include such cases. Fourth, in the spring of 2009 and again in the spring of 2011, the government amended s.28.4(2) of Regulation 552. The amended s.28.4(2), which is further discussed in the Epilogue section of this thesis, presented a natural endpoint to critically assess the section. Fifth, this author was appointed to HSARB in 2008 and began hearing cases from April 2008 to February 2009. It was important for the research and the potential for the perception of bias that none of the author’s decisions were part of the research period.

Research Matrix

A coding system, reflecting contextual, procedural and substantive issues, was developed in order to perform quantitative statistical analysis associations between research factors seen in the case data. The coding system was tested on 30 cases, refined and the initial 30 cases were subsequently recoded. The coding system was then used on all cases including the initial 30 cases. An independent researcher randomly reviewed the accuracy of ten of the three hundred and eighty seven coded cases. The random review confirmed that the research matrix and coding system provided a level of accuracy. The coded data was then inputted into a statistical package and analyzed. From this statistical analysis of frequencies and cross tabulations, associations, trends and further questions emerged.

The research matrix sought to analyse the contextual, procedural and substantive theory in resource allocation decision making relative to the actual decision making. Contextual, procedural and substantive theory indicators were utilized. For example, contextual indicators included medical diagnosis, patient demographics, and the geographic distribution of requests for out of country health care. Procedural theory indicators included timeframe for hearing, type of hearing, self-representation at hearing, language interpretation, type of appeal and appeal requests. Substantive theory indicators included the regulatory criteria of medically necessity and the delay accessing domestic care.

Limitations of this Thesis

This thesis will focus on the resource allocation decision making regarding health care out-of-country criteria found in s.28.4(2) of HIA Regulation 552. There are also several

administrative requirements under section 28 of Regulation 552. It was understood by the author at the outset of this study that these administrative requirements for out-of-country insured health care under section 28 of Regulation 552 are activated once a health care service had been determined under section 28.4(2) to be an insured health care service under OHIP. These administrative requirements include: approval for insured services prior to the treatment,³¹¹ the production of written documentation,³¹² the submission of accounts within given time limits³¹³ or the General Manager of OHIP discretion to pay accounts in extenuating circumstances despite non-compliance with prescribed requirements.³¹⁴ This thesis was to focus on section 28.4(2) rather than focusing on the administrative requirements, cited above, following the determination whether a health care service is an insured service under OHIP. However, the administrative requirements – particularly the s.28.4(5) requirement for OHIP's prior approval before obtaining an out of country health service – became increasingly dominant in the five year case review. As such, it became necessary to include the s.28.4(5) for OHIP's prior approval of an out of country request in the case analysis as time progressed in the study period.

It is important to note that the statistical relationships between procedural and substantive factors and the decisions of the Board are correlations not causation relationships. As

³¹¹ Regulation 552, Supra Note 3 at s.28.4.(5) – Conditions of Payment
Recent relevant Case law - C.C.W. v. Ontario Health Insurance Plan, 2009 CanLII 712 (ON S.C.D.C.) – is actually three cases – that of C.C.-W., J.F.-T. and the Estate of Linda Mailloux. All three cases were heard and decided upon at the same time. The cases deal with the s.28.4(5) requirement for prior written approval for payment of medical expenses when services cannot be obtained in Ontario. The court held that OHIP does not have the discretion to waive this legislative prior approval requirement.
<http://www.canlii.org/en/on/onscdc/doc/2009/2009canlii712/2009canlii712.html>

³¹² Regulation 552, Supra Note 3 at s.28.4(5)2 – Conditions of Payment requirement of Written Documentation

³¹³ Regulation 552, Supra Note 3 at s.28.4(5)3 – Time limits for submitting accounts

³¹⁴ HIA, Supra Note 4 at s.18(4) – General Manager payment discretion despite non-compliance with prescribed requirements

correlations, the factors must be more closely examined. It is highly recommended that further qualitative research be undertaken to further explore the correlations in order to determine the meaning behind the results. .

Chapter 7

Patient Profiles: Results

Introduction

Patient Age

Patient Sex

Patient Residence

Patient Diagnosis

Patient's Requested Treatment

Requested Location of Treatment

- Country
- USA State
- Northern USA State
- Northern USA State – Requested Health Facility
- Northern USA State – Requested Treatment

- Northern USA State – Requested State and Requested Treatment
- Northern USA State – Requested Health Facility and Requested Treatment

Conclusion

Chapter 7

Patient Profiles

RESULTS

Introduction

The Board operates in response to appeals brought by patients seeking OCCNEIHS. As such, it is the patient who activates the Board's jurisdiction and process. While extensive information is available about the Board and OHIP, little is known about patients appearing before the Board. For example, it is not known who is coming before the Board (their age, sex, place of residence), for what medical reason (diagnosis) and where they wish to go for medical assistance (the requested country, facility) or what procedure they are requesting. This is a gap in our understanding of the Board and tribunals in general.

To address the gap, each Board decision during the study period was analyzed in terms of the contextual factors of patients' age, sex, place of domestic residence (Appendix F), patients' diagnosis (Appendix G), treatment requested, requested out of country treatment, and requested location of treatment (Appendix H and Appendix I). The purpose of collecting and analyzing this information was to – in an investigational manner – produce a 'patient profile' and to determine if any trends might emerge which might affect Board decisions.

Patient Age

Only about 40% of the cases documented the age of the patient – as such, the results should be interpreted with caution. Approximately 60% of the cases did not provide the age of the patient. The majority of the patients (21.9%) appear to be in the age range of 25-64 – 11.7% of the cases were in the 45-64 year old range and 10.2% of the cases were in the 25-44 year old range. Approximately 7.3% were minors in the 0-17 year old range, 2.5% were in the 18-24 year old range, 7.3% were in the 65-79 year old range and 2.2% were in the 80+ year old range. As will be discussed later, 100% of patients stated some form of diagnosis yet 60% of cases did not provide the age of the patient. Thus, it is difficult to link patient diagnosis to the patient's age.

Patient Sex

The patient sex or deduced sex³¹⁵ found in the Decisions indicated that the patients appearing before the Board are approximately split evenly between males (47.9%) and females (52.1%). There does not appear to be a significant difference between the number of males and females accessing the Board.

Patient Residence

The residence of the patient or their deduced residence was mapped to their associated LHIN designation which was further mapped to four areas of the province: North, South, East, and West Ontario. The Patients' Residence data indicated a high percentage (51.7%) of the cases were ‘Unknown’ as they did not stipulate the geographic residence of the patient. Of those that did, patients from the Southern part of Ontario (15.2%) and

³¹⁵ ‘Deduced sex’ refers to those cases where the sex of the patient was not stated but may have used the pronoun. For example, the pronoun “her”, “she” or “the patient’s husband” deduced sex of the patient as female.

the Western part of Ontario (14.6%) most often appealed to the Board. This number was closely followed by the Northern part of Ontario (11.1%).

Patient's Diagnosis

The highest percentage of patients appealing to the Board have a collection of 'Other' conditions (21.6%). 'Cancer' (15.6%) was the second highest diagnosis followed by 'Back Pain' (11.4%), 'Head' (11.1%), 'Joints' (10.8%), 'Addictions/Mental Health/Anorexia' (9.2%), 'Obesity' (7%), 'General Pain' (7%), 'Heart Disease/Circulation' issues (5.4%) and 'Unknown' diagnosis at (1%).

Patient's Requested Treatment³¹⁶

The patients requested surgery 49.2% of the time – almost half of all cases. This was followed by medical assessments (14%), treatment (13.3%) and diagnostic procedures such as an MRI, CTscan etc. (12.4%). The combination of categories dealing with counseling, drug treatment, follow up to an existing out of country health care service and unknown requests for treatment amounted to 9.2% of cases. Only 1.9% dealt with transplants.

Table 1: Patients' Requested Procedure

	Frequency	Percent	Valid Percent	Cumulative Percent
Surgery	155	49.2	49.2	49.2

³¹⁶ The patient's requested treatment as outlined in the Decision was coded. Based on the large variations in frequency for each code, the treatment requested was recoded based on the following six codes: surgery, treatment (chemo, radiation, angioplasty, angiogram, scleroderma, the drug Herceptin), transplant, diagnostics (MRI, XRay, CT scan, PET), assessment (medical opinion), and counseling, drug treatment only, follow up, and 'unknown'.

Treatment	42	13.3	13.3	62.5
Transplant	6	1.9	1.9	64.4
Diagnostics	39	12.4	12.4	76.8
Assessment	44	14.0	14.0	90.8
Counseling/Drug TMT only/Follow up/Unknown	29	9.2	9.2	100.0
Total	315	100.0	100.0	

Requested Location for Treatment

a) Country:

The patient's requested location for treatment was coded by country, state/province and facility location. Based on the large variations in frequency for each country code, the requested location treatment by country was re-coded globally into 7 categories – the USA, Europe (including the UK), India, China, Israel, ‘Other’, and ‘Unknown’.³¹⁷

³¹⁷ All global locations were known/stated in the Decisions. There were no cases of a category of ‘Unknown’ location for treatment. As a result, the ‘Unknown’ location for treatment category was not used.

Table 2: Global Location of Patients' Requested Treatment

	Frequency	Percent	Valid Percent	Cumulative Percent
USA	263	83.5	83.5	83.5
Europe + UK	27	8.6	8.6	92.1
India	9	2.9	2.9	94.9
China	4	1.3	1.3	96.2
Israel	2	.6	.6	96.8
Other	10	3.2	3.2	100.0
Total (*)	315	100.0	100.0	

The clear majority of requests are for health care services in the USA (83.5%). The next closest requested treatment location is Europe and the UK (8.6%) followed by India (2.9%), 'Other' (3.2%), China (1.3%) and Israel (0.6%).

b) USA State:

Within the USA, there was a large variation of frequency for each American State. As a result, the USA States listed in the Decisions were further coded as North, East, South and West.³¹⁸ Approximately 44.1% - the majority of Ontario patients before the Board - sought treatment in the Northern USA.³¹⁹ From the data, Ontario patients are seeking

³¹⁸ The North included Ohio, Wisconsin, Michigan, Minnesota, Pennsylvania, Montana, Idaho and Illinois. The East included New York, Maryland, Massachusetts and Connecticut. The South included Florida, New Mexico, Utah, Arizona, Alabama, Louisiana, Texas, Kansas, Kentucky, North Carolina and Virginia. The West included California and Oregon.

³¹⁹ Northern States:

treatment in the Northern States of the USA (44.1%) is almost double the rate of those seeking treatment in Southern States (20.3%). Patients also appear to infrequently access the Eastern States for treatment (16.5%) and rarely appear to be accessing Western USA States (1.9%).

Northern States – Requested Health Facilities:

If one looks at the facilities in the Northern States requested by the Ontario patients appearing before the Board, 34.6% of patient requests are for the Mayo Clinic (Minnesota), 10.2% are for the Cleveland Clinic (Ohio), 11.0% are for Detroit area facilities (Michigan), 3.9% are for Royal Oaks (also Michigan), 34.6% are for “Other Facilities” and 5.5% are ‘Not Stated’ in the case Decision. Note that Detroit facilities (11.0%) and Royal Oaks (3.9%) combine to total 14.9% of cases for the State of Michigan – or the second most requested State after Minnesota.

Of the Northern States, Minnesota was the State most often requested (40.9%) followed by Michigan (38.6%) and Ohio (14.2%). The States of Illinois, Pennsylvania, Montana, Wisconsin and ‘Not Stated’ totaled 6.4%. Thus, from this data, approximately 80% of Northern States accessed for out of country health care services were in Minnesota and Michigan.

Table 3: Patients' Requested Facility

	Frequency	Percent	Valid Percent	Cumulative Percent
1 Mayo Clinic	44	34.6	34.6	34.6
2 Cleveland Clinic	13	10.2	10.2	44.9
3 Detroit	14	11.0	11.0	55.9
4 Royal Oaks	5	3.9	3.9	59.8
8 Other	44	34.6	34.6	94.5
9 Not stated	7	5.5	5.5	100.0
Total	127	100.0	100.0	

Northern States – Requested Treatment:

Of patients requesting out of country health care services in Northern States, almost 50%

- the clear majority of cases - are requesting Surgery (49.6%), followed by almost a quarter (24.4%) requesting Assessments. Treatment was requested 13.4% of the time followed by Diagnostics at 11.0%. Only small percentage – 1.6% - requested an out of country health care service that was not surgery, treatment, diagnostics or assessment.

Thus, from this data, one can see that three quarters of the out of country requests were for surgery and assessment.

Table 4: Patients' Requested Procedure

	Frequency	Percent	Valid Percent	Cumulative Percent
1 Surgery	63	49.6	49.6	49.6
2 Treatment	17	13.4	13.4	63.0
4 Diagnostics	14	11.0	11.0	74.0
5 Assessment	31	24.4	24.4	98.4
6 Other	2	1.6	1.6	100.0
Total	127	100.0	100.0	

Northern States – Requested State and Requested Treatment:

In order to understand what Northern States Ontario patients requested to perform a given health care service, the Northern States were cross tabulated with the health care services (surgery, treatment, diagnostics, assessment and other).

Minnesota had 28.8% of its cases requesting Surgery and 44.2% of its cases requesting Assessment. Michigan had 65.3% of its cases requesting Surgery and 12.2% of their cases requesting Assessment. Ohio has 66.7% of its cases requesting Surgery and 5.6% of its cases requesting Assessment.

Northern States – Requested Health Facility and Requested Treatment:

Ontario patients are not going to a particular State but to a health care facility within the State. This raises the question what facilities and procedures within a given State are being requested by Ontario patients?

A cross tabulation of the patients' requested health care facility by the type of health care service produced the following results: of the requests for the Mayo Clinic (Minnesota) half of the requests were for Assessments (50%) and Surgery 30% (29.5%). The Cleveland Clinic (Ohio) requests were primarily for Surgery (84.6%) with no requests for Assessment. The Detroit and Royal Oaks requests (both Michigan) has 71.5% and 2.5% requests for Surgery respectively and 7.1% and 1.2% requests for Assessment respectively.

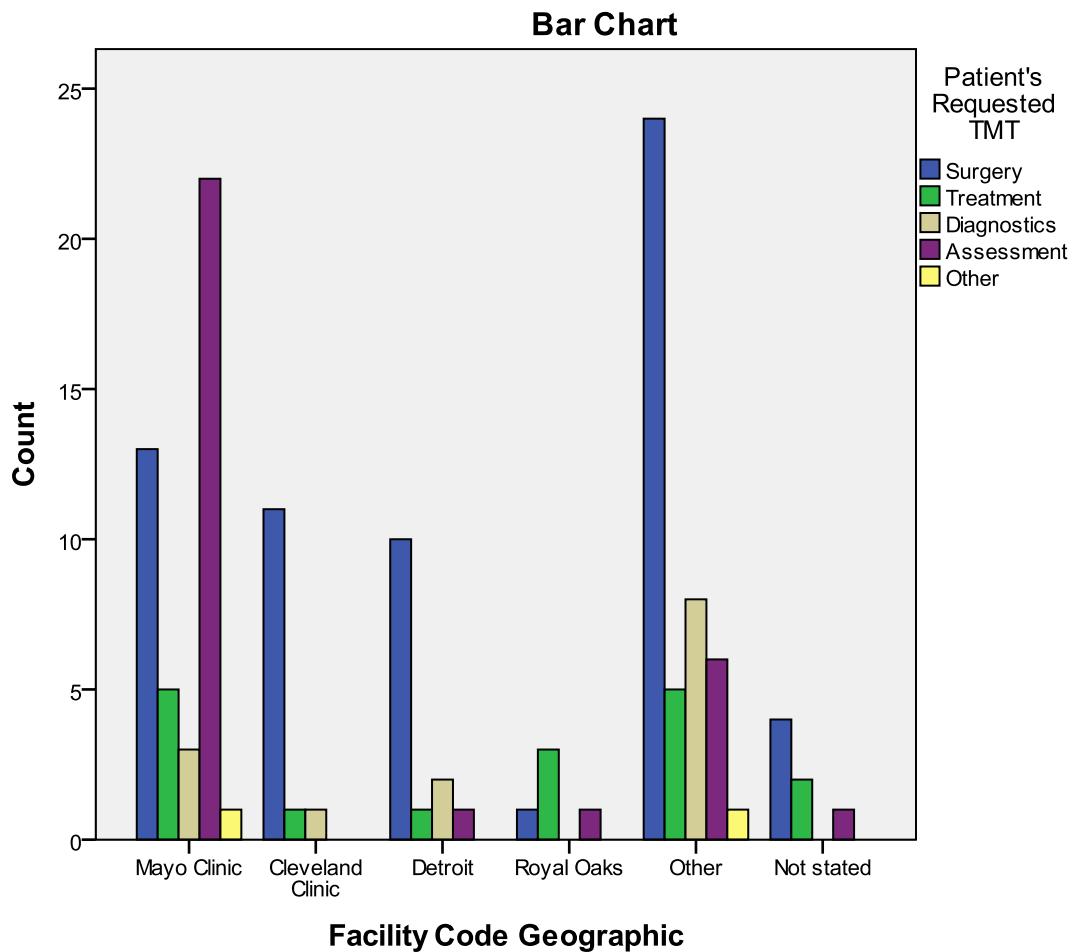


Table 5: Patients' Requested Health Care Facility

Clearly, from this Northern State data, patients are requesting different States for different health care services – Mayo Clinic (Michigan) for assessments, the Cleveland Clinic (Ohio) for surgery, followed by the Detroit and Royal Oaks also for surgery. Of note is the highest request for surgery ('Other' category) where the facility was not stated in the Board's decision.

Conclusion

From the results, we can see that the age of the patient was only given 40% of the time. Of this 40%, approximately 7% were minors (0-17 years old), 2.5% were 18-24 years old, 10% were 25-44 years, 12% 45-64, 7% were 65-79 year age range and 2% were over 80 years of age. Approximately 48% of females and 52% of males came before the Board. While over 50% did not report their geographic location in Ontario, those that did report were from the North (11%), the East, the West (15%) and the South (15%).

Patients indicated variable diagnosis including: ‘Other’ conditions (21.6%). ‘Cancer’ (15.6%) Back Pain (11.4%), Head (11.1%), Joints (10.8%), Addictions/Mental Health/Anorexia (9.2%), Obesity (7%), General Pain (7%), Heart Disease/Circulation issues (5.4%) and ‘Unknown’ diagnosis at (1%).

The treatment requested was surgery (49%), medical assessments (14%), treatment (13%) and diagnostic procedures (12%). The combination of categories dealing with counseling, drug treatment, follow-up to an existing out of country health care service and unknown requests for treatment amounted to 9.2% of cases. Only 1.9% dealt with transplants.

The majority of requests were for the USA (84%) followed by Europe and the UK (9%), India (3%), ‘Other’ (3%), China (1%) and Israel (0.6%). Of the USA treatment requests, the majority of requests (44%) were for the northern USA compared to 2% of requests for the western USA. Approximately 80% of northern State requests were for Minnesota and Michigan. Patients before the Board requested different States for different

procedures. For example, Minnesota was requested for assessments (44%) and surgery (29%) while Michigan was requested for assessments (12%) and surgery (65%) and Ohio was requested for assessment (6%) and surgery (67%). Patients before the Board also requested particular facilities to undertake particular treatment. For example, the Mayo Clinic in Minnesota was requested for assessment (50%) and surgery (30%) compared with the Cleveland Clinic in Ohio was requested primarily for surgery (85%) and not for assessments (0%).

Based on this data, it is clear that the patients' context (age, sex, place of residence, diagnosis) as well as their request for out of country coverage (requested treatment, geographic treatment location and specific treatment facility) were factors before the Board and outlined in the Board's decision. Of particular interest is the number of 'pain' cases and the fact that patients were requesting particular facilities for specific treatment.

Chapter 8

Procedures: Results

Introduction

Duration Appeal is at the Board

Hearing Date to Decision Date

Type of Hearing – Oral, Written, Teleconference, Split

Type of Hearing relative to Disposition

Parties: Represented by Lawyer or Self-Represented

Interpreter

Definitions: Prior Approval, Reimbursement, Both

Results: Prior Approval, Reimbursement, Both

Review Requests

Conclusion

Chapter 8

Research Question #1:

Do procedures statistically affect resource allocation decisions of the Board?

If so, what elements of the procedures create this statistical effect?

Procedures:

RESULTS

Introduction:

Tribunals, such as the Board, attempt to ensure procedural fairness and natural justice for the parties. Ideally, a tribunal's procedures facilitate rather than hinder the parties' arguments on substantive issues. The purpose of analyzing the Board's procedural data was to explore whether there is a correlation between the procedural aspects of the Board's procedures and the Board's decision to grant or deny the patient's request for out of country coverage. As such, this thesis seeks to answer the following question:

Research Question #1:

Do procedures statistically affect resource allocation decisions?

If so, what elements of the procedures create this statistical effect?

These procedural factors included: the time a case proceeds through the Board's system – from the date of the appeal request to the hearing date through to the decision date

(Appendix J); whether the hearing is oral, written or by teleconference call, or some combination of oral/teleconference/written (Appendix K); whether a review was requested of the Board's decision; the presence of an interpreter at the hearing; whether parties were represented by a lawyer or were self-represented at the hearing; and whether the hearing request was based on OHIP's denial of a prior approval application, a reimbursement application or a combined prior approval-reimbursement application.

Duration the Appeal is at the Board:

Why are File Date, Hearing Date and Decision Date important in terms of number of days a case is within the Board's system? These procedural elements – time within the system - may influence the ability of the parties to present substantive arguments i.e. the procedures' appropriateness relative to the patient's changing health status, whether equivalent procedures exist in Ontario, and if there is a delay accessing a hearing or a delay receiving a Board decision.

The analysis of dates sought to assess the total time a case took to be processed within the Board. The timeframe in which cases came to the Board office (the File Number), the time from the case arriving at the Board office to the time a Hearing was scheduled (the Hearing Date) and the time from Hearing to the release of the Decision (the Decision Date) were analyzed in terms of total time and total time by year.

The data only permitted date assessments between the Hearing Date and the Decision Date because of comparable day, month and codes. The File Number only provided the year code and thus are not comparable.

Based on data analysis of the time from Hearing Date to Decision Date, a wide variation was seen. Over the study's five year period, cases took between 3 days to 1,220 days from the date of the Hearing to the date the Decision was released. The average over the five years from Hearing Date to Decision Date was 160 days – or about 22.8 weeks (160/7days) – or about 5.7 months (22.8/4weeks).

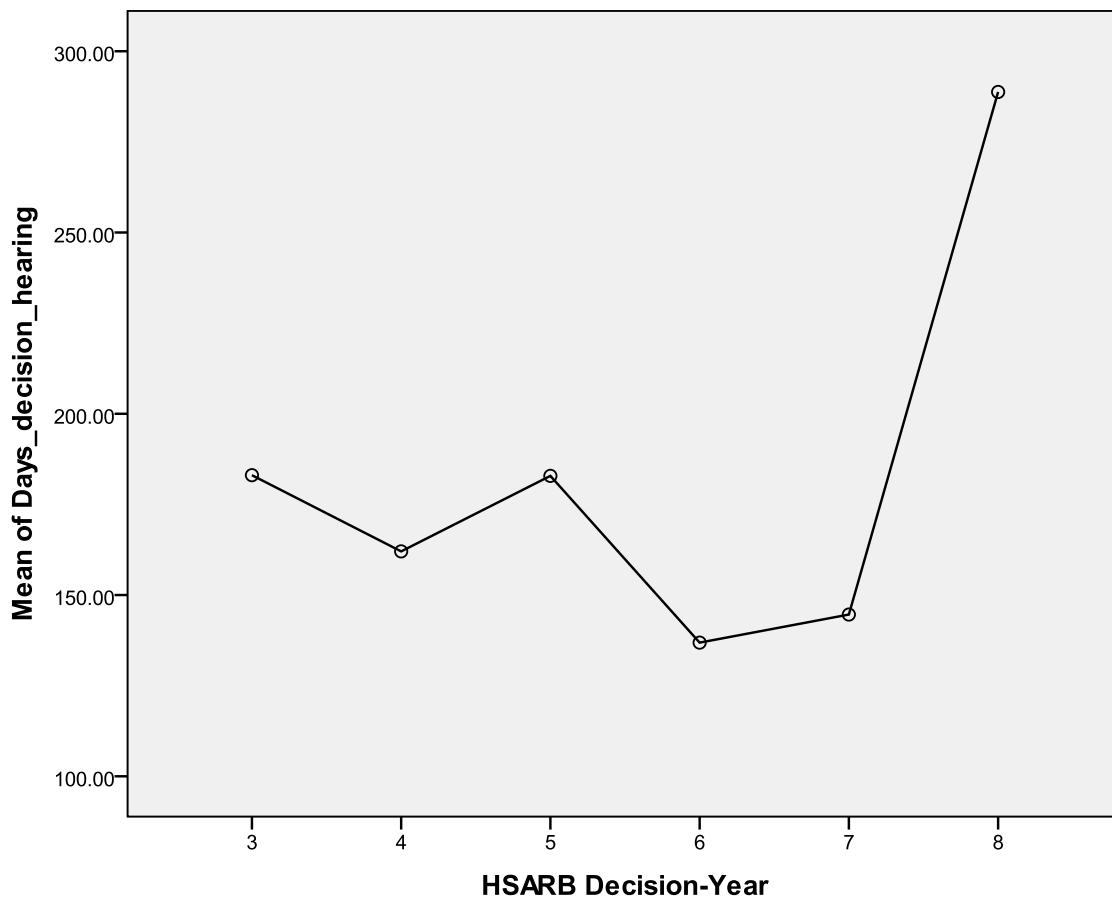
This range – 3 days to 1,220 days – is very skewed in comparison to a normal distribution. This is a distribution which is very skewed to the lower values of Decision days. The degree of skewness is indicated by a few extreme cases. In other words, the majority of days between the Hearing Date and the Decision Date were in the lower range of days – 0 to 200 days with a few outliers.

Hearing Date to Decision Date:

It is important to restate that the database selection of the cases over five years was based on the Decision Date. As such, it is possible that a File Date and Hearing Date came before the study period while the Decision Date would have fallen within the study period.

The overall average number of days in the system was approximately 160 days, but this varied enormously between 2004 and 2006 years. In 2006, the average number of days from Hearing Date to Decision Date was 137 days. In 2006, the average number of days from Hearing Date to Decision Date was 289 days. Is this 'Decision Date Year' significant? The year 2008 is very significant in terms of accounting for why a case takes time between the Hearing Date year and the Decision. The graph below depicts the average number of days between Hearing Date and Decision Date data:

Table 6: Average Number of Days between Hearing Date and Decision Date



From this graph, we can see how the fifth year rises beyond the other years of the study in terms of mean number of days between the Hearing Date and the Decision Date. It

raises the question what was taking place in the fifth year that caused this significant finding. The cases in the fifth year may shine some light on this issue.

Further analysis identified that there were 17 cases in fifth year with respect to this study's timeframe. The majority of these cases had a Hearing Date of 2007 and a Decision Date of 2008. These 17 cases were then cross tabulated to see if the Board had Granted or Denied the application. Only one of the 17 cases was Granted.

Type of Hearing – Oral, Written, Teleconference or Split

The Board can conduct three types of Hearings - where the parties appear in person, referred to as Oral Hearings, by Teleconference or by Written submissions. Each party – the Applicant and Respondent - determines which method of Hearing they wish for themselves. While the majority of cases involves one type of Hearing, it is possible to have a ‘split’ Hearing where one party elects one type of Hearing while the other party elects a different type of Hearing. For example, one party may elect an Oral Hearing while the other party elects to join the Hearing by Teleconference. In such a case, the Panel would appear in person, one party would appear ‘orally’ and be in the room with the Panel while the second party would join the group by teleconference call. In all cases, the Board and the parties have the parties’ written submissions before them.

Of all 315 Hearings, 192 cases - 61% - were Oral Hearings, 52 cases - 17.8% - were Teleconference Hearings and 85 cases - 27% - were Written Hearings. These cases did not add up to 100% because some of the cases were split cases. For example, the patient

may have presented before the Board by teleconference call while OHIP attended in person or vice versa.

Analysis was done on ‘split’ Hearings to determine the type and number of split Hearings that took place during the five year study period. Of the total cases for the five year period, Oral-Teleconference Hearings took place 11 times, Oral-Written Hearings took place four times and Teleconference-Written Hearing took place three times.

Type of Hearing relative to Disposition:

Of interest was whether the type of Hearing – oral, written, teleconference or ‘split’ – gave a party an advantage over the other party in terms of whether the appeal was Granted or Denied by the Board. As will be discussed later, the Board has an overall Grant rate of approximately 20% and a Deny rate of approximately 80% for the five year study period. Based on this, further analysis was done on the majority of 192 Oral Hearings. The table below indicates that an Oral Hearing was significant in a Board Granting an appeal.

Table 7: Oral Hearing vs. Board Grant of Appeal

Cross tabulation

			Oral		Total
			No	Yes	
Board -Grant	No	Count	109	143	252
		Expected Count	98.7	153.3	252.0
		% within Board-Grant	43.3%	56.7%	100.0%
	Yes	Count	14	48	62
		Expected Count	24.3	37.7	62.0
		% within Board- Grant	22.6%	77.4%	100.0%
Total		Count	123	191	314
		Expected Count	123.0	191.0	314.0
		% within Board-Grant	39.2%	60.8%	100.0%

The analysis indicates that there was a very significant association between an Oral Hearing and the Granting of the appeal. This significant association was based on 48 granted cases. The 48 cases represented 77.4% of the oral cases granted where the statistical average number of oral cases granted was only estimated to be 60.8%. In other words, if the Hearing was Oral, the application was granted significantly more times (77.4%) than expected (60.8%).

The 48 oral cases were individually identified and subsequently analyzed. Of the 48 oral cases granted by the Board for the study period, the majority of Grants by the Board appear to be because the requested health care service is not ‘Identical or Equivalent’ to health care service in Ontario or there is a Delay accessing an Identical or Equivalent health care service in Ontario that would result in the patient’s death or medically significant irreversible tissue damage to the patient.

This significant association between the type of Hearing – in this case an Oral Hearing – and the Granting by the Board of the patient’s appeal – was further analyzed by Year. In the interest of time, only Decisions in the year 2004 and year 2006 were explored. No significance was found for Year 2001. However, significance was found for Year 2006. In other words, an Oral Hearing did not result in a significant number of Grants by the Board for Year 2004 but it did result in a significant number of Grants by the Board for Year 2006.

Parties: Represented by Lawyer or Self-Represented

The prevalent thought is that parties may be in a better position to present their facts and argue the law if they are represented by a lawyer who knows the applicable law. Parties who are self represented may not argue as effectively as a lawyer who knows the law in question. In all court and tribunal hearings, there is significant concern that if a Hearing takes place between a self represented party and a lawyer, the self represented party may be at a disadvantage in arguing his or her case and the Hearing does not represent a ‘level playing field’. Is this true?

To determine if this is the case at the Board, within the study period, the number of times the patient was self represented versus represented by a lawyer and how many times OHIP was represented by a non-lawyer versus an OHIP lawyer was analyzed. Then the number of times both the patient and OHIP were represented by a lawyer was analyzed relative to the Board's Decision to grant or deny the patient's appeal (See Appendix L for details).

We know overall that the Board denied cases 80% of the time and granted cases 20% of the time during this study period. Of interest was whether having a lawyer significantly increased the percentage of granted application above the overall 20% rate on behalf of the patient. It is understood that this is a crude measure as the nature of the case may have influenced the Board's Decision within the study's timeframe. However, this measure was examining Procedural aspects of the Board's Hearing – in terms of representation at the Hearing - not the Substantive elements of that representation.

The data indicates that a very small percentage of patients were represented by lawyers. In only 32 cases out of 315 total cases – 10.2% - did a lawyer represent the patient at a Hearing. Approximately 282 cases out of 315 – 89.5% - did not have representation by a lawyer.

In 42 cases of 315 total cases – 13.3% - a lawyer represented OHIP at a Hearing.

Approximately 273 cases out of 315 – 86.7% - OHIP did not have representation by a lawyer.

In 28 cases out of a total of 315 cases – 8.9% - both the patient and OHIP were represented by lawyers. In 4 cases, the patient had a lawyer and OHIP did not. In 14 cases, OHIP had a lawyer and the patient did not.

Of the 28 cases with legal representation for both parties, how many of the cases resulted in a grant or denial of the patient's appeal? Of the 28 cases where both parties had legal representation, 9 cases – or about 32% of the cases – resulted in the Board granting the Application on behalf of the patient. This grant rate of 32% is higher than the overall grant rate of 20%.

Interpreter

This study sought to analyze the number of times an Interpreter was used and the language of the Interpretation. The study found that Interpreters were seldom used in Hearings. Only 3 cases - 1% of the time - used Interpreters.

Type of Appeal: Definitions

As of the timeframe for this study, there were at least three types of patient appeals to the Board from OHIP Decisions not to fund an out of country coverage health care service. These included:

i) Prior Approval

- a request for approval of an out of country coverage health care service before the patient accessed the out of country coverage health care service (termed ‘Prior Approval’ or ‘Prior’ requests);

ii) Reimbursement

- a request for approval of an out of country coverage health care service after the patient accessed the out of country coverage health care service (termed ‘Reimbursement’ requests) where Prior Approval not ever requested by the Patient;

iii) Both – Prior Approval and Reimbursement

- a request for an out of country coverage health care service both before and after the patient accessed the out of country coverage health care service where, the Patient had requested the out of country coverage health care service but had been denied by OHIP but the Patient went ahead with the out of country coverage health care service anyway – or - the Patient had requested the out of country coverage health care service but had not yet heard back from OHIP on its acceptance or denial at the time of the out of country coverage health care service delivered, but subsequent to the out of country coverage health care service delivery, the Patient learned that OHIP denied its coverage (termed Prior Approval and Reimbursement).

The challenge in the reading of the Decisions for this study was the cases' reference to the Prior Approval Form. The Prior Approval Form was intended to be submitted to OHIP prior to receiving the out of country coverage health care service, in order for OHIP to determine if the health care service qualified for OHIP funding. However, in practice, the Prior Approval Form was often submitted after the out of country coverage health care service was delivered. Thus, the Prior Approval Form was used for Prior Approvals but also for Reimbursement requests as well as for combined Prior Approval and Reimbursement requests. For this study it was important, therefore, to determine how the Prior Approval Form had been used, not just that it had been used. This determination was made after carefully reading each case.

Results:

i) Prior Approval

Approximately 28.5% of the time the Board overruled OHIP's denial of coverage if the patient had sought prior approval from OHIP for the out of country treatment. Thus, the patient who had sought prior approval from OHIP was significantly more likely to have their request granted by the Board - 28.5% compared to an overall granting rate of approximately 20%. It is important to note that approximately 72% of those with Prior Approval still were not granted.

ii) Reimbursement

The Board overruled OHIP's denial and granted the out of country reimbursement to the patient/Applicant 16.3% of the time - which is less than the overall grant rate of 20%.

iii) Both - Prior Approval and Reimbursement

However, the picture appears to change if both Prior Approval and Reimbursement were requested by the patient. The numbers of Prior Approval cases and Reimbursement cases overlap such that 54 cases – or 25.8% - requested both Prior Approval and Reimbursement for out of country health care service from OHIP.

A cross tabulation of the 54 cases was undertaken to determine if the Board granted the appeal of those patients requesting both Prior Approval and Reimbursement for an out of country health care service proved ‘extremely’ significant. Of the 54 cases requesting both prior approval and reimbursement, 17 cases were granted out of country coverage by the Board. It appears that the chances of a Board grant were improved significantly if the patient requested both a Prior Approval and a Reimbursement. Approximately 32% of the time the Board overruled OHIP’s denial and granted the Prior Approval-Reimbursement request.

Review Requests

Under a ‘Review Request’, one or both parties to a Hearing before the Board may, upon receiving the Decision of the Board, request that another Panel of the Board review the evidence and render its own Decision. The 315 case were reviewed to see the frequency of Review Requests during the study period. There were extremely few Review Requests. Only one case or 0.3 – less than 1% - requested another panel of the Board to Review of the Board’s Decision.

Conclusion

The purpose of analyzing the Board's Procedural data was to explore whether there is a correlation between the procedural aspects of the Board's procedures and the final decision by the Board to grant or deny the patient's request for out of country coverage. These procedural factors included: the time a case proceeds through the Board's system – from the date of the appeal request to the hearing date through to the decision date; whether the hearing is oral, written or by teleconference call, or some combination of oral/teleconference/written; whether a review was requested of the Board's decision; the presence of an interpreter at the hearing, whether parties were represented by a lawyer or were self-represented at the hearing; and whether the hearing request was based on OHIP's denial of a prior approval application, a reimbursement application or a combined prior approval-reimbursement application.

It was found that the data only permitted an analysis of duration of the time a case took from hearing date to decision date and not the total time from appeal application to decision date. The duration of time from the hearing date to the decision date was variable and was skewed by a few cases. In terms of hearing formats, oral hearings were more likely to be correlated with a decision to grant of out of country coverage than other formats – for a particular time period. It was also found that patients were unrepresented 90% of the time but when they did have representation they were more likely to be correlated with the decision to grant coverage. The data revealed that interpreter and decision reviews were seldom used. The data indicated that patients who had requested

prior approval of out of country coverage from OHIP were more likely to be granted coverage by the Board. However, patients who had requested prior approval and reimbursement from OHIP received more coverage grants than prior approval requests alone.

Chapter 9

Substantive Arguments: Results

Introduction

Phase I: Overview of Arguments

Screening Test – s.24(1)17 ‘Experimental Treatment’

Section 28.4(2) Test

Test Element #1 - s.28.4(2)(a): Generally Accepted in Ontario for Patient

Test Element #2 - s.28.4(2)(b)(i): No Identical/Equivalent Treatment in
Ontario

Test Element #3 – s.28.4(2)(b)(ii): Delay causing death and/or MSITD

Phase II: Discrepancies within Team Patient

Types of Discrepancies within Team Patient

All s.28.4(2) Elements Assessed for Year 5

Out of Country ‘Grants’ by the Board

Granted Cases in Year 5

Conclusion

Chapter 9

Research Question #2:

What substantive arguments affect resource allocation decisions?

Substantive Arguments:

RESULTS

Introduction:

The Board's Decision in a given case is based on its agreement or disagreement with argument put forth by the parties – OHIP and the patient – relative to the Board's jurisdiction, statute and regulations. According to the data, the Board denies the patient out of country coverage approximately 80% of the time. The Board overrules OHIP's denial of coverage 20% of the time resulting in a grant of coverage for the patient.

However, prior to this study, there was no empirical research to establish which element(s) of the s.28.4(2) regulation were being argued and accepted by the Board regarding the granting or denial of out of country coverage. Even though Board decisions typically gave reasons for the decision, the reasons – particularly in the first years of the study – often did not specifically comment on the acceptance or denial of s.28.4(2) test elements. Thus, in order to clarify the acceptance or denial of s.28.4(2) elements, this thesis asks the following question:

Research Question #2:

What substantive arguments affect resource allocation decisions?

In order to analyse this question in more detail, this ‘Substantive Argument’ section is divided into two parts: Phase I³²⁰ and Phase II.

Phase I is an overview of the patient’s argument, OHIP’s argument and the Tribunal’s Decision on each of the three main elements of the s.28.4(2) test (see Appendix M) as well as the screening test of ‘experimental’ treatment. The details regarding the s.28.4(2) test definitions, standard of proof, burden of proof and the evidence required is outline in Appendix E. In hindsight, requests for prior approval and/or reimbursement should have been included in the ‘substantive argument’ analysis rather than ‘procedural’ analysis in order to determine the significance of s.28.4(2) relative to the prior approval requirement of s.28.4(5). The prior approval requirement of s.28.4(5), as will be further discussed, represents administrative non-medical criteria which can supersede the medical necessity determination of physicians. In this respect, the importance of this development for the substantive argument of the parties is better categorized under the substantive argument analysis than the procedures analysis.

Phase II of this study examined the discrepancies between the patient and the patient’s physician(s) prior to a request being submitted to OHIP. This discrepancy between the

³²⁰ Phase I further analyzed the s.28.4(2) cases to determine the: definition of test elements, the onus/burden of proof for each element, the required standard of proof, an overview of the evidence presented to the Board and any Board reasons/insights. The results and analysis can be found in the Appendix.

patient and the patient's physician(s) is termed – for the purpose of this study - the 'discrepancy within team patient' (see Appendix N). Phase II only examine discrepancies within team patient that occurred in year 5 cases. Almost half of the year 5 cases coming before the Board indicated there was a discrepancy within team patient regarding one or more of the elements of the s.28.4(2) test. In hindsight, all years in the study period should have been assessed for discrepancies in team patient. The reason year 1-4 were not analyzed was the unanticipated nature of the 'discrepancy within team patient'. The author had – incorrectly – assumed that only if the OCCNEIHS was approved by the patient's physician would the patient come before the Board. This was not the case in actuality. Patients who requested an OCCNEIHS but did not receive approval from their own physician did come before the tribunal. In essence, the patient's physician and OHIP were of the same opinion that the OCCNEIHS requested by the patient was not approved.

PHASE I – OVERVIEW OF ARGUMENTS

Screening Test – s.24(1)17 'Experimental Treatment'

According to the legislation, if a treatment is determined by the Board to be experimental it is automatically not funded by OHIP. The vast majority of patients - 81.9% - did not argue that the out of country treatment was either experimental or non-experimental while 13.3% argued the treatment was not experimental and about 4.8% argued the treatment was experimental. OHIP argued the treatment was experimental in 13% of cases and not experimental 4.8%. As with the patient data, OHIP did not argue for or

against experimental in 82.2% of cases. From the data, the Board determined that a procedure was experimental 7.6% of the time and not experimental 6.7% of the time.

Table 8: Summary of Arguments – whether procedure is “Experimental”

	Experimental	Not Experimental	No Argument
Patient	4.8%	13.3%	81.9%
OHIP	13.0%	4.8%	82.2%
Board Decision	7.6%	6.7%	85.7%

Section 28.4(2) Test

Section 28.4(2) was amended in April of 2009. However, given that the study period preceded the amendment, the following earlier version of s.28.4(2) that was in force during the study period was used:

section28.4(2)

Services that are part of a treatment and that are rendered outside Canada at a hospital or health facility are prescribed as insured services if,

- (a) the treatment is generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person; and
- (b) either,
 - (i) that kind of treatment that is not performed in Ontario by an identical or equivalent procedure, or

(ii) that kind of treatment is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage.³²¹

The results are as follows:

Test Element #1 - s.28.4(2)(a)

'Generally Accepted in Ontario as Appropriate for a Person in the Same Medical Circumstances as the Insured Person'

According to the data, 81% (80.6%) patients argue that the treatment they requested is generally accepted for a person in the same medical circumstances as they were in.

Approximately 4.8% of patients argued that the treatment is not generally accepted as appropriate for them. In 14.6% the patient did not argue that the treatment was or was not generally accepted as appropriate for patients in their condition. In almost 50% of the cases – approximately 30% less frequently than the patient - OHIP agreed that the out of country treatment is generally accepted as appropriate for the patient. Approximately 26% of the time OHIP argued the treatment was not generally accepted as appropriate for the patient. In 25% of the cases, OHIP did not argue that the treatment was or was not generally accepted for the patient. The Board determined that in 68% of the cases the treatment was generally accepted for the patient and in 21% of the cases it was not generally accepted for the patient. The Board did not make a determination regarding general acceptability in 12% of cases.

³²¹ Regulation 552 Supra Note 3 at s.28.4(2)(a)(b)(i)(ii)

Table 9: Summary of Arguments – whether procedure is “Generally Accepted”

	Generally Accepted	NOT Generally Accepted	No Argument
Patient	81%	5%	15%
OHIP	49%	26%	25%
Board Decision	68%	21%	12%

Test Element #2 – s.28.4(2)(b)(i)

‘Treatment That Is Not Performed In Ontario by an Identical or Equivalent Procedure’

In approximately 48% of cases, the patient argued that there was identical / equivalent treatment performed in Ontario and 30% there was not identical / equivalent treatment in Ontario. In 23% of cases, the factor of identical/equivalent was not argued. OHIP argued in 5% of the cases that there was no identical/equivalent and in 66% of the cases that there was identical/equivalent. OHIP did not present an argument on this point in 29% of cases. The Board determined that there was not identical/equivalent treatment in Ontario 14% of the time and 58.4% there was identical/equivalent treatment. In 28% of cases, the Board did not address the issue in the Decision. At least half the time, the parties and the Board agreed that there was identical/equivalent in Ontario (48% patients, 66% OHIP, and 58% Board).

Table 10: Summary of Arguments – whether procedure is “Identical/Equivalent”

	I/E in Ontario	NO I/E in Ontario	No Argument
Patient	48%	30%	23%
OHIP	66%	5%	29%
Board Decision	58%	14%	28%

Test Element #3 – s.28.4(2)(b)(ii)

‘Treatment is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay³²² that would result in death or medically significant irreversible tissue damage’

Over 59.7% and 44.8% of cases delay causing death or MSITD respectively was not argued by the patient.

OHIP argued that delay would cause death (0.3% - or 1 case) or MSITD (1%). OHIP argued that the delay the patient experienced would not cause the patient’s death (36%) or MSITD (42%). OHIP did not argue delay causing death 63.8% and MSITD 57.5% of the time.

The Board determined that the delay would cause the patient’s death 5% and MSITD 11% of the time. The Board determined that the delay would not cause the patient’s death

³²² Delay itself was not enough reason for OHIP to fund out of country treatment. The delay, once established, had to likely cause the patient’s death or MSITD. The patient need only establish that the delay is likely to cause their death or MSITD rather than both death and MSITD. The author assumes that if there is patient death there is also MSITD.

(46%) or MSITD (51%) – versus patients and OHIP who argue delay causing death – 26% and 0.3% respectively and delay causing MSITD – 45% and 1%. The Board did not determine delay causing death 49% or MSITD 38% of the time. Clearly, there is a significant patient-OHIP-Board difference of opinion regarding ‘delay’.

Further analysis attempted to ascertain where the patient was experiencing a delay. This was done by estimating potential points of medical assessment experienced by the patient - delay accessing the patient’s Ontario general practitioner, delay accessing an Ontario specialist and delay accessing Ontario surgery. In terms of delay accessing their Ontario general practitioner, 90% did not discuss this type of delay. Approximately 9% said there was a delay accessing the general practitioner and 1% stated there was no delay accessing the general practitioner. Approximately 79% did not discuss access to Ontario specialists as a cause of the delay. Of those patients discussing delay causing death and/or MSITD, delay to access an Ontario specialist was reported in 14% of cases. No delay accessing an Ontario specialist was reported in 7% of cases. Approximately 83% did not discuss access to Ontario surgery as a cause of the delay. Of those patients discussing delay causing death and/or MSITD, delay to access Ontario surgery was reported in 15% of cases. No delay accessing Ontario Surgery was reported in 2% of cases.

Table 11: Summary of Arguments – whether procedure requested is due to Delay, Delay causing Death, Delay causing MSITD

	Delay	No Delay	N/A	Delay	No Delay	N/A
	Death	Death	Death	MSITD	MSITD	MSITD
Patient	25.7%	14.6%	59.7%	45.1%	10.2%	44.8%
OHIP	0.3%	35.9%	63.8%	1.0%	41.4%	57.5%
Board	4.8%	46%	49.2%	11.4%	50.5%	38.1%
Decision						

PHASE II: DISCREPANCIES WITHIN TEAM PATIENT

Phase II was an unexpected research finding that emerged during case analysis. The patients' argument for s.28.4(2) was not always cohesive. In Year 5, approximately 50 of the 106 cases showed discrepancy within the patient's s.28.4(2) arguments. These discrepancies within Team Patient were found in every area of the s.28.4(2) test.³²³ While there may also have been discrepancies within the OHIP argument and dissent in the Board's deliberations, these were not recorded in the written Decision.

Types of Discrepancies within Team Patient

There were a variety of types of discrepancies within Team Patient which reflected a number of differences of opinion including:

- disagreement between the patient and the general practitioner,

³²³ Discrepancies within the 'Experimental' screening element were not analyzed for the purpose of this paper but are available for future analysis

- disagreement between the patient and the general practitioner and specialist (the latter who agree with each other),
- the patient and the general practitioner agree but the specialist disagrees,
- the patient and general practitioner disagreeing but the patient and specialist agree,
- the patient only reports the specialist disagreeing but does not report the general practitioner's position and
- discrepancies between the patient's Ontario based medical team and an out of country medical opinion typically a specialist.

In one case, the patient reported that he did not have a physician and thus could not present a medical opinion of his need for a particular out of country treatment. On the other extreme, one patient reported seeing fourteen specialists who did not agree that she should receive the out of country treatment.

All s.28.4(2) Test Elements of Patients' Argument Assessed for Year 5

While initially the first element of the s.28.4(2) test – GA - was assessed, this only represented 17 of the 50 cases. As a result, all 50 GA, I/E, and Delay cases were analyzed in order to increase the sample size and determine if any patterns could be seen. In hindsight, Year 1 to 5 cases should have been included in the analysis of possible discrepancies within Team Patient. Of the 50 cases, there were only 4 grants of out of country coverage.³²⁴ The remaining 46 cases that had discrepancies within Team Patient were denied coverage by the Board.

³²⁴ Cases #292 (06-HIA-0047 L.S.), Case #322 (06-HIA-0265 D.A.M.), Case #329 (06-HIA-0293 D.K.), Case #362 (07-HIA-0018 S.F.)

Out-of-Country “Grants” by the Board

A cross tabulation analysis of GA versus Board decisions and I/E versus the Board decisions found a pattern when there was a discrepancy in the argument of Team Patient - the Board did not grant the patient’s out of country request. The pattern is not significant given the sample size of 4 grants. A larger sample size should be included to assess if this pattern is significant.

The pattern changes when analyzing Delay (s.28.4(2)(b)(ii)). Delay causing death and Delay causing MSITD both show the same pattern to each other which differed from the pattern shown in GA (s.28.4(2)(a)) and I/E (s.28.4(2)(b)(i)). When there was a discrepancy within team patient over delay, the Board granted out of country coverage 50% of the time.

Granted Cases Year 5

Four (4) cases in year 5 were granted by the Board when there were discrepancies within Team Patient. Each case was reviewed in more detail in an effort to determine where the discrepancy within Team Patient relative to the required elements of s.28.4(2). In all four cases, the Ontario specialist was acting as a ‘gatekeeper’. In three of the four cases there was a discrepancy between the patient and the specialist regarding Delay causing MSITD – s.28.4(2)(b)(ii). The remaining case dealt with the experimental nature of a procedure. It is also interesting to note that physicians were not present at the Hearing to answer questions from the parties or the Board.

Chapter 10

Analysis of Quantitative Research Relative to Theory and Empirical Research

Introduction

Need for Empirical Research

A4R Theory

Appeals Condition

Publicity Condition

Enforcement Condition

Relevance of Evidence Condition

Problems Comparing A4R to Empirical Research Results

Patient Profile Analysis

Procedures Analysis

Question #1

Do procedures statistically affect resource allocation decisions of the Board?

If so, what elements of the procedures create this statistical affect?

Substantive Argument Analysis

Question #2

What substantive arguments affect the resource allocation decisions of the Board?

Conclusion

Chapter 10

ANALYSIS

of Quantitative Research Relative to Theory and Empirical Research

Introduction

This research sought to examine the influence of a tribunal's procedures as well as the influence of substantive arguments of the parties on a tribunal's resource allocation decision making. The challenge was to find a theory that addressed this research. Of the multitude of theories, academic debate, academic discussion and review of existing limited – and often flawed -- empirical research, this author found an absence of theories which examined the correlation between a tribunal's procedures as well as the influence of substantive arguments of the parties on a tribunal's resource allocation decision making. In addition, none of the theories or academic discussion analyzed who was coming before the tribunal, for what reason and how this might impact on the tribunal's decision.

Given the overall lack of applicable theory relative to this thesis' research, this author chose to review an academic discussion and a theory for the purpose of this analysis. First, the academic discussion regarding the lack of empirical research in legal analysis – specifically in terms of tribunal decisions - was reviewed. Second, this author reviewed the A4R theory regarding the process of making resource allocation decisions. The A4R theory was chosen because of the theory's potential for analysis relative to objective data

on the Board's procedures. For example, the premise of the A4R theory is that, in the absence of consensus of substantive distribution principles, a fair, transparent resource allocation process should lead to the acceptance of a resource allocation decision. As such, the focus of the A4R theory is on procedures rather than technically difficult substantive medical and administrative substantive arguments. These substantive arguments are difficult to quantify based on the empirical data source of Board decisions. The study's data source - Board's decisions – consistently and in a standardized manner recorded the Board's procedures. The Board's decisions did not consistently and in a standardized manner record the submissions of the parties or information regarding the patients' profiles. In this respect, patient profiles and the substantive arguments of the parties allowed room for subjective interpretation while the Board's procedures did not. Given the importance of objectively analyzing data in this quantitative study, the author chose to statistically analyse the Board's process and subsequently compare it to the A4R theory.

The A4R theory requires four conditions of transparency – publicity, appeals, enforcement and relevance of evidence. This author analyzed each of the four conditions relative to the study data. The A4R theory, as will be discussed in more detail, did not represent the complexity of the tribunal resource allocation decision making in terms of the influence of a tribunal's procedures as well as the influence of substantive arguments of the parties on a tribunal's resource allocation decision making.

The empirical results were then analyzed – not according to the A4R – but relative to their original categories: patient profiles, procedures and substantive arguments by the parties before the Board. Each element was analyzed in detail to determine if any trends existed as they related to the research questions. The empirical results found numerous trends. These trends are discussed later in this chapter.

Need For Empirical Research

This author's extensive literature review and attempt to analyse the research results identified that the majority of legal scholarship exhibited a dearth of empirical research and an abundance of theory and doctrine. According to Heise, current legal scholarship is dominated by theory and doctrine.³²⁵ While the traditional approaches of theory and doctrine are important, they cannot identify issues and shed light on key issues which are more amenable to empirical research.³²⁶ According to Schuck, the call for legal academic empirical research is not new.³²⁷ The use of empirical research is necessary to support theory and doctrine. For example, Bok states that the development of good theories is difficult without the benefit of good data.³²⁸ Posner states that the lack of an empirical footing poses a threat to legal theory's persuasiveness and influence.³²⁹

There are a number of reasons why empirical legal research is not prevalent or the focus of legal scholarship. Lowery and Evans argue that scholarly research lacks institutional

³²⁵ Heise, Supra Note 102 at 834.

³²⁶ Ibid at 834.

³²⁷ Schuck, Supra Note 100 at 329 observes that the two main forms of legal scholarship – theoretical and doctrinal – account for “almost the entire corpus of legal scholarship.”

³²⁸ Bok, Supra 112 at 581.

³²⁹ Posner, Supra Note 113 at 3.

support, and there is a failure to teach research methods and paradigms regarding empirical research. This lack of rigor in research methods creates a crisis of confidence concerning research that does exist.³³⁰

Need for Empirical Research on Tribunals

This author's theory research identified that there was a lack of empirical research on tribunals. The author found extensive academic debate regarding judicial review of administrative action. The literature by Hadorn, Syrett, Mariner, Flood, Sheldrick, Greschner, Jackman, Lahey, Pitfield, and Heise - provides a rich legal academic discussion – but focuses on the judicial discussion of administrative tribunals. Thus, in addition to the dearth of empirical research by legal academics generally, there is a lack of empirical research by legal academics on administrative law.

One of the few academic sources discussing the lack of empirical research on tribunals can be found in the writings of Sossin and Hoffman. In a 2010 article, the authors state that tribunals are key decision makers in allocating scarce resources but that the current research on tribunals focuses on theory, doctrine, and procedures.³³¹ The use of empirical research to evaluate the accountability of tribunals ‘is one of the least scrutinized areas of administrative law.’³³² Jacobs also stated that there was a ‘dearth’ of Canadian administrative law theory and information, that the realities of tribunal existence are not neatly packaged³³³ and factors affecting tribunal independence did not ‘jump out’.³³⁴

³³⁰ Lowery, Supra Note 104 at 308.

³³¹ Sossin and Hoffman, Supra Note 120.

³³² Sossin and Hoffman, Supra Note 120.

³³³ Jacobs, Supra Note 127 at 343.

Chipman's empirical research also found that there was little published empirical scholarly analysis regarding tribunal day-to-day activities.³³⁵ The tribunal did not perform according to the theoretical models or regulatory theory. It was far more complex and ambiguous and reviewed patterns far removed from theoretical norms.³³⁶

Sossin and Hoffman state that the lack of empirical research may be due to system and research method complexity, a lack of empirical skills and academic prestige as well as the pervasive culture within academia of deference to experts and authority. These factors further diminish the perceived value of objective empirical work. For example, one empirical study sought to 'evaluate' HSARB as compared to the courts in providing patients with an accessible and effective way to challenge government decisions.³³⁷ However, the 'evaluation' indicators of tribunal versus court elements were not described or analyzed according to research design protocols. Sossin and Hoffman recommend the need for evidence and data driven strategies in order to evaluate and achieve a tribunal's intended purpose.³³⁸ According to Sossin and Hoffman, the fact that evaluation is not easy does not detract from its importance. Sossin and Hoffman also believe that the lack

³³⁴ As a result of the dearth of theoretical application of models to the actual practice of tribunals, Jacobs develops three new theoretical model regarding administrative independence; independence informed by judicial dictates; independence informed by cultural understandings; independence informed by fundamental values of fairness.

³³⁵ Chipman, Supra Note 134 at 4 "There is no lack of "how to be successful before the Board" presentation materials, often of high quality, prepared by lawyers, planners and other professionals who appear before it, but this is of necessity of a limited and practically-focused nature, and is no substitute for analysis which attempts to place the Board's decision-making in a more analytical context, to get behind what it does to examine how and why it does it.".

³³⁶ Ibid at 319.

³³⁷ Pitfield, Supra Note 72.

³³⁸ Sossin and Hoffman, Supra Note 120.

of empirical research is not only a missed opportunity but may also pose a significant risk by not studying changes over time or evaluating decision-makers.

These two authors state “that an assessment of health-related adjudicative tribunals has never before been comprehensively undertaken and is ripe for research and, potentially, reform.” However, there has been preliminary research regarding HSARB undertaken which forms the basis for further exploration. For example, Flood and Pitfield identified the low success rate of appeals at HSARB and Pitfield identified a gap between the parties’ expectations of HSARB and the Board’s limited jurisdiction.

In order to address the gap of a lack of empirical research -- identified by Heise, Schuck, Bok, Posner, Lowery and Sossin and Hoffman, Jacobs and Chipman -- and to address the methodological challenges, this author undertook a literature review of existing tribunal empirical research. The author reviewed the existing empirical research of Jacobs, Gamble, Chipman, Fernandez, Pitfield and Pitfield and Flood in order to identify possible research design strategies, statistical indicators and to learn from the limitations of the empirical research on tribunals. After an extensive review, no research design, statistical indicators or analysis could be identified regarding interplay between the influence of tribunal procedures and substantive arguments by the parties on the tribunal’s decisions. However, the literature identified several statistical indicators that were incorporated into the author’s methodology. These statistical indicators included: unforeseen factors influencing Board’s decision (Jacobs); the exclusion of the general public and lack of information on subject inclusion (Gamble); the coding and statistical analysis of actual

tribunal decisions (Chipman);³³⁹ approval rates, decision outcomes, and the position taken by the Board (Fernandez); insights into significant role of lawyers in formulating effective arguments (Pitfield); the gap between the parties expectations of HSARB and the Board's limited jurisdictional powers (Pitfield)³⁴⁰ and the low success rates of appeals (Pitfield and Flood).

From these empirical studies, this author saw the need to further explore who were the parties appealing a government decision (patient profiles), why the party was appealing the government decision (substantive argument) and what part of the party's substantive appeal was accepted by the tribunal, if any. It was also assumed that the process (procedures) by which parties appealed a government decision before the tribunal was a neutral process and did not affect the tribunal's decision. This latter aspect – the Board's procedures – was analyzed relative to the A4R theory. The details of this analysis are listed below.

³³⁹ Chipman, Supra Note 134.

³⁴⁰ Pitfield, Supra Note 72 at 100.

Accountability for Reasonableness (A4R) Theory:

The A4R theory states that societies lack consensus on substantive distributive justice principles. Because of this lack of consensus, society will only accept resource allocation decisions if the process used to determine the resource allocation is considered by those affected to be fair. Fair processes are those processes which are transparent. Transparent processes are characterized as having four conditions: publicity, relevance, appeals and enforcement. In essence, if the four conditions of transparency are fulfilled – publicity, relevance, appeals and enforcement – the resource allocation decision is considered to be fair and transparent and thus more likely to be acceptable even if there is no consensus regarding the resource allocation decision.

Why is the A4R theory important? The A4R theory is important because – if society continues to have a lack of consensus on substantive distribution principles, and the process used to determine the resource allocation is not considered fair by those generally affected, would the society still accept the resource allocation decision? What if the process itself influences the resource allocation decision irrespective of the submissions of the parties before the decision maker? What is a revised resource allocation decision making mechanism? According to the A4R, the four conditions of transparency are required for a process to be considered ‘fair’ and thus important to the acceptability of a resource allocation decision. If the four conditions of transparency are not met, is a resource allocation decision still acceptable?

This study will analyse the Board process relative to the A4R theory with the assumption that there is a lack of consensus on substantive distribution principles – as seen in the substantive arguments of the parties before the Board.

Overall, elements of the theory of A4R were found in the analysis of the cases. However, the theory's transparency conditions of publicity, relevance, appeals and enforcement are not 'fine grain' enough to capture procedural elements that may affect decision making.

Second, the A4R theory strays away from its purpose of focusing on the process of decision making and into the area of substantive arguments via its relevancy of evidence condition.³⁴¹ The A4R provides an important starting point for a critical analysis of the procedures involved in resource allocation decision making. An analysis of the A4R's transparency conditions of appeals, publicity, enforcement and relevance is outlined below. However, the A4R needs to be supplemented with quantitative research in order to provide a more "fine grain" analysis of the impact of the general procedure and individual procedural factors on Board decisions.

Appeal Condition

Under the A4R's 'appeals' condition, a mechanism for challenging a resource allocation decision must be made available. While the Board has jurisdiction to hear appeals from OHIP decisions, a decision of the Board can review its own decision or its decision can be appealed to the courts.

³⁴¹ Paul Brest, "The Substance of Process" (1981) 42 Ohio St. L.J. 131.[hereinafter "Brest"]. – Brest argues that the role of the courts in terms of representational-reinforcing review and the fundamental values cannot be separated.

The mechanism for challenging a resource allocation decision of the Board is based on the legislative scheme outlined in Chapter 2. The province, according to s.92(7) of the Constitution, deals with the delivery of health care. The provincial HIA outlines the jurisdiction of the Board to hear appeals from ‘insured persons’ who have been refused health care coverage and or the reimbursement of claims by the General Manager of OHIP. The Board also has the jurisdiction to review and reconsider a decision made by a previous panel of the Board.³⁴² This appeal option for the Board to review and reconsider its own decision was only used once in this five year case study. Whether or not the Board’s decision to review and reconsider its own decision, a decision of the Board may be further appealed to the Ontario Divisional Court by ‘any party’.³⁴³ During the study time period and based on the data source of Board decisions, it was unknown how many Board decisions were appealed to the Divisional Court.

While the condition of ‘appeals’ requires a ‘mechanism’ for challenging a resource allocation decision, the A4R theory does not require a knowledge of who is appealing the decision and why a resource allocation decision is being challenged. It is unclear if the Board decision was appealed for procedural or substantive distribution reasons. In summary, the A4R appeals condition to make available a mechanism for challenging a resource allocation decision is established in the legislative context within which the Board operates. Thus the appeals condition is present.

³⁴² based on 2009 Rules s.21.2(1).

³⁴³ HIA, Supra Note 4 at s.24(1).

Publicity Condition

According to the A4R's 'publicity' condition, decisions by the decision maker must be publicly accessible. The publicity condition as it relates to the Board is weakly met, according to the author, due to the difficulties in electronically accessing the decisions that corresponded to the study period. These difficulties in electronically accessing the decisions are outlined in more detail in the methodology chapter of this thesis. The Board decisions analyzed for this study, were retrieved in 2009 from the Board's public website. It is unknown if the study period decisions were available online or through the Board office prior to 2009. The Board's decisions were posted on CanLII as of August 2, 2010.³⁴⁴

The core research element for this study – Board decisions – did not indicate if the hearing was attended by members of the public other than those involved in a given case. Thus, it is difficult to determine from the data within the decisions if the hearings were attended by the public. Even if the decisions and hearings were / are public, it is important – for future research – to analyse whether the public experiences and perceives the hearings and the decisions to be accessible. The public may be encountering barriers to access that are not captured in the study. Overall, the publicity condition is present.

Enforcement Condition

The A4R theory's condition of 'enforcement' requires the regulation of the process to ensure the conditions of publicity, relevance and appeals. Board decisions may be appealed to the courts. Through the oversight mechanism of judicial review of

³⁴⁴ <http://www.hesarb.on.ca/scripts/english/default.asp>

administrative action, discussed in detail in Chapter 4, the courts have the jurisdiction to review the Board's decisions. In a review of the Board's procedures, the court may examine the conditions of publicity and appeals – and infrequently the substantive conditions of relevancy. However, this judicial review oversight by the court takes place only if a Board decision is appealed to the courts. Few tribunal decisions are appealed to the courts. As such, there is only the enforcement condition of judicial review if an appeal is granted by the court.

Currently, according to the legislative scheme, there is a requirement that the Board reports its activities to the Minister of Health annually. It is possible that this requirement could provide an enforcement condition. However, there is no requirement that the Board report the conditions of publicity, relevance, appeals or enforcement to the Minister or any member of the public. Overall, the enforcement condition is present.

Relevance Condition

The A4R relevance condition requires that the evidence be based on what fair minded parties agree is relevant. In the opinion of this author, the relevance condition is challenging for two reasons. First, the relevance condition requires evidence. Second, the evidence is based on what fair minded parties agree is relevant. In this study, the parties before the Board do not agree on what evidence is considered relevant. For example, OHIP may consider the evidence of the medical necessity of out of country treatment only if it is provided by a physician. The patient may consider their own non medical assessment of the medical necessity of out of country treatment to be relevant evidence.

Patients may feel that their own evidence of medical necessity outweighs the medical necessity determination of physicians – either their own physicians or the physicians providing evidence for OHIP. The challenge is who decides what is relevant evidence upon which resource allocations are to be made? Currently, it is the lay Board that makes the final decision on medical necessity and insured out of country health services. Overall, it is unclear to the author if the relevance condition is met.

Problems Comparing A4R Theory to the Empirical Research Results:

The application of the A4R theory to the actual resource allocation decisions of the Board was difficult. The difficulty arises for several reasons.

First, in addition to the dearth of empirical research specifically with respect to tribunals, it is the opinion of this author that there is no research or theoretical model on the interplay between tribunal procedures, submissions by the parties before the Board and the Board's resource allocation decision. Although the A4R theory deals with the process of resource allocation decision making – in the author's opinion -- it is incomplete as it does not address the substantive arguments of the parties or the interaction of the procedures and the tribunal's decision. It also does not address who is appearing before the resource allocation decision making body or the reasons for this appearance.

Second, three of the four A4R conditions - publicity, appeals and enforcement were not included in the tribunal's written decisions – the main data source for this research. The conditions of appeals and enforcement had to be analyzed relative to the legislative

scheme outlined in Chapter 2. The appeal condition does not examine the applicant – in this case the patient – and why a decision is being appealed. The condition of publicity was analyzed relative to the author’s assembly of Board decisions located on the Board’s public website. As a result, three of the four conditions for the A4R were not part of the quantitative study that was undertaken. Only the fourth condition of the A4R theory, the relevance of evidence condition, could apply to this quantitative study. Thus, from the initial analysis of the empirical study results relative to the theory there was the expectation that the theory did not apply to the majority of the study.

Third, the ‘relevance’ condition of the A4R can be reviewed based on data analyzed for this study. However, the relevance condition deals with the acceptability of evidence that is considered relevant by fair minded parties. Evidence supports substantive arguments. If this analysis is correct, there is a contradiction with the purpose of the theory and the components of the theory. The purpose for the A4R theory is to provide a process for making acceptable resource allocation decisions when the society cannot agree on substantive distribution. The theory does not purport to deal with substantive issues. Evidence is a substantive issue. As such, the A4R theory moves to the realm of substantive distribution. It is unclear how the agreement between the parties regarding what evidence is acceptable is to take place. The results of this study indicate there is not agreement between the parties or the Board regarding what evidence is acceptable. For example, in the study, one party – OHIP – may only accept medical evidence provided by physicians regarding the medical necessity of an OCCNEIHS. The patient may rely on medical evidence that is provided by non-physician sources. There may be disagreement

between the patient and their own physician(s) – what is termed in this study as “Disagreement within Team Patient” - regarding the medical necessity of a given OCCNEIHS for that patient. Thus the evidence submitted by the parties at the tribunal hearing – is not considered relevant by all parties. As such, this author questions whether the relevance condition is an assessment of acceptable procedures or if it is an assessment of the submission of the parties before the Board.

Fourth, this author is of the opinion that the A4R theory is a general replication of legal process undertaken by the courts and tribunals.³⁴⁵ Each of the A4R conditions of publicity, appeals, enforcement and relevance of evidence are seen in judicial and quasi-judicial resource allocation decision making. For example, court proceedings and decisions – unless sealed – are ‘publicly’ accessible. Unless outlined otherwise by statute, all court decisions can be ‘appealed’ to a higher court. Preliminary court proceedings and appeal courts can ‘enforce’ the conditions of publicity, appeals and the relevance of evidence. The courts also give extensive consideration to relevance, admission and weight of evidence. In fact, extensive rules of civil procedure, rules of criminal procedure, case law and academic discussion are available to guide the determination of what evidence is relevant.

Fifth, based on the quantitative data in this study, the A4R theory itself is a traditional but limited theory to analyse the procedural factors in this study of the Board - for several reasons. The main reason is that the A4R theory does not address key significant factors

³⁴⁵ In a criminal proceedings for first degree murder, for example, the court decision may not be agreed with but if the process for determining the decision is considered fair and transparent the decision will be accepted.

in decision making that are only evidenced through quantitative research. For example, according to Heise, traditional approaches of theory and doctrine are important, but they cannot identify issues and shed light on key issues that are more amenable to empirical research.³⁴⁶ For example, the A4R does not capture who is requesting the appeal, why the appeal is being requested, the influence of specific procedural factors on the Board's resource allocation decisions (Research Question #1) and the substantive arguments of the parties (Research Question #2) on the Board's decision. The use of empirical research is necessary to support theory and doctrine. Bok states that the development of good theories is difficult without the benefit of good data.³⁴⁷ Posner states that the lack of an empirical footing poses a threat to legal theory's persuasiveness and influence.³⁴⁸

Why is this empirical research important? It is important because it provides a more holistic understanding of what is taking place before the Board relative to the Board's decisions. The empirical research provides a holistic analysis that is essential to accurately support recommendations of what should ideally be the resource allocation decision making mechanism versus what currently is the resource allocation decision making mechanism.

This study identified many trends that were not evident from the A4R theory. Additionally, the empirical results of this study did not map easily onto the A4R theory. An attempt was made by the author to integrate the empirical research into the A4R

³⁴⁶ Heise, Supra Note 102 at 834.

³⁴⁷ Bok, Supra Note 112 at 581.

³⁴⁸ Posner, Supra Note 113 at 3.

theory. In this respect, the study's empirical results regarding the patient profile, and the procedures of the Board could be analyzed relative to the appeal condition of the A4R theory. The study's empirical results regarding the substantive arguments of the parties could be analyzed relative to the relevance condition. However, instead of attempting to force the research results into a limited theory, the author analyzed the results according to their original categories of patient profile, the procedures and the substantive arguments of the parties. The results, listed in detail in the previous chapter, are analyzed below:

Empirical Analysis:

Patient Profile Analysis

Why is data on the patients' age, sex, residence location, diagnosis, requested treatment, geographic treatment location and specific facility of importance to this thesis? This thesis critically examines what is currently taking place regarding the granting or denial of OCCNEIHS by the Board. While Chapter 2 outlines the larger context within which the Board operates in response to an appeal request - little is known about the party which activates the appeal process or why they are appealing a resource allocation decision.

To address this gap in information, patient data referred to in the decisions during the study period was coded and analyzed. Based on this analysis of patients' factors, several patterns and novel issues emerged. The first three factors – patient age, sex and residence – did not highlight any major patterns or novel issues. This lack of patterns or novel issues may be the result of under reported data within the decision. However, in the

analysis of the patients' diagnosis, requested treatment, requested location and facility for treatment, certain patterns and novel issues began to emerge.

Patient Age

Approximately 60% (58.7%) of the cases did not provide the age of the patient. This may be due to the development of privacy legislation at the provincial and national level that may have heightened the need to protect personal health information. Thus, the role of external legislation to the HIA may have influenced the data recorded within the decision. This lack of data makes any potential patterns or themes questionable.

Patient Sex

With approximately an even split between male and female requests, there does not appear to be a significant difference between the sexes in the ability to access the Board. The success rates of male versus female requests are beyond the scope of this thesis, but the data is available for statistical analysis.

Patient Residence

The residence of the patient coming before the Board may be a proxy indicator for political, cultural, philosophical and economic factors – which require further study.^{349 350}

³⁴⁹ Residence may be one proxy indicator of different geographic variations in OCCNEIHS diagnosis, referral patterns and 'access to health' philosophy by the medical profession. For example, it is difficult to say why patients in Southern and Western Ontario appeal most frequently to the Board. Southern Ontario may be geographically closer to the Board's oral hearings based in Toronto making access to the Board easier. The West is farther away from the Board than parts of Eastern Ontario, yet Western Ontario has almost double the rate of Eastern Ontario cases before the Board. The West may be tempted by health care services closely accessed in the United States relative to those available domestically and thus appealed to the Board for OHIP funding more frequently than the East. In terms of the East, it may be that the East is satisfied with their access to domestic health care services. It may also signal a barrier – such as a language

Patient Diagnosis

Unlike the under reporting of patient age, sex and residence, only 1% of patients did not know their diagnosis. This low percentage of unknown diagnosis would indicate that 99% of patients who knew their diagnosis had some form of contact with the health care system in order to receive a diagnosis. This raises an important issue of ‘who’ is assessing the patient and determining the patient’s diagnosis.

In terms of the actual diagnosis, the highest percentage of patients appealing to the Board have a collection of ‘Other’ conditions (21.6%),³⁵¹ with ‘Cancer’ (15.6%) ranking second. Of interest in this data is the high percentage of pain³⁵² cases. If one adds the Back Pain category (11.4%) with the General Pain category (7%), pain ranks second (18.7%) as the diagnosis for the patient wanting to go out of country for health care services – ahead of the category of cancer (15.6%).

‘Pain’ is an interesting category. Pain is often considered a patient’s subjective experience rather than an objective, quantifiable medical diagnosis by a physician. The high percentage of ‘pain’ cases reported coupled with the lack of objective, quantifiable

barrier - to accessing the Board. Further analysis and focus group or key informant surveys may distill this information.

³⁵⁰ The Board decisions did not reference the duration of residence or previous residence. For example, university students seeking OCCNEIHS may reside within a geographic area for the duration of their education while previously and in the future reside in a different geographic location. Such information is important to understand the history and culture.

³⁵¹ See Appendix G: Patient Profile – Diagnosis and Pain. Appendix G provides a list of the “Other” conditions which comprise the 21.6% of cases.

³⁵² It should be noted that while all categories may include pain – such as pain with cancer or pain with degenerative hips – pain was only ranked as a category if it was the primary health concern. Thus, cancer was not ranked in a pain category but rather in the ‘cancer’ category. Similarly, a painful degenerative hip was ranked in the ‘joints’ category rather than in the ‘pain’ category.

medical diagnosis by the physician may lead to a discrepancy between the patient and the physician regarding generally acceptable treatment and the urgency or delay in receiving the treatment. This possible correlation requires further research.

Patient Requested Treatment

Almost half of the out of country requests were for surgery (49.2%) followed by medical assessments (14%), treatment (13.3%), and diagnostic procedures such as an MRI, CTscan etc. (12.4%). The combination of categories dealing with counseling, drug treatment, (9.2%) of cases and only 1.9% of the requests dealt with transplants.³⁵³

It is interesting to note that the potentially most expensive health care services – surgery and transplants – occupy spots for both the most (surgery) and least (transplant) requested health care services. As will be discussed later, the Ontario judicial decisions dealing with transplants (for example, live liver transplant) provided some of the most detailed judicial direction at interpreting the legislative criteria of s.28.4(2). In other words, despite being the least requested service – less than 2% of all cases -- the transplant category has provided judicial interpretation guidance on s.28.4(2) for 98% of the other requested out of country cases.

Requested Location for Treatment

Country:

Based on the data, the current OCCNEIHS issue is clearly one of health care sought in the USA. While the numbers of non-USA out of country coverage requests are currently

³⁵³ See Table 1: Patients' Requested Procedure

very small, a preliminary review of the non-USA cases appears to indicate a ‘family of origin’ link. For example, a patient may request out of country coverage from OHIP for a medical procedure in China. The relatives in China may have arranged the Ontario patient’s visit to a Chinese specialist in China who subsequently conducts the medical procedure in China. The Ontario patient’s follow up home care may also be undertaken in China by Chinese relatives. In this respect, requests for out of country health care service may be based on family and or friend origin as well as factors such as the reputation of physicians/facilities/procedures, physical proximity, access to websites or peer networks, etc. – rather than based only on an Ontario physician’s determination of medical necessity.

Geographic Location and Treatment Requested

It appears that out of country cases under s.28.4(2) are predominately seeking American treatment (84%) with almost half of Ontario patients before the Board requesting treatment in the northern USA (44%) – specifically in Minnesota, Michigan and Ohio. Thus, as of 2003/04-2007/08, OHIP’s out of country program is based largely on requests for treatment in a few northern states. Overall, patients are requesting out of country surgery approximately half the time (49%) followed by Assessments (14%), Treatment (13%), Diagnostics (12%) and a Combination of medical care (9%). Organ transplants only represent 2% of cases.³⁵⁴

³⁵⁴ Again, caution must be used in interpreting the geographic location and treatment requested as these variables were not standardized across the case decisions or OHIP medical codes. Ideally the out of country locations for each treatment requested – standardized based on Ontario medical codes - should be cross tabulated with the Board’s granting or denying of OHIP funding. This data is available within the database constructed for this thesis and is an area for further research.

Patients know, very clearly, what their diagnosis is, what treatment they want and the facility they want to go for that treatment. In this respect, patients are not going to the State but to the health care facility within the State. Another way to look at the data is that patients are requesting different States for different treatment e.g. Mayo Clinic (Michigan) for assessments, the Cleveland Clinic (Ohio) for surgery, followed by the Detroit and Royal Oaks also for surgery. Of note is the highest request for surgery ('Other' category) where the facility was not stated in the Board's decision.

Conclusion - Patient Profile Analysis

The research revealed several patterns and novel issues with respect to diagnosis, treatment requested, and requested location of treatment. For example, 99% of patients knew their medical diagnosis, desired treatment and where the treatment was offered. Almost 50% of requests were for surgery. Patients are predominately seeking American treatment (84%) and requested different States and health facilities for different health services. Interestingly, pain was significantly reported as a reason for requesting OCCNEIHS. The analysis raises the question - who is determining the patients' medical diagnosis and treatment and according to what standard? This data may inform the type of expertise required to assess medical conditions, the quality, location and availability procedures and those procedures which are insured by OHIP.

The volume of locations and services requested by the patients implies that health care resources themselves are not scarce. Health care out of country appears to be plentiful.

Thus, it is questionable if the theory of ‘scarce health care resources’ is accurate for this situation. The scarcity appears to be the limitation on domestic public tax dollars to fund the out of country care. As such, the decision whether or not to publicly fund out of country health care may be more of a public policy decision than one of procedural fairness and medical necessity.

The specificity of the patients’ requests also implies that the patients had contact with an out of country medical system and/or had likely conducted some of their own research into their condition and treatment options and facilities – this research appears to have taken place through friends, family and/or the Internet – not necessarily through the medical profession in Ontario. This raises interesting questions regarding the role of the patient and the role of the patient’s medical professional(s) in the out of country treatment of the patient. The patient may be playing a greater role in determining their medical treatment than was previously assumed. However, the Ontario legislative criteria for out of country coverage appeared to be aimed – for the study period -- at the opinion of the medical profession in Ontario. If research regarding the medical facility, the treatment research and request for this treatment is conducted predominantly by the patient and not the physician, the evidence presented to the Board would likely be that of the patient and not the physician. The theory that physicians are determining the appropriate medical care for a patient and are assessing the delay in accessing this care may not be valid. Patients may be attempting to determine the medical care they are to receive and whether or not there is a delay in accessing this self determined care – either because of dissatisfaction with the medical professional, gaps within the medical system, the

increased use of technology such as the internet to access medical options and/or a development in our culture to think and access resources globally. If both the patient and physicians are independently determining medical care and assessing medical delay, the medical system has two sets of ‘gatekeepers’ – patients and physicians -- attempting to access publicly funded health care services.

Alternatively, if physicians are acting in a fiduciary role for their individual patient by supporting the patient’s request for out of country treatment, OHIP and then the Board are forced to take on a greater gate keeping non-fiduciary role in allocating resources. The fiduciary role and gate keeping role of the individual’s physicians are conflicting and require new theoretical discussions which are beyond the scope of this paper.

Ideally, the contextual patient factors would be cross referenced with the Board’s granting or denial of OHIP funding. Due to the exploratory nature of this research, it is recommended that this further study be undertaken.

Procedures Analysis

The A4R theory suggests that, in the absence of consensus, the procedure for making difficult resource allocation decisions is critical. According to the theory, parties that are unable to achieve consensus on substantive elements should accept the outcome if the procedure for determining the outcome is considered fair and legitimate. The following

analyses show the actual as opposed to the theoretical decision-making results.

Significant trends were found for the variables of legal representation, forum and administrative requirements.

Duration Appeal is at the Board:

It is important to note two facts about tribunals and procedure time. First, access to a tribunal and the resulting decision is commonly thought to be a faster process than access to the courts and the resulting decision. Second, unlike some tribunals, the Board is not required by statute or regulation to receive, hear and issue a decision within a specified time.

From the data, case Decisions in 2008 took significantly longer from Hearing Date to Decision Date. So, what happened in 2008 that made this significant difference in the number of days a case was within the system between the Hearing Date and the Decision Date? Among many possible explanations, three in particular come to mind.

First, in 2008, the leadership of the Board changed. The transition from the old Chair of the Tribunal to the new Chair of the Tribunal may have affected the timing of the review of the Decisions by the Chair and thus the release of Decisions.

Second, two Boards – the Health Services Appeal and Review Board (HSARB) and the Health Professions Appeal and Review Board (HPARB) were amalgamated and fell under the same Chairperson. Many of the members of one Board were then cross-

appointed to the other Board. This administrative procedure and new member learning curves may have influenced the release of Decisions. While the focus of Administrative Law is on the procedural fairness a Tribunal provided to the parties, it may be underestimated how important Tribunal internal processes are on procedural fairness in terms of the ability to conduct timely Hearings and release Decisions.

Third, several key s.28.4(2) cases were before the courts in mid 2008 – after the study period’s completion. The author speculates that Board’s Decisions regarding out of country coverage that were before the courts may have influenced the timing of the release of further Board Decisions e.g. the Board may have wished to wait for judicial guidance on s.28.4(2) cases before releasing its Board Decision.

Overall, this empirical study found that the results for one year – 2008 – cannot be generalized to all years. This is important because recommendations for an ideal decision making mechanism must examine data over time to accurately address issues. If only the data results from 2008 were used for example, the results would inaccurately reflect what has been taking place in the other four years.

Type of Hearing Relative to Disposition:

If a Hearing was oral, the application was granted significantly more times (77.4%) than expected (60.8%) but only for one year (2006). Again, this analysis points to the fact that significance cannot be generalized but rather one year – 2006 but not 2004 -- may be accounting for the importance of the oral hearing. This is important because any

procedural changes must accurately address issues not blips in the data that are generalized.

The importance of oral hearings in 2006 raises a number of interesting questions – was the increased number of Grants a function of the Year 2006, the cases themselves, the oral advocacy at the Hearing, the Panel deciding the case or other factors? The exploratory research nature of this project does not propose to answer the question but recognizes that further research needs to be done on the Year and influencing factors rather than just on type of Hearing.

Parties: Representation by Lawyer or Self-Represented

Statistical analysis of the data indicated that legal representation was significant for the patient relative to the grant of an Appeal. A number of issues come to mind regarding legal representation.

First, the presence of a lawyer representing the applicant/patient and arguing against an OHIP lawyer appears to lead to an increased chance of the appeal being granted in favor of the patient. It is unclear, based on the data, if it is the presence of a lawyer for the patient or the actual argument of the lawyer for the patient that results in a higher Grant rate. One might also speculate if a lawyer acts as an initial filter by only representing

cases before the Board which are considered “strong” cases which may result in a grant of resources.

Second, the legal representation by both parties may move the argument from the patient’s compelling circumstances argument and OHIP’s physician/medical argument to a more legal argument about the s.28.4(2) Test. Legal representation may not only affect how the arguments are delivered but also the relevancy of the evidence used to support the arguments. In this respect, legal representation may move the s.28.4(2) argument to become more of a legal argument rather than a focus on a medical opinion – in essence, changing the focus of the test based on the capacity and skill of the party – in this case the lawyer.

Third, the representation by both parties before the Board may indicate that the nature of the actual case is of legal significance.

Fourth, at s.28.4(2) Board Hearings, the patient was always arguing against OHIP. OHIP was typically not represented by a lawyer. OHIP was typically represented by the OHIP General Manager -- or his designate -- overseeing out of country applications. The General Manager or his designate is a physician. OHIP is consistently represented at all s.28.4(2) Hearings before the Board. While not ranking as representation by a lawyer, the OHIP representatives would have had successive experiences over the five year study period with s.28.4(2) which might give them a legal knowledge advantage over the patient who had no representation. In other words, the fact that OHIP was not represented

by a lawyer at the Hearings should not indicate they were not proficient in the legal arguments that may have been put forth by legal representation.

Fifth, OHIP appears to match or exceed the patient lawyer with an OHIP lawyer in all but 4 cases out of 315 cases – the 4 cases where the patient had a lawyer but OHIP did not. In a relatively small number of cases -- 14 cases -- OHIP had a lawyer and the patient did not. This low number needs to be taken in the context of the OHIP General Manager or his designate consistently arguing OHIP's case in 273 cases in front of the Board. Given the 273 cases argued by OHIP, it may no longer be accurate to say OHIP is unrepresented but instead has specialized knowledge.

Interpreter

The study found that Interpreters were seldom used in Hearings. Only 3 cases -- 1% of the time -- used Interpreters. One fundamental aspect of natural justice is the ability to understand the case being put forward. If a patient did not understand the procedural or substantive case being put forward there could be a significant denial of natural justice. An official Interpreter, in the language of the patient's choice, is arranged and provided in advance of the Hearing to the patient by the Board – free of charge. It is up to the patient to determine if an Interpreter is needed. Given the availability of these resources to address any financial and/or language barrier, it is interesting why more parties do not request an Interpreter. Parties in need of an Interpreter may either be unaware of this free service or those in need of an Interpreter are not coming forward with appeals to the

Board. More research needs to be done on this area as it represents a possible barrier to access justice.

Type of Appeal: Prior Approval, Reimbursement or Both

As with all administrative tribunals, the Board must operate within its statutory jurisdiction. The Board cannot decide on issues outside its jurisdiction. As of January 2009, the Divisional Court of the Ontario Superior Court, in the case of C.C.W. clarified the Board's jurisdiction. The Court determined that OHIP has no discretion to grant out of country coverage for cases that have not received prior approval from OHIP. Thus, OHIP can only grant prior approval for out of country coverage. The Board, as of January 2009, only hears cases that deal with Prior Approval for a health care service outside the country that have been denied by OHIP. Based on the court's direction, the Board does not have discretion to grant cases that request reimbursement without prior approval for a health care service outside the country. In other words, a case may fulfill the criteria s.28.4(2) but may then not be eligible for actual funding because Prior Approval from OHIP according to s.28.4(5) was not received. It is important to note that this Prior Approval requirement under s.28.4(5) always existed in the regulation. However, the enforcement of this regulation did not come into prominence until the later Decisions in the study period. Thus the extent of enforcement of an existing legislated provision was a key factor.

The time frame for this study was before the Ontario Court of Appeal's ruling of January 2009 on Prior Approval. This study of the Board's Decisions therefore analyzed cases that had Prior Approval and those that did not.

Early study period cases made little reference to s.28.4(5) criteria or the lack of discretion OHIP had to approve out of country coverage health care service if the Patient's request came in after the Patient had received out of country treatment. The author observed that there was a gradual tightening up of s.28.4(5) criteria such that it became more of an issue in the written Decisions as the years progressed. In essence, the one part test of s.28.4(2) – a determination if the health care service was insured by OHIP -- has evolved into a two part test which included not only the medical assessment of s.28.4(2) but also the administrative assessment of s.28.4(5) – the requirement for prior approval. This two part test for out of country coverage – s.28.4(2) and s.28.4(5) -- represents a key shift in focus. Instead of the s.28.4(2) criteria of ‘medically necessary, based on medical opinion, an out of country health care service was being denied on administrative basis – requiring Prior Approval under s.28.4(5). Where initially the focus was on determining if a health care service was an “insured service”, now a grant of out of country coverage under s.28.4(2) may be denied if the patient did not request administrative approval before accessing the health care service under s.28.4(5).

In terms of analysis, the author speculates that there may have been an influx of applications to OHIP where patients had researched and accessed the out of country treatment on their own without physician assistance or even approval. Physicians may

also have abdicated their referral role to patients because they didn't have the time, networks and/or the technology to seek out of country services or to assess the availability of domestic services. In terms of health care costs, it may have been easier for the government and the courts to tighten up an administrative regulatory process rather than to tighten up the medical opinion process. It is also important to note that most privately funded health care plans also require Prior Approval for the funding of non-emergency procedures. In this respect, the tightening up of s.28.4(5) to require Prior Approval was in line with the private health care insurance plans.

It is of interest, but beyond the scope of this current study, to analyze the number of cases granted approval as OHIP insured services under s.28.4(2) but ultimately denied for not receiving Prior Approval as required in the legislation s.28.4(5).³⁵⁵

Review Requests

This ‘Review’ request is a form of a second appeal to the Board. Given that only one Review was requested during the five year study, it is assumed by the author that parties either take the decision of the Board as the final decision on the matter or proceed to judicial review of the matter through Divisional Court. Alternatively, it is speculated by the author that, having been denied by the Board, the patient will then access their private

³⁵⁵ A further analysis was undertaken of the 17 Prior Approval-Reimbursement cases which the Board had granted thus overturning OHIP’s Decision. The majority of the Decisions for the 17 cases took place in 2006 (n=9) and 2007 (n=6). This is interesting because although the Divisional Court clarified the Prior Approval-Reimbursement issue under s.28.4(5) in its 2009 ruling, the three combined cases before the Court in 2009 received Decisions from the Board in 2006 and 2007. The Board in those three cases ruled that only prior approved health care service would receive OHIP funding. Yet at the same time there appears to be Prior Approval-Reimbursement cases also being granted by the Board. Hence, the Board was not consistent with its application of the legislation and judicial interpretation was sought.

insurance coverage once they have, at the request of the insurer, attempted to have the health care service paid for by government public insurance rather private insurance. If this is correct, corporations – such as the private health insurance companies -- are using the Board as a screening method for out of country coverage.

Conclusion – Procedures

Research Question #1:

Do procedures statistically affect resource allocation decisions of the Board?

If so, what elements of the procedures create this statistical effect?

Answer

Yes, procedures statistically affect resource allocation decisions. There is a statistical correlation between certain Board procedures and Board decisions. The elements of the type of Hearing (oral, written, teleconference), legal representation, and the enforcement of previously unenforced legislation create this statistical effect.

The assumption of the procedural theory of A4R is that people will accept a substantive outcome if the procedure to determine the substantive outcome is considered fair. This research identifies that at the Board the procedure itself can influence the outcome. It is difficult to say if individuals would accept a substantive outcome if they understood the significant influence procedure had on the outcome. In essence, procedure is not neutral. If procedures are not neutral they may not be considered fair. If procedures are not considered fair, the substantive outcome may not be acceptable. On the other hand, it

may not be humanly possible for a tribunal to create a ‘fair’ procedure – only to approximate ‘fairness’. For example, a tribunal may in good faith attempt to facilitate access to a hearing by making the hearing forum available to those who cannot appear before the Board in person. In this respect, hearings may be available by teleconference, via written submissions or a combination of forums.

Of interest is the tightening up of the interpretation of regulatory criteria during the study period such that the emphasis on compliance was not just the medically focused s.28.4(2) test but also the administrative requirement s.28.4(5) test – moving the test from a one part test to a two part test. It is interesting to note that the s.28.4(5) requirement for prior approval is an administrative requirement not a medical requirement. Thus, a patient may meet the medical criteria for out of country coverage but not meet the defining criteria of prior approval for the out of country coverage. In essence, the one part test for OCCNEIHS has moved from a medical necessity determination by physicians (s.28.4(2)) to a two part test that now includes administrative requirement (s.28.4(2) plus s.28.4(5)).

The statistical relationships, it must be stressed, were correlations not causation relationship.³⁵⁶ In other words, the study cannot report that having legal representation at the hearing caused the Board to significantly grant insurance coverage for out of country health services. The study can only say that there was a correlation between the factors. As a correlation, the factors must be more closely examined in order to determine the

³⁵⁶ For example, cases that had legal representation at the hearing were more likely to receive their requested resource allocation from the tribunal irrespective of the submissions of the parties before the decision maker

meaning behind this result. It is highly recommended that further qualitative research be undertaken to further explore the correlations.

Substantive Argument Analysis

Phase I – Overview of Arguments

Screening Test: s.24(1)17 - ‘Experimental Treatment’ Analysis

According to the legislation, if a treatment is determined by the Board to be experimental it is automatically not funded by OHIP. It is therefore surprising that 4.8 % (approximately 5%) of patients argued that their requested treatment was experimental -- in essence, sealing their fate as there is no chance of OHIP funding.³⁵⁷ It is likely that the patient did not understand the legislation and/or that the jurisdiction of the Board does not allow the funding for a treatment that is determined to be experimental. If a patient had representation by a lawyer, the lawyer should have advised the patient of the inability of the Board to fund ‘experimental’ procedures. Even if the patient was self represented, the pre-Hearing conference (PHC) should identify if the patient plans to argue that the treatment is experimental and thus beyond the jurisdiction of the Hearing.

Test Element #1 - s.28.4(2)(a)

‘Generally Accepted in Ontario as Appropriate for a Person in the Same Medical Circumstances as the Insured Person’

³⁵⁷ It is possible that a treatment was experimental at the time of the patient’s request to OHIP but it is no longer the case at the time of the Board Hearing. In such a scenario, it would be questionable if OHIP would not have tried to settle the case before it appeared before the Board. However, the patients’ argument was coded at the time of the Hearing making it unlikely that the health care service was not currently experimental

This element of the s.28.4(2) test – whether the out of country treatment is generally accepted as appropriate for the particular patient (GA) -- is of critical importance. If an out of country procedure is not considered generally acceptable for the patient, the s.28.4(2) test stops here. The legislation will not fund a patient’s procedure that medical professionals have determined not to be appropriate for the given patient. The patient who fails on this element of the test will not be eligible for consideration under the identical/ equivalent or delay elements of the test.

Automatic Denial:

It is unclear why approximately 5% of patients would argue that the requested procedure is not generally accepted as appropriate.³⁵⁸ Several thoughts come to mind upon reviewing this result. First, the patient may not understand that he/she will not receive funding for a requested procedure if they argue the procedure is not appropriate for their condition. This misunderstanding should be clarified at the Pre Hearing Conference.³⁵⁹ The fact that it is not clarified prior to the Hearing leads one to question the

³⁵⁸ It is not possible, from the written Decisions, to know if the patient had a disagreement one or more physicians as to the appropriateness of the treatment but chose not to present this medical opinion at the Hearing.

³⁵⁹ Pre Hearing Conference Screen
Pre Hearing Conferences are held prior to the Hearing so that the parties – the patient and OHIP – can assess each other’s arguments as well as allowing for any questions or assumptions to be clarified. Because Pre Hearing Conference information is not available to the Board Panel for the Hearing and is not contained within the written Decision, it is unclear if the discrepancy within Team Patient was evident at the time of the Pre Hearing Conference. This area – the Pre Hearing Conference – needs to be further investigated to determine if Team Patient discrepancies are evident at this stage of the process and need to be addressed before proceeding to the Hearing stage.

successfulness of the Pre Hearing Conference as a means of screening cases for compliance with the Board's jurisdiction. Second, the Pre Hearing Conference may accurately communicate the Board's jurisdiction but the patient may choose to make a policy argument that the treatment should be covered by OHIP. Again, policy arguments such as this are outside the jurisdiction of the Board. Third, the patient may present a medical opinion – that the treatment is not appropriate – but the patient may be in disagreement with that medical opinion.³⁶⁰

OCCNEIHS Sought but Not for an Ontario Delay:

An interesting issue arises here – and again in the ‘discrepancies in team patient’ section - patients may not be requesting to go out of country solely for ‘delay’ reasons. Patients may be requesting out of country treatment because Ontario physicians do not deem the treatment appropriate for the patient. For example, the patient argues the treatment is generally accepted 81% of the time while OHIP agrees that the treatment is generally accepted 49% of the time. This 30% difference is a significant difference of opinion between the patient and OHIP. This is an interesting finding because the popular belief is that patients are going out of country for treatment because of domestic delay when, in reality, patients may be seeking treatment that is not medically considered by Ontario physicians as being appropriate for them.

Lay Board versus OHIP Medical Expertise

³⁶⁰ The patient may also present a medical opinion from a physician from an out of country institution indicating the treatment is medically necessary thus countering the Ontario physician’s opinion.

The lay Board is overturning medical expertise of OHIP's Decision in 19% (68% Board - 49% OHIP=19%) in favor of the patient. If OHIP has medical expertise to assess if an OCCNEIHS is or is not generally accepted by physicians in Ontario as being appropriate for the patient and the Board is a lay panel without this expertise, the 19% overruling must be based on the quality of the parties' medical evidence coming before the Board and/or its interpretation of that medical evidence.³⁶¹

Test Element #2 – s.28.4(2)(b)(i)

'Treatment that is Not Performed in Ontario by an Identical or Equivalent Procedure'

There is a significant difference between the patient (30%) and OHIP (5%) whether the treatment is not available in Ontario. This may be due to the nature of the test (proving a negative) and/or the fact the treatment is available in Ontario but not available for the specific patient.

Evidentiary Difficulty:

In this element of the test, the patient must prove a negative – that the identical/equivalent treatment is NOT performed in Ontario. It is unclear how the patient is to know and thus to prove that a treatment is NOT performed in Ontario. This element is very difficult to prove if there is no access to a centralized database.³⁶² For example, OHIP appears to

³⁶¹ – given that the Board's jurisdiction does not allow for financial, compassionate grounds or Charter claims.

³⁶² If the patient must rely on the doctor for treatment or for a referral, the doctor may or may not have the knowledge or the network to know where – if at all – the treatment is performed in Ontario. It is unrealistic – with the current technology available to general practitioners – to expect a practitioner to know what treatments are available throughout the province of Ontario. The practitioner, in acting in the interest of the patient and with the limited resources of time and technology, may state that there is – to the practitioner's knowledge – no identical or equivalent treatment in Ontario. From the cases reviewed, it was unclear what

have OHIP billing records that substantiate that a treatment is performed in Ontario.

However, in 29% of cases, OHIP does not state a position whether the treatment is identical/equivalent in Ontario. Given the OHIP billing records, OHIP should have an idea if the treatment is performed in Ontario -- as they are paying for the treatment.

The difficulty proving this element of the test may cause patients to rely on the alternate criteria of domestic ‘delay’ as the reason for requesting GA out of country coverage.

Available – but not for the Patient:

Even if an identical or equivalent treatment is performed in Ontario, the physicians at the treatment location may override the general practitioner or specialist’s referral and state they will not perform the treatment on the given patient – perhaps because they do not do enough of the procedure to keep up their skill, they consider the patient too risky for the procedure or they consider another out of country location a better option for the patient.

In all cases, the treatment would be available in Ontario and generally acceptable as appropriate for the patient – but just not available to the patient.³⁶³ Again, the patient may

evidence could be used by the patient to substantiate the argument that there was no identical/equivalent performed in Ontario i.e. was evidence based on the number of attempts to determine if an identical/equivalent existed – or – the actual total number of treatment services offered.

³⁶³ An interesting question arises whether an identical/equivalent treatment performed in Ontario that is privately insured qualifies as an identical/equivalent treatment performed in Ontario for OHIP’s out of country purposes. The understanding may have been that only OHIP treatment is considered. This is not clear from the legislation and there has been no judicial direction from the courts on this matter. OHIP has argued that non-OHIP treatment in the private sector qualifies as an identical/equivalent treatment performed in Ontario.³⁶³ The Board disagrees with this position taken by OHIP and has ruled that only OHIP identical/equivalent treatment qualifies as identical/equivalent treatment.

have difficulty proving this element of the test and choose to rely on the alternate criteria of domestic ‘delay’ as a reason for requesting out of country coverage.

Test Element #3 – s.28.4(2)(b)(ii)

‘Treatment is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage’

Significant Differences:

It is interesting to note that approximately half the time, delay is not argued by the patient – 59.7% do not argue a delay would cause death, 44.8% do not argue that a delay would cause MSITD. When the patient does argue delay, a delay causing death (25.7%) and/or a delay causing MSITD (45.1%) significantly differs from OHIP’s agreement that a delay would cause death (0.3%) and/or MSITD (1.0%). Clearly, OHIP and the patient are not in agreement over the question of a “delay”. This may point to a difference in expectations as to the amount of time that constitutes a “delay”.

How Delay is Measured:

The difference in expectation as to what constitutes ‘delay’ may be a function of how delay is measured. For example, the test for ‘delay’ is a prospective assessment of the

This element of the test also raises the question whether ‘identical’ treatment is the same as ‘equivalent’ treatment. It also raises the question who determines if the given treatment is ‘identical’ and/or ‘equivalent’? Currently, it appears to be the patient arguing against OHIP. It is also unclear when a treatment no longer is deemed ‘identical’ or even ‘equivalent’. For example, in a treatment for tumor removal, the medical procedure for tumor removal may be via traditional surgery or traditional surgery using a different surgical technique. In this example, is the tumor removal the identical? Is it equivalent? Or is it the technique to remove the tumor? Currently, it is the lay panel of the Board that must determine, based on the evidence presented by the patient and by OHIP, whether the treatment is identical or equivalent.

impact of delay on the patient's health. This would be particularly difficult if a health problem – such as chronic pain – was diagnosed based on a subjective report or if a health condition had a little known etiology – such as in the case of rare diseases.

The data also raises the question ‘when does the delay start’? Where delay is reported, it appears to occur at the level of getting an appointment with an Ontario specialist and getting an Ontario surgery appointment. However, the Ontario Wait Time Strategy lists wait times from the time the specialist recommends a treatment i.e. surgery. The wait time does not include the time the patient incurs waiting to see his/her GP, to get diagnostics for the GP, to get a referral from the GP for an appointment with a SP, to wait for the appointment with the SP, to meet with the SP, to have diagnostics done for the SP – all of which may be months to years – before the SP determines the treatment is required, or not. This additional time may be what the patient refers to as ‘delay’ rather than just the delay experienced on the waitlist for treatment. The patient, OHIP and the Board may be operating on different definitions of ‘delay’. In essence, there may be at least two types of delay – one delay as defined by medical professionals in the Wait Time Strategy and another delay based on the experience and expectations of the patient.

Phase II: Discrepancies within Team Patient

Team Patient discrepancies in Years 1 through 5 were not coded initially for one main reason -- the author made the assumption in designing this research study and code book that if the patient appeared before the Board then there would be a medical necessity determined by a physician. In this respect, it was assumed that there were no

discrepancies within Team Patient. In other words, the patients and the physicians were in agreement regarding the criteria for s.28.4(2). It became clear, while analyzing the cases, that this was not the case. By Year 5 cases, the author was attuned to these discrepancies. The voided assumption of ‘no Team Patient discrepancies’ led to the development of a more detailed coding system for Year 5 patient arguments.

The rate of discrepancies within Team Patient – between patients and their own physicians -- is remarkable because the legislative grounds for granting out of country coverage are based on medical opinion for medically necessary services. The discrepancies had an effect on the Board’s granting of out of country coverage in that the Board appears to grant primarily in favour of the medical opinion. Although this is preliminary exploratory data, the difference of patterns warrants more investigation beyond this study.

Conclusion:

A key finding of this research is the Board’s five year study denial rate of 80%. However, this means that in 20% of the decisions the lay Board overruled the medical expertise of OHIP. This raises the question -- what element or elements of the s.28.4(2) test caused the Board to overrule OHIP’s decision?

Research Question #2:

What substantive arguments affect resource allocation decisions made by the Board?

Answer

All substantive arguments are correlated resource allocation decisions but most clearly when there was a discrepancy between patients and their own physicians. For example, the research found a significant number of discrepancies within Team Patient at all levels of the s.28.4(2) Test. The patients were, in essence, seeking out of country treatment when it was not medically approved by their own physicians. When there was a discrepancy within Team Patient, the Board appears to side with the medical opinion.

It is important to note that the appearance of a pattern of ‘discrepancies’ between the patient and his/her doctors regarding treatment out of country may be signaling a challenge to medical opinion as the gatekeeper to medical resources. Patients now have multiple sources of medical information and social networks to assist them in determining medical options. This discrepancy within team patient may reflect a significant change in the doctor-patient relationship.

Discrepancies within Team Patient may also be evidence of an indirect method of health care resource allocation. For example, if a physician does not consider a medical procedure to be GA for the patient, the physician may state that the procedure is not immediately available – as it is not immediately required medically for the patient. This may be interpreted by the patient as a ‘delay’. In another example, the patient’s physician may actually state to the patient that the treatment requested is not GA but the patient still wishes to proceed. In this respect, the patient and the patient’s physician disagree on GA but the patient still requests OCCNEIHS from OHIP.

Three other trends are worth noting. First, across all study years, the patient only argued ‘delay’ approximately 50% of the time. However, patients did argue GA over 80% of the time. This may indicate patients are requesting OCCNEIHS for treatment not considered GA in Ontario rather than solely for the popular belief that OCCNEIHS are sought because of delay in accessing Ontario care.

Second, patients clearly see “delay” differently than OHIP or the Board. There appears to be at least two perspectives on ‘delay’ – one delay time considered by medical professionals and one delay time considered by the patient.

Third, there is a complete absence in the decisions of economic discussions, cost-benefit analysis, official medical and political consensus regarding OCCNEIHS that are covered by OHIP, regulations specific to OCCNEIHS, or algorithms to calculate coverage.

It is important to note that there was no requirement under s.28.4(2) or s.28.4(5) or anywhere else in the legislative scheme that required evidence to be presented regarding the financial costs of the OCCNEIHS. It is understandable, therefore, that the Board would not require evidence regarding the financial cost of the OCCNEIHS or make reference to financial costs in Board decisions. No submissions regarding financial costs were presented by the parties. There was no indication that the Board considered – either implicitly or explicitly – the cost of the OCCNEIHS. The cost per patient or the cost to society was not discussed as an element in the resource allocation decision making.

Overall Conclusion

This chapter reviewed the academic discussion regarding the lack of empirical research in legal analysis – specifically in terms of tribunal decisions. The lack of Canadian empirical research relative to the overabundance of theories reflected the author’s research experience. This chapter also reviewed the A4R theory regarding the process of making resource allocation decisions. The author analyzed each of the four conditions of transparency - publicity, appeals, enforcement and relevance - relative to the study data and found that the four conditions were present but were not ‘fine grain’ enough to identify procedural factors which statistically influenced Board decisions. The author concluded that the A4R theory does not represent the complexity of the tribunal resource allocation decision making in terms of the influence of a tribunal’s procedures. For this analyses, empirical research was needed.

The empirical data of tribunal decisions was analyzed to determine if correlations and trends could be established. The data was analyzed relative to the categories of patient profiles, procedures and substantive argument. This was done in order to accurately determine what was currently taking place and what an ideal resource allocation decision making mechanism should entail. The empirical results found numerous correlations and trends that were not identified by the A4R theory.

In term of a Patient Profile, the analysis revealed patients know what diagnosis they have and are requesting specific facilities for specific treatment. Overall, Ontario’s OCCNEIHS issue is largely based on patients requesting surgery in northeastern USA.

Of interest was the large number of ‘pain’ cases. Why is this important? Pain, unlike many other health conditions, is very subjective. It is not easily diagnosed by, for example, MRIs or blood tests. There may be a connection – while beyond the scope of this thesis – between a patient’s subjective experience of pain and their attempt to seek treatment which often is at odds with the approval of that treatment by their own Ontario physician.

In terms of Procedures, the analysis revealed a correlation between legal representation and the resource allocation of OCCNEIHS in the Board’s decisions. As discussed earlier, oral hearings and delays between hearing date and decision release were found to be significant – but only for one year – 2006 and 2008 respectively. While the empirical results highlighted trends – such as the influence of legal representation – it also highlighted that there was no data to analyse regarding cost considerations.

In terms of Substantive Arguments of the parties before the Board, the empirical research highlighted a number of interesting issues including:

- a number of experimental and unnecessary medical cases that did not fall within the Board’s jurisdiction;
- patients – rather than solely physicians - played a significant role in determining OCCNEIHS;
- administrative requirements, such as prior approval, could overrule treatment that qualified under medical requirements;

- counter to public perception, more patients were arguing that a OCCNEIHS was GA rather than arguing that there was a Delay to access that treatment;
- patients appear to be defining one of the legislative criteria – delay – differently than the medical authorities.

The empirical research also identified the lack of reference to economic factors when determining resource allocation. This lack of reference to economic factors included: the absence of cost-benefit analysis of treatment and non-treatment. There was also a lack of reference to medical expert consensus on approved treatment and treatment protocols or to multi-disciplinary panels of experts to assess ethical/medical/fiscal issues. There was also no reference to a separate regulation that specifically dealt with OCCNEIHS or an alternate forum to the Board where patients could bring their concerns about the health care system in general. Given that these factors – economic factors, expert consensus on approved treatment, treatment protocols, multi-disciplinary panels of experts, separate regulations or alternate forums for patient concerns – were not the HIA or in Regulation 552, it is not surprising that they were not included in the Board's decisions.

Chapter 11

WHAT IT SHOULD BE

Research Question #3:

The Revised Resource Allocation Decision Making Mechanism

A revised resource allocation decision making mechanism may mean different things to different people. For this thesis, a revised decision making mechanism would be based on empirical data, expert consensus on multiple relevant factors and would involve a clear process that produced decisions that are acceptable to the parties affected and society in general.

In order to develop a revised resource allocation decision making mechanism, it was necessary to assess what system currently existed. The previous chapters examined procedural and substantive resource allocation theories, analyzed the current resource allocation decision making mechanism of HSARB relative to the A4R theory, and reviewed the academic discussion regarding the need for empirical legal research. It also analyzed the existing qualitative and quantitative empirical studies. While the scholarship indicated that resource allocation decision making was difficult, it did not provide guidance or analysis of the interaction between procedures, substantive arguments guidance and resource allocation decisions. The scholarship did not propose a revised resource allocation mechanism.

A4R

The scholarship did present several theories for determining acceptable resource allocations. This thesis focused on one of these theories - the A4R theory. The assumption behind the A4R theory is that due to a lack of consensus on substantive distribution principles, a fair, transparent resource allocation process is necessary in order to create the acceptance of a resource allocation decision. This author analyzed each of the A4R theory's four conditions relative to the study results and found that the four conditions were present but did not identify several factors identified by the empirical data results of this study. If the A4R theory did not capture these complexities of the Board's decision making process, the A4R would not accurately inform Question #3 – What should a revised resource allocation decision making mechanism entail?

Empirical Research

As a result, this author undertook an empirical analysis of current activities taking place at HSARB hearings – as documented in Board decisions - in order to accurately identify what procedural and substantive factors currently influenced Board decisions. Based on this analysis, factors were identified that should and should not be added to a revised resource allocation decision making mechanism. The current HSARB system was analyzed with respect to: what patients were coming before the Board and why and what the Board's procedures were in an attempt to create a neutral, fair proceeding which focused on the substantive arguments, as well as the substantive arguments put forth by the parties. The Board's procedures and the parties' substantive arguments were analyzed relative to the Board's decision to grant or deny resources. The analysis of these factors – the patient profile, the Board's procedures and the actual substantive arguments of the

parties. This impact of these factors on Board decisions what analyzed. This analysis informed the following proposed resource allocation decision making mechanism.

Patient Profile

The empirical analysis revealed that patients knew their diagnosis and were requesting specific facilities for specific treatment. These results indicate that the patients were very motivated and had undertaken extensive research not only of their own diagnoses but also of the services available to address their diagnosis.

Importance of Patient Input

Instead of assuming that patients are subverting physicians as the assessor of medical necessity by inserting the patient's own opinion of appropriate medical necessity, patients need to be included in the determination of OCCNEIHS. Their expectations, experiences and their attempts to problem solve difficult health care situations are, in effect, an invaluable evaluation of the system. Ideally, patients are not only able to provide insights into the existing system but they are also well positioned to contribute 'bottom up' solutions. In this respect, the experiences, formal and informal networks, information sources, research and ideas of patients needs to be more closely examined and incorporated into a revised resource allocation decision making mechanism. A revised resource allocation decision mechanism therefore includes the patient's diagnosis, experience attempting to attain the required health service, the type of treatment sought and its location, patient expectations and information sources, insights, and proposed 'bottom up' solutions.

Importance of Specialized Medical Expertise Relative to Diagnosis

Of particular interest arising from the empirical analysis of patient diagnosis was the large percentage of patients experiencing pain and seeking OCCNEIHS. Pain is a subjective medical experience which may not lend itself to objective diagnosis by physicians. The issue of pain may be signaling that not all medical conditions are suitable for traditional objective physician medical necessity assessment. Future research should analyse whether patients with difficult to diagnose medical conditions – such as pain – are significantly more likely to apply for OCCNEIHS. If this is the case, there will need to be policy discussions regarding subjective/difficult to diagnose medical conditions, the current domestic system and OCCNEIHS. In terms of a revised resource allocation decision mechanism, specialized expertise should be included in the area of highly prevalent subjective medical conditions such as pain.

Procedures

Importance of Time Series Empirical Research

The empirical research undertaken for this study identified that specific procedural factors had a significant effect on the Board's resource allocation decisions. For example, across all years, the presence of legal representation was correlated with positive resource allocation decisions. The empirical research also identified certain year-specific variations in the data, such as the significant effect of oral hearings on resource allocation decisions – but for only one year. These two trends – legal influence over all years and oral format influence for one year – point to the need to undertake time series empirical

research in order to correctly assess what is currently taking place and what ideally should take place. For example, if the research only examined the year and found that oral formats influenced decisions, the research might conclude that oral formats always influenced decisions. This would be incorrect and misleading. Only an empirical time series would identify ongoing versus time limited trends. Thus, a revised resource allocation decision mechanism must include a time series of data in order to correctly identify trends.

Elimination of Non Neutral Procedural Factors

The fact that the empirical results indicated that procedures were not neutral changes any assumptions and theories. For example, the A4R theory, as it currently stands, states that if agreement cannot be reached on substantive distribution principles, people are more likely to accept a substantive distribution decision if the process is considered fair. In other words, according to the theory, it is the substantive argument that influences the resource allocation decision, not the process. However, if the Board's procedures are not considered neutral with respect to legal representation such that it is disadvantaging non-represented parties, would the decision still be accepted? If the procedures of the Board are not neutral but could affect the resource allocation decision, it is questionable if such procedures should be required at all. Possibly not. The challenge would be to create a revised resource allocation decision making mechanism that decreased or eliminated the influence of procedural factors while still attempting to ensure the procedures were fair and neutral. The resource allocation mechanism would ideally depend on factors available to all current and potential parties. Thus, a revised resource allocation

mechanism would eliminate the influence of procedures on decision outcomes and ensure that all information was available to the parties.

It is important to note that the research not only identified trends in the present data but also identified that certain factors were not present. These missing factors included: the lack of a separate regulation that specifically dealt with OCCNEIHS and the lack of discussion of economic factors such as the cost and the cost-benefit of OCCNEIHS.

Separate OCCNEIHS Regulation

A revised resource allocation decision making mechanism should have a separate and specific regulation regarding OCCNEIHS within the HIA. Within the regulation, key definitions, the criteria to apply to OHIP for an OCCNEIHS, the criteria to appeal an OHIP decision to HSARB, the jurisdiction of HSARB and the factors which HSARB uses to assess an OHIP decision should be clearly outlined. Such an OCCNEIHS regulation should clarify the role of HSARB and patients' expectations.

Further Stratification of “Delay”

One of the issues, discussed in this thesis, is the concept of ‘delay’ and the difference in the understanding of this term. This difference of understanding can lead to conflicting expectations. For example, patients are defining the ‘delay’ accessing treatment significantly differently than OHIP or medical experts. Patients begin to experience ‘delay’ from the time they have an appointment with their family doctor. OHIP may define “delay” as the time between a specialist’s recommendation for treatment and the

actual delivery of treatment. The gap – the time between seeing a family doctor and the actual treatment versus confirmation by a specialist that treatment will proceed and the actual treatment – may result in appeals before the Board. Thus, the clarification of terms and expectations via a separate OCCNEIHS regulation should address this discrepancy and potentially decrease the number of appeals before the Board.

Economic Factors

If a revised resource allocation decision making mechanism must consider whether or not public funds should be allocated to an OCCNEIHS, it should consider economic factors related to this OCCNEIHS. For example, there is no discussion in the data or the regulation regarding the cost of a particular treatment, the cost of the OCCNEIHS relative to the domestic equivalent treatment or an economic benefit of such a treatment. Thus, a revised resource allocation decision making mechanism that determines the allocation of public funds should consider the cost and benefit economic factors related to the OCCNEIHS and how these factors are evaluated, not just the medical necessity of the OCCNEIHS.

Substantive

The empirical research highlighted a number of interesting substantive issues including: the number of experimental and unnecessary medical cases that did not fall within the Board's jurisdiction but were not screened out before the hearing process; the increasing role of patients and administrative requirements in determining OCCNEIHS; the definition of 'delay' – as discussed earlier -was significantly different between patients

and OHIP; and more patients were requesting OCCNEIHS because they felt the treatment was generally acceptable for their situation rather than because there was a delay accessing the treatment domestically. A revised resource allocation decision making mechanism would screen out appeals that did not fall within the jurisdiction of the Board. For example, cases where both the patient and OHIP agreed that the OCCNEIHS was not appropriate for the given patient would not proceed to appeal. The administrative requirements – such as the requirement to receive prior approval from OHIP before receiving an OCCNEIHS – would, as discussed earlier, be clearly established. Including the increased role of the patient, as discussed earlier, is an essential evaluation tool of the current system. A revised system would also clearly establish how and who determined the medical necessity of OCCNEIHS. Currently, there appears to be some confusion whether the patient, the general practitioner, the specialist, an out of country physician or some combination of these individuals, determines if an OCCNEIHS is required. A revised resource allocation decision making mechanism would continue to include the actual patient diagnosis by an Ontario physician, but would require that the actual diagnosis be mapped to the official treatment consensus statements of medical experts in order to determine the required medical treatment.

It is important to highlight three essential factors that should be taken into account in a revised resource allocation decision making mechanism: political uncertainties, variations in medical consensus over time and unforeseen circumstances. For example, a newly elected provincial political party may have a different perspective on the extent of OCCNEIHS provided. Medical technology may evolve for a particular medical condition

such that a disease like cancer would no longer require surgery but be treated by generic drugs. This development in the medical technology would influence the medical consensus on treatment. Unforeseen circumstances, such as social unrest or natural disasters, may divert expertise and funding away from a revised OCCNEIHS mechanism. Each of these factors would need to be continually updated.

Computer Assisted Algorithm as a Decision Making Mechanism

It is unrealistic to assume that the current lay Board has the expertise in multiple relevant considerations – such as medical, administrative, economic and political factors. Each of these factors requires a significant level of expertise and the field of expertise has its own internal challenge in achieving consensus. A revised resource allocation decision making mechanism would use the expert consensus on each factor rather than trying to establish consensus about the factor. Given that expert consensus evolves over time, the resource allocation decision making mechanism would be a ‘living tree’ based on criteria and consensus information available at the time of decision making.

Given the potential extensive developments within each factor, the multitude of factors and potential variations, uncertainties and interactive complexities, it is recommended by this author that a revised resource allocation decision making algorithm be developed and utilized to allocate resources. The algorithm should include the following variables with respect to the OCCNEIHS: screen out any factors which do not fall within the jurisdiction of the Board, physicians diagnosis of the patient in question, expert consensus on medical treatment for a given diagnosis, the OCCNEIHS administrative requirement in order to

qualify for OCCNEIHS review, the cost-benefit analysis of OCCNEIHS treatment, fiscal budget for the given time period, patient feedback including their experience, insight and ideas regarding potential solutions as well as political issues and/or uncertainties. All of these factors would vary over time as unforeseen circumstances arose and factors developed. The complexity of this algorithm would require computer assistance for continually updating each factor. In this respect, one decision making body is not required to have expertise in all areas that may influence the resource allocation decision. Rather, the combined expertise of multiple factors would influence the resource allocation decision.

This expert consensus and the algorithm itself would be made available to health care professionals and the public. In this respect, interested parties could assess the probability of being granted resource allocation. Individual patients and their doctors could request that OHIP apply and provide reasons why the algorithm resulted in the approval or denial of an OCCNEIHS. Algorithm denials could be appealed to HSARB.

Jurisdiction of HSARB

One of the key issues of this study was the jurisdiction of HSARB. The study identified – as part of Question #1 – that the Board's procedures were inadvertently not neutral and may, in and of themselves, have affected the Board's decision. This was true of legal versus non legal representation. The study also identified that, for a certain year, an oral hearing format significantly influenced the Board's decision. To avoid these inadvertent influences, this author recommends that the jurisdiction of HSARB change. HSARB

would no longer be required to hear de novo evidence from lawyers or non-lawyers in an oral format. Rather, HSARB would review whether OHIP had utilized the algorithm, discussed above, in making their decision to grant or deny an OCCNEIHS. The lay HSARB Board would be well positioned to review OHIP's compliance with the algorithm, while not being required to have expertise in any of the algorithm factors.

CHAPTER 12

Conclusion

Our current understanding of tribunal resource allocation decision making has been through the analysis of judicial review of tribunal decisions and/or the capacity, independence and appointment process of tribunal members. This analysis of tribunals provides incomplete information. This thesis sought to provide a more comprehensive understanding of tribunal resource allocation decisions by empirically analyzing whether a tribunal's procedures and the substantive arguments of the parties affected the tribunal's decision. In terms of procedures, the public perception is that the tribunal's procedures are neutral and did not affect the tribunal's decision. A leading theory, Accountability for Reasonableness (A4R), is based on the assumption that resource allocation decisions are acceptable even when society does not agree on the substantive distribution principles if the process for arriving at the decision is fair and transparent. If the procedures are not fair, transparent or neutral, the author questions whether resource allocation decisions would still be accepted. If there is a statistical effect of the tribunal's procedures on the tribunal's decision, it was of interest to know what factor(s) caused this effect and how a revised decision making mechanism can deal with the factor(s).

An extensive review of the literature did not identify a theory that applied to three key elements of the Board's decisions- a profile of the patient before the tribunal, the procedures of the Board and the substantive arguments of the parties. Given the lack of applicable theory and the academic need for legal empirical research, a research methodology had to be developed, tested and implemented in a case study of

approximately 400 HSARB decisions over a five year period. The empirical research methodology developed for this thesis is a preliminary but significant contribution to the understanding of tribunal resource allocation decision making. The analysis of the research results identified the following key trends with respect to patient profiles and the effect of the Board's procedures and the substantive arguments of the parties on Board decisions.

Patient Profile

In terms of a Patient Profile, the analysis revealed patients know what diagnosis they have and are requesting specific facilities for specific treatment. Overall, Ontario's OCCNEIHS issue is largely based on patients requesting surgery in northeastern USA. The specificity of the patients' requests also implies that the patients had contact with an out of country medical system and/or had likely conducted some of their own research into their conditions and treatment options and facilities. Unlike the statutory requirement for physicians to determine medical resource allocations, patients appear to be playing a major role in determining and advocating for their own OCCNEIHS. Of interest was the large number of 'pain' cases and a possible connection between a patient's subjective experience of pain and their attempt to seek treatment which often at odds with the approval of that treatment by their own Ontario physician.

Research Question #1:

Do procedures statistically affect the resource allocation decisions of the Board? If so, what elements of the procedures create this statistical affect?

It is important to note that the majority of procedures did not affect resource allocation decisions. It is also important to note the analysis of data over time is critical to identifying trends across all study years versus trends which may have only taken place in a specific year. For example, using quantitative methods, the author's statistical analysis found that the Board's procedures significantly affect resource allocation decisions with respect to self-representation and, for specific years, oral hearings. These identified trends were not evident from the A4R theory. If the quantitative analysis correctly identified elements of the Board's procedure which significantly influenced the Board's decision, these elements of the Board's procedures were not neutral. If this element of the procedure was known not to be neutral, it is questionable if the decision outcome would be acceptable to those affected.

The author analyzed the procedural quantitative research results relative to the A4R theory's four procedural conditions of transparency – appeals, publicity, enforcement and relevancy of evidence. The author concluded that the four conditions were present, but that the A4R theory does not represent the complexity of the tribunal resource allocation decision making in terms of the influence of a tribunal's procedures.

Research Question #2:

What substantive arguments affect the resource allocation decisions of the Board?

While all substantial arguments affect resource allocation decisions, the empirical research highlighted a number of interesting issues including: the number of experimental

and unnecessary medical cases that did not fall within the Board's jurisdiction; patients and administrative requirements – rather than solely physicians - played a significant role in determining OCCNEIHS; counter to public opinion, more patients were arguing that a OCCNEIHS was generally accepted as appropriate for the patient rather than arguing that there was a delay to access that treatment; patients appear to be defining one of the legislative criteria – delay – differently than the medical authorities. As with the importance of identifying the above trends, the empirical research also identified the lack of trends including: the absence of discussion of economic factors, of cost-benefit analysis of treatment and non-treatment, medical expert consensus on approved treatment and treatment protocols or multi-disciplinary panels of experts to assess ethical/medical/fiscal issues. There was also no reference to a separate regulation that specifically dealt with OCCNEIHS or an alternate forum to the Board where patients could bring their concerns about the health care system in general.

Research Question #3

What It Should Be

What Should Be a Revised Resource Allocation Decision Making Mechanism?

Based on the research results of this study, the thesis asked: What Should the Revised Resource Allocation Decision Making Model Be? The revised resource allocation decision making mechanism would eliminate the procedural elements which influence the resource allocation decision – such as oral forums and legal representation. The jurisdiction of the Board should be revised such that the Board would review the resource

allocation decisions of OHIP for compliance with agreed upon guidelines. The guidelines would be multi factorial and based on expert consensus and include medical, administrative, economic and political factors as well as patient input and unforeseen developments. These multi factorial guidelines would be available publicly. Given the extensive potentially varying factors, the multi factorial guidelines would take the form of an algorithm. OHIP would apply the algorithmic equation to requests for OCCNEIHS. Parties could appeal OHIP's decision to HSARB if it fell within the jurisdiction of the Board. HSARB would conduct a review – as opposed to a hearing – to ensure that OHIP had utilized the factors which comprise the algorithm and the decision of OHIP was reasonable given the algorithm results. In this respect, the Board would depend on the expert consensus on the evidence rather than attempting the near impossible task of determining OCCNEIHS based on the evidence presented at the hearing. In this respect, the role of the Board would be significantly narrowed.

CHAPTER 13

Final Thought

The focus of this research is on tribunal resource allocation decision making based on a five year case study of HSARB OCCNEIHS decisions. This thesis reveals several challenges with respect to the effect of the Board's procedures and the substantive arguments on the decision to allocate health care resources. These challenges are not solely those of the Board. The challenges reflect many systemic problems in domestic health care. The issue of OCCNEIHS can be seen as embedded within the systemic problems.

However, the issue of OCCNEIHS also presents an opportunity to research, innovate and evaluate the assessment and delivery of health care services.³⁶⁴ Researchers and policy analysts could use OCCNEIHS to pilot test a number of innovative algorithms and service delivery models for the following reason: OCCNEIHS is outside the jurisdiction of the CHA and the requirements for provincial governments to receive federal health care financial support. OCCNEIHS is also outside the established contractual negotiations and fee-schedule of the Ontario government and Ontario Medical Association. As such, OCCNEIHS is a discretionary provincial program free of the

³⁶⁴ For example, a “heat map” could be created and updated continually regarding OCCNEIHS patients age, sex, geographical residence, diagnosis, requested treatment and requested facility out of country. This information could be ‘mapped’ onto utilization of the domestic health care system and health outcomes. Such information could be analyzed relative to the municipal, provincial and federal political and economic environment, historical medical practices, cultural norms and population emigration and immigration.

federal and provincial governments and medical association constraints. As a unique subcomponent of publicly funded health care system, OCCNEIHS should be used to guide research and policy developments at the provincial, national and international level.

CHAPTER 14

EPILOGUE

Recent Changes to Regulation 552 s.28.4(2)

During the course of the research for this thesis, several major changes were made to Regulation 552 with respect to the OCCNEIHS test criteria under section 28.4(2). These changes to Regulation 552 took place in April 2009 and in April 2011 – subsequent to the Ontario courts issuing decisions in the Flora case of 2008 and the CCW case of 2009.³⁶⁵ The changes clarified that in order to receive OCCNEIHS, a specialist practicing medicine in Ontario must approve the requested medical service as being medically necessary. The changes also clarified that OCCNEIHS requests must be approved by OHIP as insured services before the services are rendered.

Changes in 2009:

The author's analysis of the 2009 changes to Regulation 552 found physicians practicing in Ontario (s.28.4(2)(a)) must deem the OCCNEIHS medically necessary (s.28.4(2)(b)) for the specific patient. The services can also be provided by a health facility not just a hospital.

Section 28.4(2) - as of 2009 - stated:

³⁶⁵ Flora, Supra Note 5.
C.C.W., Supra Note 100.

(2) Services that are rendered outside Canada at a hospital or health facility are prescribed as insured services if,

(a) the service³⁶⁶ is generally accepted by the medical profession³⁶⁷ in Ontario as appropriate for a person in the same medical circumstances as the insured person;

(b) the service is medically necessary;³⁶⁸

(c) either,

(i) the identical or equivalent service is not performed in Ontario, or

(ii) the identical or equivalent service is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage;

(d) in the case of a hospital service or a service rendered in a health facility described in clause (a) of the definition of “health facility” in subsection (1), the service, if performed in Ontario, is one to which the insured person would be entitled without charge pursuant to section 7 in the case of an in-patient service or section 8 in the case of an out-patient service; and

³⁶⁶ Previously “treatment” is now listed as “service”

³⁶⁷ Previous “generally accepted in Ontario” is now listed as “generally accepted by the medical profession in Ontario”

³⁶⁸ This test – ‘the service is medically necessary’ – is a new criteria for s.28.4(2)

(e) in the case of an in-patient service, in Ontario, the insured person would ordinarily have been admitted as an in-patient of a public hospital to receive the service. O. Reg. 135/09, s. 4.

In essence, the OCCNEIHS criteria changed in April 2009. This new criteria – requiring an Ontario medical professional - may have arisen following section 28.4(2) interpretation by the Ontario Court of Appeal in the July 2008 cases of Flora³⁶⁹ – which endorsed an Ontario standard for determining the general acceptability of an OCCNEIHS.³⁷⁰

Changes in 2011:

In April of 2011, Regulation 552 changed again to clarify that specialists practicing in Ontario - as defined by the Ministry-Ontario Medical Association jointly negotiated Schedule of Benefits (or a general practitioner if the services requested are within their scope of practice) - must approve the OCCNEIHS for the specific patient. Section 28.4(7)2 states:

28.4(7) 2. The application mentioned in paragraph 1 includes written confirmation that the conditions set out in clauses (2) (a) and (b) and one of the conditions set out in clause (2) (c) are satisfied, from,

³⁶⁹ Flora, Supra Note 5.

³⁷⁰ Under s.28.4(2)(a)

- i. a physician who is a specialist, as defined in the schedule of benefits, in the type of service for which approval of payment is sought,
- ii. a general practitioner, if the type of service for which approval of payment is sought is within the general practitioner's scope of practice,
or
- iii. in emergency circumstances, a physician who practices medicine in Ontario or an emergency patient referral service.

As such, the regulation now endows the specialist with the responsibility of gatekeeping a patient's access to OCCNEIHS.

Section 28.4(4)1 – as of 2011 – also states:

28.4(4) Despite anything in this section as it read before April 1, 2009, a service is not, and is deemed never to have been, an insured service under this section unless the following conditions are satisfied:

- 1. For services rendered in circumstances that are not emergency circumstances,
 - i. written approval of payment of the amount for the services is granted by the General Manager before the services are rendered,
and

- ii. the services are rendered within the time limit set out in the written approval.

As such, there is no discretionary power to approve an OCCNEIHS retroactively. This author speculates that the regulatory changes were based on the court's direction in C.C.W. v. Ontario Health Insurance Plan, 2009 CanLII 712 (ON S.C.D.C.) that prior approval was required for an OCCNEIHS.

Absence of Attention to Changes:

In final reflection on the changes to Regulation 552, this author notes an absence of attention and debate by academics, the Legislature, the media and the public at large. Given the extensive debates about health care, this author would have expected more public discussion. However, Regulation 552, as with all regulations but unlike statutes, can be amended by the government without approval by the Legislature and therefore without public debate. This lack of attention to changes in Regulation 552 is in opposition to the media attention given to high profile cases seeking OCCNEIHS and the extensive public discussion regarding public health insurance and the delays accessing insured care in Ontario.³⁷¹

³⁷¹ While not directly related to this thesis, the biggest change to s.28.4(2) is the addition of (d) which deals with the provision of insured services by a 'health facility'. The section refers to s.28.4(1)(a) which states:

"health facility" means,

- (a) a health facility licensed as a health facility by the government in whose jurisdiction the health facility is situated in which complex medical and complex surgical procedures are routinely performed,

-
- (b) whether or not described in clause (a), a facility licensed by the government in whose jurisdiction the facility is situated with whose operator the Minister has entered into a preferred provider arrangement;

It is questionable if the ‘health facility’ referred to in s.28.4(1)(a) are bound by the CHA and the Ontario contractual fee schedule agreement for insured services.

So, what are the ‘insured services’? The new s.28.4(2)(d) also refers to s.7 of Regulation 552 which is the insured inpatient services in Canada – previously directed at ‘hospital insured services’. Section 7 states:

7. Subject to section 10, the in-patient services to which an insured person is entitled without charge are all of the following services:
 1. Accommodation and meals at the standard or public ward level.
 2. Necessary nursing service, except for the services of a private duty nurse who is not engaged and paid by the hospital.
 3. Laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability.
 4. Drugs, biologicals and related preparations that are prescribed by an attending physician, oral and maxillofacial surgeon or midwife in accordance with accepted practice and administered in a hospital, but not including any proprietary medicine as defined from time to time by the regulations made under the Food and Drugs Act (Canada).
 5. Use of operating room, obstetrical delivery room and anaesthetic facilities, including necessary equipment and supplies. R.R.O. 1990, Reg. 552, s. 7; O. Reg. 794/93, s. 2; O. Reg. 345/01, s. 2.

Basically, section 7 covers diagnostics, prescriptions and operating facilities in addition to nursing services and ward accommodations. Why is section 28.4(2)(d) so important?

Because of its reference to section 28.4(1)(a) and section 7, section 28.4(2)(d) allows health facilities in Ontario to provide insured services – diagnostics, prescriptions, operating facilities, nursing services and ward accommodations - but leaves open the question of ‘top up’ incurred by the provincial government. If the provincial government ‘tops up’ insured health care services for private health facilities, the patient does not encounter a ‘two tiered’ extra billing/user fee health care system based on ability to pay and contra indicated by the CHA. The cost of private health care is directly incurred by the province and not by the patient. The provincial government is not bound by the Schedule of Benefits for insured services or the CHA conditions for transfer payment funding if the provincial government pays the ‘tops up’ out of discretion. This author speculates while health care is funded through tax dollar allocations or new additional taxes, the patient is not directly experiencing extra billing counter to the CHA but is indirectly subsidizing extra billing. This author further speculates that the provincial government may wish to keep Ontario tax dollars used to fund health care public insurance within Ontario and not lose those tax dollars to health care services out of country.

In summary, this obscure, difficult to understand amended regulation s.28.4(2) may have introduced a novel way to address the public-private health care insurance debate, the demand for health care and the interest in out of country health care options.

APPENDIX

APPENDIX A – HSARB Search Engine Results

Original Search Results		
Health Services Appeal and Review Board		
March 2010		
<u>1. HIA Out of Country Coverage Search Terms</u>		
HIA Out of Country Coverage, Section 28.4(2)	No Dates	No Matches
HIA Out of Country Coverage Section 28.4(2)	No Dates	No Matches
HIA Out of Country Coverage	No Dates	4 Cases
<u>2. Prior Approval Search Terms</u>		
HIA Prior Approval s.28.4(2)	No Dates	No Matches
HIA Prior Approval s.28.4	No Dates	No Matches
HIA Prior Approval	No Dates	704 Cases
<u>3. Geographic Location Search Terms</u>		
HIA Windsor	No Dates	62 Cases
HIA Winsor s.28.4(2)	No Dates	No matches
<u>4. Out of Country Facility Search Terms</u>		
HIA Mayo Clinic	No Dates	89 Cases
<u>5. Regulation “Test” of s.28.4(2) Search Terms</u>		
HIA Medically Significant Tissue Damage	No Dates	509 Cases
HIA Generally Accepted in Ontario	No Dates	555 Cases
HIA Identical / Equivalent	No Dates	595 Cases

ACTUAL CASES		
Five (5) Year Breakdown: April 1, 2003 to March 31, 2008		
Year 1	April 1/03-March 31/04	
Year 2	April 1/04-March 31/05	83 Cases
Year 3	April 1/05-March 31/06	84 Cases
Year 4	April 1/06-March 31/07	104 Cases
Year 5	April 1/07-March 31/08	101 Cases
SUBTOTAL CASES	April 1/03-March 31/08	372 Cases
Duplicate/Not Relevant		- 58 Cases
TOTAL CASES		<hr/> 314 Cases

NOTE: The Database Search string of “HIA 28.4(2)” produced 353 cases while the previous search strings of “HIA Out of Country Coverage” and “HIA Out of Country Coverage s.28.4(2)” the same database produced 4 cases and no cases respectively. Thus, the search engine for the database was variable based on the search string.

APPENDIX B – Code Book February 28, 2011

EXCEL Code Book

Tribunal (HSARB) Case Decisions (n = approx. 315)³⁷²

2003-2008

NOTE: “3” = not accepted cases³⁷³

Case Identification³⁷⁴

A)	Case #	Hard copy decision (off by 1)
B)	File Number	Year
C)	File Number	Legislation ³⁷⁵
D)	File Number	Office Code Number
E)	HSARB Hearing Date	Day (“9” = unknown) ³⁷⁶
F)	HSARB Hearing Date	Month
G)	HSARB Hearing Date	Year

³⁷² Note: Word Count for Cases will be done for Phase II selected cases but not for this Phase I study

³⁷³ There are 6 cases in this database that appeared in the online search of s28.4(2) cases but were subsequently not accepted typically b/c the Applicant misused s28.4(2) ie for out of province but within Canada claims – as such, all columns will have “3” if the case is not accepted for analysis. The 6 not accepted cases are line 11/case 25=5-149; line 23/case 38=4-134; line 50/case 69=3-267; line 65/case87=2-57; line273/case330=6-298; line 295/case 352=6-431 – ‘not accepted cases’ moved to Excel Sheet 2 and deleted from Sheet 3 to avoid complication with stats concerning ‘3’s

³⁷⁴ File Number – focus on primary issue not Joiner files

Date Heard – only initial Hearing Date recorded even if Hearing covered more than one date

³⁷⁵ Legislation category will always be HIA

³⁷⁶ This happens for one case = CCW Part II

AS)	HSARB Decision Date	Day
AT)	HSARB Decision Date	Month
AU)	HSARB Decision Date	Year
AV)	Explanation	Details
**)	HSARB Repeat Case	“1” = yes “0” = no/otherwise ³⁷⁷

Parties

H)	Applicant Represented by Lawyer	“1”=yes “0”=no ³⁷⁸
I)	Respondent Represented by Lawyer	“1”=yes “0”=no
J)	Interpreter	“1”=yes “0”=no ³⁷⁹

Type of Hearing

K)	Oral Hearing	“1”=yes “0”=no
L)	Teleconference Hearing	“1”=yes “0”=no
M)	Written Hearing	“1”=yes “0”=no

³⁷⁷ At this stage of analysis, Repeat Cases will refer to both the same patient with the same health condition as well as the same patient with an additional health condition – this category was not used in coding as it was unclear which cases were repeat OHIP cases

³⁷⁸ Representation by ‘Agent’ or Friend/Family Member will be coded as “0”=no representation

³⁷⁹ If number of Interpreters is significant, Phase II will investigate the language of Interpreters

Request

N)	Prior Approval	“1”=yes “0”=no ³⁸⁰
O)	Reimbursement	“1”=yes “0”=no ³⁸¹
P)	Review	“1”=yes “0”=no ³⁸²
Q)	Accept Case	“1”=yes “0”=no “3”=not accepted ³⁸³

Patient

R)	Patient’s Diagnosis	Text if known ³⁸⁴ “9”=unknown/na
S)	Patient Age	actual age, “99”=unknown, “65”= retired/senior, “17”=minor
T)	Patient Sex	1=male ‘5’=female “9”=unknown/na
U)	Patient Residence	Text= known, ³⁸⁵ Not Stated=unknown

Treatment

V)	Requested Treatment	Text if known, ‘9’=unknown/na
W)	Requested Treatment Location	Text if know, “9”=unknown/na

Patient Reason for Out of Country Treatment Request

³⁸⁰ ‘Prior Approval’ cases include cases where an Application Form was submitted requesting or prior to departure for out of country treatment

³⁸¹ ‘Reimbursement’ cases include a request for coverage after the out of country treatment was received.

³⁸² Applicants or Respondents may request a ‘review’ of the HSARB decision by another panel of HSARB members. This request may/not be granted by HSARB. A Party is not required to have a case reviewed in order to proceed to the next step of entering the Court system

³⁸³ Accepted Cases are further reviewed for this s.28.4(2) study

³⁸⁴ ‘C-P’= cut and paste

³⁸⁵ Actual residence location state by Decision or extrapolated from Office location of Family Physician and/or Place of Employment

- X) Experimental “1”=yes “0”=no “9”= not applicable
- Y) Generally Accepted for patient “1”=yes “0”=no “9”= not applicable
- Z) No Identical or Equivalent in Ontario “1”=yes “0”=no “9”= not applicable
- AA) Delay resulting in Death “1”=yes “0”=no “9”= not applicable
- AB) Delay resulting in MSITD “1”=yes “0”=no “9”= not applicable
- AC) Delay to see GP “1”=yes “0”=no “9”= not applicable
- AD) Delay to see Ontario Specialist “1”=yes “0”=no “9”= not applicable
- AE) Delay to get Ontario TMT/Surgery “1”=yes “0”=no “9”= not applicable
- AF) Other “1”=yes “0”=no “9”= not applicable

or Text

OHIP Decision

- AG) Experimental “1”=yes “0”=no “9”= not applicable
- AH) Generally Accepted for patient
- AI) No Identical or Equivalent in Ontario
- AJ) Delay resulting in Death
- AK) Delay resulting in MSITD

Health Services Appeal and Review Board Decision

- AL) Experimental “1”=yes “0”=no “9”= not applicable
- AM) Generally Accepted for patient
- AN) No Identical or Equivalent in Ontario

- AO) Delay resulting in Death

AP) No Delay resulting in MSITD

AQ) HSARB – Deny “1”=yes “0”=no “9”=not applicable

AR) HSARB – Grant

“Categorized Data”

1. Age Categories - BA, BB columns

- a) Column BA = raw age actually cited in case (same as column "S")
 - b) Column BB = coded / grouped raw ages based on Canada Census 2006, Stats Canada categories:

$$0\text{-}17 = 1^{386}$$

$$18-24 = 2$$

$$25-44 = 3$$

$$45-64 = 4$$

$$65-79 = 5$$

$$80+ = 6$$

Unknown =

Census and Stats Canada use 0-14 and 15-24 categories – I have adjusted this age category to 0-17 and 18-24 b/c many cases state age as ‘a minor’ which is defined in legislation to be under age 18 [. If I kept the category of 0-14 and 15-24, I would not know if ‘17’ referred to a minor or the age of 17 – thus possibly falling w/in two categories

2. Patient's Residence - BC, BD columns

Based on LHINS boundaries^{388 389}

a) Column BC = raw Patient Residence cited in cases (same as column “U”)

b) Column BD = coded / grouped raw Patient Residence based on LHINS Boundaries of North, South, East, West:

North = 1

- North Simcoe, Muskoka LHINS
- North East LHINS
- North West LHINS

East = 2

- Champlain LHINS
- South East LHINS
- Central East LHINS

³⁸⁷ Case not accepted – defined originally as “3” were transferred out to Excel Sheet 2 and deleted from Sheet 3 to avoid numeric confusion

³⁸⁸ <http://www.centrallhin.on.ca/map.aspx>

³⁸⁹ LHINS Legislation [*Local Health System Integration Act, 2006*](#)

<http://www.centrallhin.on.ca/ontariolhinslegislation.aspx>

LHINS population, health utilization

South = 3

- Central LHINS
- Toronto Central LHINS
- Mississauga-Halton LHINS

West = 4

- Central West
- Hamilton/Niagara/Haldimand Brant
- South West
- Erie St Clair

Not Stated = 99

3. Patient's Requested Treatment Location - BE-BJ columns

Based on global geography

- a) Column BE – raw Requested Treatment Location cited in case (same as column “W”)
- b) Column BF – coded / grouped raw Global geographic Location
- c) Column BG – coded / grouped raw Global geographic Location converted into numeric code

1 = USA

2 = Europe³⁹⁰ (including UK³⁹¹)

3 = India

4 = China

6 = Israel

7 = Other³⁹²

9 = unknown / not provided by the case

d) Column BH – coded USA geographic location: North, East, South, West

North = Ohio, Wisconsin, Michigan, Minnesota, Philadelphia, Montana, Idaho, Illinois

East = New York, Maryland, Massachusetts, Connecticut

South = Florida, New Mexico, Utah, Arizona, Alabama, Louisiana, Texas, Kansas, Kentucky, North Carolina, Virginia

West = California, Oregon

9 = Not in USA

³⁹⁰ About half of the category 2/'Europe' cases appear to be Belgium and Germany

³⁹¹ The UK originally had its own category but the sample size was very low – so the UK – which had been coded as “5” was recategorized as “2” and lumped in with ‘Europe’ – thus, no ‘5’ exists in this category

³⁹² “Other” includes: Taiwan, Hong Kong, Argentina, South Africa, Chile, Pakistan, Mexico, Iran, and South Korea

e) Column BI = actual USA State Name cited in case

Or

9 = Not in USA

f) Column BJ = actual Global Health Facility +/- City³⁹³ cited in case

Or

9 = Not Given

4. Patient's Diagnosis/Condition

a) Column BK = raw Patient's diagnosis/condition as listed in the case (same as column "R")

b) Column BL = coded Patient's Condition

1 = Cancer (breast, colon, prostate...)

2 = Heart Disease/Circulation

3 = Back Pain

4 = General Pain

³⁹³ Excel Dbase Line 147 05-HIA-0180 = says both 'Feng Clinic + Mayo Clinic' – coded as 'Mayo Clinic' Minnesota

Excel Dbase Line 293 06-HIA-0444 = does not indicate campus location of Mayo Clinic – coded as 'May Clinic, Minnesota'

5 = Obesity

6 = Addictions/Mental Health/Anorexia

7 = Joints (hips, knee, shoulder, joint – surgery, replacement, pain, arthritis)³⁹⁴

8 = Head (eye, ear, headache, cataract, memory loss)³⁹⁵

9 = Unknown

10 = Other (transplant, gastro, renal)³⁹⁶

5. Patient's Requested Treatment

a) Column BM = raw Patient's requested Treatment as listed in the case (same as column "V")

b) Column BN = Coded Patient's Requested Treatment

³⁹⁴ Joint category (7) and General Pain category (4) very similar – I may try to analyze both separately and together(collapsing 7+4) – eg A patient may have hip or shoulder pain which could be categorized as either Joint (7) or General Pain (4) – where the patient indicated more than two cites for pain (e.g. hip and groin pain) I categorized under General Pain (4). Where a specific joint pain was stated (e.g. hip pain) I categorized under Joint (7). It may be unlikely that a Joint related health problem was not accompanied by some general pain – thus making it difficult to separate the two categories

³⁹⁵ “8 = head” also includes migraines, brain tumor, brain surgery, dyslexia, cranial nerves, ‘no sense of smell’, acoustic neuroma

³⁹⁶ “10=Other” also includes: pneumonia, CP, MS, Fabre Disease, Leukemia, Falls, Hernia, vertigo, gynecological, asthma, reconstruction after mastectomy, birthmark infection, lymph nodes, bowel polyps, stent, multiple (health issues), neuropathy in feet, gallbladder, gastrointestinal issues, liver, kidney, urine blockage, urine fibroids, endometriosis, Menier’s Disease, carpal tunnel syndrome, lesions, abdominal complaints, hereditary condition, genetic disease, menstrual disorder, lymphoma, MRI of the breast, nerve function, laryngeal issue, myelodysplasia, scleroderma morphea, pelvic organ prolapse, Wegener’s Granulomatosis

1= Surgery³⁹⁷

2 = Treatment³⁹⁸

3 = Transplant

4 = Diagnostics (e.g. MRI, XRay, CT, PET)

5 = Assessment (medical opinion)³⁹⁹

6 = Counseling

7 = Drug Treatment only⁴⁰⁰

8 = Follow up⁴⁰¹

9 = Unknown

³⁹⁷ ‘1=Surgery’ includes ‘cyber knife therapy’ which is actually a surgery and not a ‘therapy’ “Gucci Procedure”, myomectomy,

³⁹⁸ ‘2=Treatment’ includes chemotherapy, radiation, angioplasty, angiogram, scleroderma, drug Herceptin,

³⁹⁹ ‘5=Assessment’ includes ‘diagnostics and assessment’, vertigo, second opinion, surgical consult but not the surgery

⁴⁰⁰ ‘7=Drug Treatment only’ was not used for coding purposes

⁴⁰¹ ‘8=Follow up’ was not used for coding purposes – follow up or ‘redoing the surgery’ was factored under 2=treatment or 1=surgery respectively. I believe there were only a few such cases actually stating a return to an OC health professional but I suspect there was a greater number of patients returning to the original OC health professional

APPENDIX C – Three Research Questions and Cross Tabulations

THREE MAIN QUESTIONS and CROSS TABS:

1. Profile of Patients/Applicants coming to the Tribunal (HSARB)
2. Position of the Patient/Applicant, OHIP and ultimately the Tribunal and how these may differ
3. Administrative questions regarding the Tribunal Hearing

DETAILS:

1. PROFILE of PATIENT

- a) Profile of Patients/Applicants coming to the Tribunal (HSARB)
 - Age (BB)
 - Sex (T)
 - Residence (BD)
 - Diagnosis (BK)
 - Requested Treatment (BN)
 - Requested Location of Requested Treatment (BF, BG, BH, BI, BJ)

Profile of Patient Cross Tabs

Where People are, what they have and where they want to go

Residence (BD) x Diagnosis (BL)

Residence (BD) x Diagnosis (BL) x Age (BB)

Residence (BD) x Diagnosis (BL) x Requested TMT (BN)

Residence (BD) x Diagnosis (BL) x Requested Location (BG, BH)

Residence (BD) x Diagnosis (BL) x Requested TMT (BN) x Requested Location (BG, BH)

2. POSITION OF PATIENT, OHIP, TRIBUNAL AND TRIBUNAL'S ULTIMATE DECISION

a) Patient Position Totals

Experimental (X)

Generally Accepted (Y)

Identical/Equivalent (Z)

Delay causing Death (AA)

Delay causing Medically Significant Tissue Damage/MSITD (AB)

Delay to see Ontario General Practitioner/GP (AC)

Delay to see Ontario Specialist/SP (AD)

Delay to Ontario TMT/Surgery (AE)

Other (AF)

Patient Cross Tabs

Date x Test in s.28.4(2):

In a given year, why are people asking for Out of Country Coverage from OHIP?

Decision Date [AU] x Test [Experimental (X) x Generally Accepted (Y) x

Identical/Equivalent (Z) x Delay Death (AA) x Delay MSITD (AB)]

Residence x Test:

Based on the patient's geographical setting, why are people asking for Out of Country coverage from OHIP?

Patient's Residence [BD] x Test [Experimental (X) x Generally Accepted (Y) x

Identical/Equivalent (Z) x Delay Death (AA) x Delay MSITD (AB)]

Diagnosis x Test:

For a given diagnosis, why are people asking for Out of Country coverage by OHIP?

Patient's Diagnosis [BL] x Test [Experimental (X) x Generally Accepted (Y) x

Identical/Equivalent (Z) x Delay Death (AA) x Delay MSITD (AB)]

TMT Location Out of Canada x Test:

Based on a requested procedure location, why are people asking for Out of Country coverage by OHIP?

TMT Location [BG, BH] x Test [Experimental (X) x Generally Accepted (Y) x Identical/Equivalent (Z) x Delay Death (AA) x Delay MSITD (AB)]

Requested TMT and TMT Location Out of Canada x Test:

Based on a requested procedure and procedure location, why are people asking for Out of Country coverage by OHIP?

TMT Requested [BN] x TMT Location [BG, BH] x Test [Experimental (X) x Generally Accepted (Y) x Identical/Equivalent (Z) x Delay Death (AA) x Delay MSITD (AB)]

b) OHIP Position Totals

Experimental (AG)

Generally Accepted (AH)

Identical/Equivalent (AI)

Delay causing Death AJ

Delay causing MSITD (AK)

OHIP Cross Tabs

Date x Test:

In a given year, what is OHIP's position on each test factor?

Decision Date [AU] x Test [Experimental (AG) x Generally Accepted (AH) x Identical/Equivalent (AI) x Delay Death (AJ) x Delay MSITD (AK)]

Residence x Test:

Based on where the patient lives/geographical setting, what is OHIP's position on each test factor?

Patient's Residence [BD] x Test [Experimental (AG) x Generally Accepted (AH) x Identical/Equivalent (AI) x Delay Death (AJ) x Delay MSITD (AK)]

Diagnosis x Test:

For a given patient diagnosis, what is OHIP's position on each test factor?

Patient's Diagnosis [BL] x Test [Experimental (AG) x Generally Accepted (AH) x Identical/Equivalent (AI) x Delay Death (AJ) x Delay MSITD (AK)]

TMT Location Out of Canada x Test:

Based on a requested procedure location, what is OHIP's position on each test factor?

TMT Location [BG, BH] x Test [Experimental (AG) x Generally Accepted (AH) x Identical/Equivalent (AI) x Delay Death (AJ) x Delay MSITD (AK)]

c)Tribunal Position Totals

Experimental (AL)

Generally Accepted (AM)

Identical/Equivalent (AN)

Delay causing Death (AO)

Delay causing MSITD (AP)

Tribunal Cross Tabs

Date x Test:

In a given year, what is the breakdown for the test factors considered by the Tribunal?

Decision Date [AU] x Test [Experimental (AL) x Generally Accepted (AM) x

Identical/Equivalent (AN) x Delay Death (AO) x Delay MSITD (AP)]

Residence x Test:

Based on the patient's location/geographical setting and the test factors considered by the Tribunal, does the Tribunal 'grant' or 'deny' the patient's request?

Patient's Residence [U] x Test [Experimental (AL) x Generally Accepted (AM) x

Identical/Equivalent (AN) x Delay Death (AO) x Delay MSITD (AP)] x Grant (AR)

Patient's Residence [U] x Test [Experimental (AL) x Generally Accepted (AM) x
Identical/Equivalent (AN) x Delay Death (AO) x Delay MSITD (AP)] x Deny (AQ)

Diagnosis x Test:

Based on the patient's diagnosis, and the test factors considered by the Tribunal, does the Tribunal 'grant' or 'deny' the patient's request?

Patient's Diagnosis [BL] x Test [Experimental (AL) x Generally Accepted (AM) x
Identical/Equivalent (AN) x Delay Death (AO) x Delay MSITD (AP)] x Grant (AR)

Patient's Diagnosis [BL] x Test [Experimental (AL) x Generally Accepted (AM) x
Identical/Equivalent (AN) x Delay Death (AO) x Delay MSITD (AP)] x Deny (AQ)

TMT Location Out of Canada x Test:

Based on a requested procedure location, and the test factors considered by the Tribunal, does the Tribunal 'grant' or 'deny' the patient's request?

TMT Location [BG, BH] x Test [Experimental (AL) x Generally Accepted (AM) x
Identical/Equivalent (AN) x Delay Death (AO) x Delay MSITD (AP)] x Grant (AR)

TMT Location [BG, BH] x Test [Experimental (AL) x Generally Accepted (AM) x
Identical/Equivalent (AN) x Delay Death (AO) x Delay MSITD (AP)] x Deny (AQ)

d) Tribunal Decision Totals

Deny (AQ)

Grant (AR)

Tribunal Cross Tabs

Decision Date (AU) x Test [Experimental (AL) x Generally Accepted (AM) x

Identical/Equivalent (AN) x Delay Death (AO) x Delay MSITD (AP)] x Grant (AQ)

Decision Date (AU) x Test [Experimental (AL) x Generally Accepted (AM) x

Identical/Equivalent (AN) x Delay Death (AO) x Delay MSITD (AP)] x Deny (AR)

3. ADMINISTRATIVE QUESTIONS REGARDING TRIBUNAL HEARING

a) Dates: Hearing Requested, Hearing Date, Decision Date

File Submitted to Office (B, C, D)

Hearing Date (E, F, G)

Decision Date (AS, AT, AU)

Total days it takes from when a file is submitted to the office till a Hearing is held and a

Decision is rendered

Total Days = File Submission Date (B,C,D) – Hearing Date (E,F,G) – Decision Date
(AS,AT,AU)

b) Legal Representation

Representation by Counsel/Lawyer

Applicant (H)

Respondent (I)

Cross Tab

What are characteristics of an Applicant represented by Counsel/Lawyer?

Applicant Represented (H) x Residence (BD) x Diagnosis (BL) x Requested TMT (BN) x
Requested Location (BG, BH)

c) Language

How many times is an Interpreter used at the Hearing?

Interpreter Present (J)

Cross Tab

Based on the patient's residence/geographical location, how many times is an Interpreter used at the Hearing?

Interpreter Present (J) x Residence (BD)

d) Type of Hearing Totals

Oral (K)

Teleconference (L)

Written (M)

Cross Tab

How many times is a Hearing conducted either orally, in writing or by teleconference?

Oral (K) x Written (M) x Teleconference (L)

Does the fact that a Hearing is conducted orally, in writing or by teleconference effect whether the Tribunal ‘grants’ or ‘denies’ the patient’s request?

Oral (K) x Deny (AQ)

Oral (K) x Grant (AR)

Teleconference (L) x Deny (AQ)

Teleconference (L) x Grant (AR)

Written (M) x Deny (AQ)

Written (M) x Grant (AR)

e) Payment Requested

Does the patient request OHIP coverage before (prior) or after (reimbursement) the out of country procedure?

Prior Approval Payment (N)

Reimbursement (O)

Cross Tab

Based on the year, does the Tribunal ‘grant’ or ‘deny’ a patient’s requests if they are ‘prior requests’ or ‘reimbursement’ requests?

Grant (AQ) x Prior Request (N) x Decision Date Year (AU)

Deny (AR) x Prior Request (N) x Decision Date Year (AU)

Grant (AQ) x Reimbursement (O) x Decision Date Year (AU)

Deny (AR) x Reimbursement (O) x Decision Date Year (AU)

f) Accepted Case

Accept case for analysis (Q) from total cases (n=315)

g) Reviewed cases

Reviewed cases (P)

APPENDIX D: Example of Excel Spreadsheet Coding

APPENDIX E – Definition of s.28.4(2) Test Elements: Standard of Proof / Onus-Burden / Evidence

a) Introduction

This section seeks to examine the legal aspects of the s.28.4(2) Test – specifically, if the Definition of each element of the s.28.4(2) Test, the Standard of Proof, the Onus/Burden of the Proof, and the Evidence required by the Board regarding the s.28.4(2) Test affect the determination of resource allocation.

In analyzing the Decisions, it became clear that the s.28.4(2) Test was greatly affected by the s.24(1)¹⁷ arguments - whether or not a treatment was deemed to be ‘experimental’ and thus not meeting the criteria for OHIP funding. As a result of this assessment, the Definition, the Standard of Proof, the Onus/Burden of the Proof, and the Evidence regarding the ‘experimental’ nature of a treatment under s.24(1)¹⁷ were also analyzed in addition to the s.28.4(2) Test.

Overall, the Standard of Proof for all aspects of the s.28.4(2) Test, was a civil standard of a balance of probabilities. In terms of Onus/Burden of Proof, the onus for the screening ‘experimental’ test (HIA 24(17)) is on OHIP as it has denied the patient’s out of country request, the s.28.4(2) Test. The onus flips to the patient to prove the test’s elements.^{402 403} The Board’s jurisdiction allows it to hear new evidence presented at the Hearing:

⁴⁰² 06-HIA-0444 BS at 12.

⁴⁰³ 06-HIA-0430 at 6.

“... the Appeal Board conducts a hearing de novo, which is a fresh determination of the issues based upon the evidence at the hearing.”⁴⁰⁴

The evidence required to prove the s.28.4(2) test regarding ‘generally accepted as appropriate for the patient’ (GA), ‘identical or equivalent treatment in Ontario’ (I/E), and/or ‘delay causing death or medically significant tissue damage (D) appears to initially be based on the Prior Approval Form signed by an Ontario physician and submitted by the patient’s physician or by the patient themselves. OHIP has stated that the Prior Approval Form must be based on a medical opinion and that medical opinion must come from an Ontario physician. Medical opinions from physicians outside of Canada are not accepted. The Prior Approval Form submitted by the patient may be counteracted by OHIP. OHIP may submit evidence based on their own medical expertise or it may contract with field experts to provide medical opinions on GA, I/E and/or D. Patients may clarify their evidence for GA, I/E and/or Delay with the submission of additional correspondence from their physician. This additional correspondence can also be contradicted by OHIP. In very rare situations does the patient’s physician attend the Board Hearing either in person or by teleconference. The patient may also produce information on out of country procedure success rates, journal articles, patient testimonials, etc. OHIP will counter argue each of these submissions.

b) Experimental

i) Definition of ‘Experimental’

⁴⁰⁴ 06-HIA-0191 MB at 5.

As stated earlier, if a treatment is found to be experimental, it is not funded by OHIP and does not qualify for review under s.28.4(2). The case Decisions appear to be using the following definition for “experimental” originally cited in A. v. General Manager, OHIP (HSARB File No. 04-HIA-0040):

The term “experimental” is not defined in the Act or in the regulations. While the Appeal Board is not bound by definitions applied in earlier Appeal Board Decisions, in assessing the evidence, it is helpful to consider those definitions. In A. v. General Manager, OHIP (HSARB File No. 04-HIA-0040), the Appeal Board applied the following definition of experimental, supported by the Respondent in that case: “a therapy is experimental when the effects are unknown and are not understood” and that “conversely a treatment which is not experimental must be one which is accepted practice within the medical profession and one that is proven to have beneficial results” and that “these results must be based on objective standards and not the subjective view of a patient”.⁴⁰⁵

Overall, the definition of “experimental” is challenging and determined by a lay Board. The definition is very broad, not linked to experimental definitions under regulatory authorities for drugs, medical devices and medical research. It is the author’s opinion that the determination of ‘experimental treatment’ is a very technical area of medicine and highly regulated by the scientific and governmental sphere. It is unclear how the lay

⁴⁰⁵ Definition also used in 06-HIA-0287 MS.

Board's assessment of the evidence fits with the scientific and governmental regulation of experimental treatment. It would be beneficial to the Board and to the parties if a technical body could review the treatment in question and determine if it was 'experimental' or not at the time of the patient's request.

ii) Onus / Burden of Proof

According to the Decisions, the onus/burden of proof to establish that a procedure is 'experimental' under s.24(17) lies with the party advocating that the treatment is experimental. It is not the Appellant [the patient in that case] who must establish that the treatment is not experimental.⁴⁰⁶ On an appeal to the Board of an OHIP denial to fund an out of country health care service, the onus rests with OHIP to show that a treatment is experimental.⁴⁰⁷

iii) Standard of Proof

The civil standard of a 'balance of probabilities' is required for OHIP to prove that a procedure is experimental and thus not fundable.

iv) Evidence Required

OHIP must use evidence to prove a procedure is experimental. Typically, OHIP will use the information from the patient's GP and/ SP from their Prior Approval Form. If the

⁴⁰⁶ 06-HIA-0383 at 7.

⁴⁰⁷ In the case analysis, when OHIP, or the patient, has not argued the out of country health care service is experimental, the author has assumed that the out of country health care service was not experimental and thus potentially fundable by OHIP.

Prior Approval from the GP and/or SP states that the out of country health care service is experimental then OHIP will define the procedure to be experimental.

The evidence for experimental determination is not only technical but it is often subject to conflicting, changing and unclear statements from medical practitioners. As of April 2011, the Regulation for s.28.4(2) requires SP evidence from on Ontario based physician. While this stipulation renders debates regarding GP, SP and/or out of country SP moot, it still raises the question regarding SPs who provide conflicting information on the ‘experimental’ nature of the treatment. The Board must still weigh the evidence provided by the SP on the Prior Approval Form and any subsequent submissions from the SP.⁴⁰⁸ Given the evolving nature of experimental treatments, the possible fluctuations of the patient’s medical condition and the time period from an initial request to OHIP through to the release of a Board Decision, the definition and the related evidence need to be precise. A precise definition of ‘experimental’ is not in the regulations. The medical evidence to meet this definition and the expertise to assess the medical evidence are variable across the Decisions. It is assumed that this makes the determination of the issue before the Board very difficult.

c) Generally Accepted as Appropriate for Patient

i) Definition

Under s.28.4(2), a treatment must be ‘generally accepted as appropriate’ for the given patient. For example, a coronary bypass may be treatment/procedure that is generally

⁴⁰⁸ Such as subsequent letters from the SP and/or oral testimony from the SP

accepted if a patient has a blocked coronary artery. However, if the patient is not likely to survive the coronary bypass surgery because of their specific condition – let us say, hypothetically, that the patient is 120 year old, in extremely poor health and is mortally allergic to the anesthetic that would be used in the surgery – the medical opinion would be that the coronary bypass surgery would not be appropriate for the given patient.

The definition of GA in Ontario as appropriate for a person in the same medical circumstances as the patient raised a number of questions regarding ‘who’ decides the GA – the patient, the medical community at large or more specifically the medical community in Ontario. It was first established in the Decisions that it is the medical community that determines if an out of country treatment is generally accepted as appropriate for the patient:

“The Appeal Board finds that the words “generally acceptable” in the context of section 28.4(2) to mean approval of a treatment as a rule, or usually, by the medical community.”⁴⁰⁹

The ‘medical community’ was further defined by Ontario Courts as the medical community in Ontario. In the Decision 06-HIA-0343, the following was clarified:

“In a recent decision of the Ontario Divisional Court, Flora v. General Manager, Ontario Health Insurance Plan, 1 (1 [2007] O.J. No. 91) Justice Epstein

⁴⁰⁹ 06-HIA-0266 EC at 8.

considered the rationale for this reference to an Ontario standard in some detail. In particular, she said:

‘Adopting an Ontario standard for determining funding ensures that limited public monies are only spent on medical treatments that (i) are accepted by doctors of a recognizable standard; (ii) are accepted as deserving of public funding in accordance with Ontario’s values and laws; and (iii) are provided in accordance with the ethics and values of Ontarians.’⁴¹⁰

“As set out in Flora, this reference to an Ontario standard is important for, among other reasons, the protection of Ontario citizens seeking medical services in other jurisdictions.”⁴¹¹

There has been much discussion in the Decisions as to ‘medical community’ in Ontario. The key issue in this discussion is ‘who’ within the Ontario medical community determines if the out of country treatment is GA for the patient. Several of the Decisions accept the opinion of the patient’s Ontario GP. Several of the Decisions accept the opinion of the patient’s Ontario SP.

ii) Onus / Burden of Proof

⁴¹⁰ Flora, Supra Note 5 at para 102.

⁴¹¹ 06-HIA-0343 at 6.

The onus/burden of proof lies with the patient to establish all elements of the s.28.4(2)

Test:⁴¹²

“The onus is on the Applicant to establish that the treatment in question is generally accepted in Ontario as appropriate for a person in his medical circumstances, and is not performed in Ontario by an identical or equivalent procedure and that there was a delay in receiving medical services. Whether or not the evidence adduced is sufficient to discharge the onus on the Appellant is a question of fact.”⁴¹³

OHIP can submit that the patient has not met the burden of proof with the evidence:

“To satisfy the criteria for insured out-of-country medical services that are set out in section 28.4 of Regulation 552, the treatment must be generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person. The Appellant bears the burden of establishing that this provision has been satisfied. The Respondent submits that the evidence provided by the Appellant does not meet this burden.”⁴¹⁴

The Decisions seem to be quite clear that the onus for proving GA is on the patient. The challenge for the patient is to establish this onus based on Ontario medical opinion. This

⁴¹² 06-HIA-0430 at 6.

⁴¹³ 06-HIA-0434 at 8.

⁴¹⁴ 05-HIA-0318 at 5 – see also 06-HIA-0417 at 6 “It is the Respondent’s position that the Applicant has not shown that intensive inpatient residential treatment was generally accepted for a patient in these clinical circumstances.”

is a difficult burden given that the majority of patients are self represented and Ontario medical opinions are only presented in writing – which may be unclear or non-existent.

iii) Evidence Required

When the onus is not met by the patient based on the evidence provided, the Board will deem that the out of country treatment is not GA:

“The onus for establishing that a treatment is generally considered appropriate is on the Applicant. In the absence of any evidence to support such a conclusion, the Appeal Board finds that the treatment received by the Applicant is not generally accepted in Ontario as appropriate.”⁴¹⁵

Where the evidence does not support GA, the Board can choose not to continue with the s.28.4(2) Test:

“There is insufficient evidence to find that the arthroscopic surgery performed on the Appellant in Florida is generally accepted in Ontario as appropriate for someone in his medical circumstances. It is therefore not necessary for the Appeal Board to address the issues of whether the surgery is performed in Ontario and if so, if there would have been a delay in receiving it.”⁴¹⁶

⁴¹⁵ 06-HIA-0444 at 12.

⁴¹⁶ 06-HIA-0231 at 10.

Thus, the GA test appears to screen cases which may or may not go on to the next steps of the s.28.4(2) Test.

The medical opinion evidence typically comes from the patient themselves in the form of website materials and/or medical journals as well as evidence from GPs, SPs and out of country SPs. The patients' argument appears to be strongest when the patient presents evidence that an Ontario SP agrees that the out of country treatment is GA. When OHIP argues against the patient's GA request for out of country treatment OHIP's opinion is typically based on medical expertise in the area of the out of country treatment in question. However, the OHIP medical expert may not have viewed the patient directly. The OHIP expert may have expertise in the treatment area but may have never had contact with the patient or review the patient's medical file.

One example of conflicting medical opinion evidence from an Ontario SPs and out of country SPs took place in the case of 06-HIA-0434. That case involved a request for nerve block treatment out of country. The patient's GP provided a medical opinion that the out of country treatment was GA. The Board stated that the GP was not a SP. The opinion of Ontario SP #1 declined to comment on OHIP's question whether the out of country treatment was GA. The opinion of Ontario SP #2, in his two letters to OHIP, was interpreted by the Board to not be GA because of the Board's assessment of SP #2's qualifications and treatment of the patient. Letters of support for the patient were provided by an American SP. Despite the medical opinion of the GP, the Ontario SP#2 and the USA SP, the Board deemed that there was insufficient evidence that the out of

country treatment was GA. The Board quoted the Ontario Divisional Court⁴¹⁷ confirming the need for an Ontario standard for determining GA.

In another case, 06-HIA-0472 AD, the Board examined medical opinion evidence from an Ontario GP. In that case, the patient, the patient's GP and the patient's USA SP provided evidence that the medical treatment was GA. The Ontario SP, according to the GP, was "unwilling to provide this service" so the Board accepted the medical opinion of the GP.⁴¹⁸ According to the Decision, OHIP did not 'seriously' contradict the evidence provided by the patient. The Board deemed the out of country treatment was GA. So, in this case, the Ontario GP and the USA SP evidence convinced the Board the out of country treatment was GA for the patient, over the evidence of OHIP. This finding differs from the previous case where the evidence of Ontario GPs was not considered knowledgeable enough and the American SP was considered irrelevant for determining the 'in Ontario' criteria.

The Board appears to take a variable stand on the evidence required of the patient. In some cases, the medical opinion of an Ontario SP was required. In some cases, the medical opinion of the Ontario GP was sufficient. If OHIP opposes the patient's GA request, the medical experts for OHIP may not have seen the patient or the patient's medical history. The variability of medical opinions accepted as evidence by the Board may have encouraged cases to come forward to the Board as it was unclear when and on what evidence the Board grants or denies GA.

⁴¹⁷ Flora (2007), Supra Note 5 at para 102.

⁴¹⁸ 06-HIA-0472 AD at 8.

The stakes are quite high for the patient at this early stage of the s.28.4(2) Test. If the patient does not meet the onus through their evidence, the case does not proceed. The challenge for the patient is to produce evidence which supports their request for GA. The patient is not only dependent on Ontario medical opinions, the patient is typically self represented before the Board and no medical opinion provider is present. As such, the Board must depend on the print medical opinion(s) provided by the patient.

Because the evidence requirement at this point of the Test is so crucial in order to proceed with the Test, it raises the question of how many medical opinions are accessed by the patient before the evidence of GA can be established. The criteria encourages accessing multiple SPs until the evidence requirement of GA is established. There is no patient follow up to determine if the treatment requested out of country is or is not appropriate for the patient.

d) Identical or Equivalent Treatment in Ontario

i) Definition

There are possibly two elements to the definition of Identical or Equivalent found in s.28.4(2)(b)(i) - that the treatment out of country being requested is 'identical' or the treatment out of country being requested is 'equivalent' to treatment that is offered in Ontario. From the definition, it appears that the two elements - identical and equivalent - can be interchanged i.e. the section uses the term "or" rather than "and". Board decisions

state that the definitions for 'identical' and 'equivalent' are not outlined in the Statute or the Regulation. As such, the Board turns to the dictionary definition. The Board states:

"The dictionary definition of "equivalent" is "similar or identical in value, meaning or effect". In deciding whether the procedures are equivalent, it is appropriate to look at the relative quality and results of the procedures....".⁴¹⁹

In another Decision the Board states:

"There is no dispute that total knee replacement surgery is performed in Ontario. At issue is whether the total knee replacement surgery performed in Ontario is equivalent to the total knee replacement surgery performed in Kentucky ... The dictionary definition of "equivalent" is "similar or identical in value, meaning or effect." In deciding whether the surgical procedures are equivalent, it is appropriate to look at the relative quality and results of the procedures. The evidence comparing relative quality and results of the procedures in this case is thin. We will now examine that evidence.".⁴²⁰

The Board states that it uses the "Canadian Oxford Dictionary" and it was suggested by an Appellant that the Board take note of the fourth definitions:

1.(often followed by to) equal value, amount importance, etc. 2. corresponding or having the same relative position or function. 3. (of words) having the same meaning. 4. having the same result or effect ... (emphasis added) ...⁴²¹

419 06-HIA-0266 EC

420 07-HIA-0068 N.A. at 6

421 06-HIA-0351 at 1

The Board does outline the definition for 'identical' it used - also based on a dictionary definition:

"In the absence of an elaboration of the terms "identical or equivalent" in the Statute, the Appeal Board relied on dictionary definitions to determine whether the Ontario eating disorder programs were identical or equivalent in their treatment approaches. The term "identical" would require that the treatment approaches to be similar to that of the South Coast program. In order to be "equivalent", the treatment would consist of a program being of equal value or having the same result."⁴²²

The Board turns to the common dictionary to derive the definition for 'identical' and 'equivalent' - and as seen from the Decisions above - the Board may quote the definition slightly differently. The Board may also not review the evidence relative to both 'equivalent' or 'identical' but may conduct the review only relative to 'equivalent'. In terms of the definition itself, the Board does use a medical dictionary or a legal dictionary.

The Board indicates, from its use of the dictionary definition, that it is looking at "quality" and "the results of the procedures". The author is concerned that a lay Board is looking at "quality" and "the results of the procedures". If a comparison between the Ontario treatment and the out of country treatment is made on the basis of quality and results, a number of possible errors may be made. For example, the comparison may be made based on the different health status patient samples. An out of country treatment facility

422 06-HIA-0204 at 8

may select very healthy patients while the Ontario treatment facility may be required to take all patients including very sick patients who may have a different negative treatment result. The health professional may perform a perfect treatment yet the results of the treatment may be negative for the patient sample that was initially in poorer health.

Currently, the comparison is between Ontario and the out of country treatment. The comparison is not between the out of country treatment and the treatment available in Canada. It may be more cost effective to seek treatment outside Canada before inside Canada because of geographic distance to the treatment -as in the case of Windsor residents accessing treatment in Detroit rather than in Quebec or Manitoba. However, in terms of medical necessity, the CHA allows for the portability of provincial health insurance when treatment is not available in the patient's home province but available in another province within Canada. Under the current I/E Test, if a treatment is not available within Ontario it can be funded by OHIP outside of Canada - there is no requirement to assess whether there is I/E treatment available first within Canada. This is interesting because within Canada treatment is still paid for by Canadian tax dollars. If the treatment is out of country, Canadian tax dollars also go out of country.

ii) Onus / Burden of Proof

The onus is on the patient to prove that there is no 'identical or equivalent' treatment in Ontario compared to the out of country treatment. The challenge for the patient is how to know what treatments are available in Ontario, and if available whether the treatment is identical or equivalent both in delivery and in its results. This appears to be a very difficult burden for the patient to meet. If the patient is relying on their physician, the

physician must also submit testimony on these factors.

iii) Evidence Required

In the cases analysed, patients tended to present comparison evidence [comparing the out of country treatment to the domestic treatment] or the absence of domestic treatment to support their argument that there was no identical or equivalent treatment in Ontario. Of the many 'identical or equivalent' evidence arguments presented in the Decisions, three evidence arguments are of particular note: the 'type of other patients argument', 'the insufficient effort' argument, the 'private health care' argument.

In the 'Type of Other Patients' Argument the patient argued that the patients attending the domestic treatment were different from the patients attending the out of country treatment. The Board did not accept this argument as evidence that the out of country treatment was not identical or equivalent to the domestic treatment. The Board stated:

"Dr. Hoffer also argues that the mix of patients at Portage [Ontario] is a basis for distinguishing it from High Frontier [out of country]. Again, without more than a bald assertion, we are not prepared to accept Dr. Hoffer's opinion on this point.

He does not explain why this mix of patient population would be harmful for this particular patient; in the absence of an explanation, we are not prepared to find that Portage is not equivalent for this reason."⁴²³

In the 'Insufficient Effort' argument OHIP argued that the patient has made insufficient effort in attempting to seek treatment in Ontario before requesting out of country treatment funding from the government. The Board did not accept this argument by

423 06-HIA-0351 at 14

stating the Regulation did not require effort on the part of the patient to access domestic treatment before seeking out of country coverage.

In the ‘Public vs. Private Health Care’ Argument, OHIP argued the legislation only required be ‘identical or equivalent’ treatment in Ontario and did not specify that this Ontario treatment was not required to be insured by OHIP. In other words, there could be identical or equivalent treatment in Ontario that was offered through the private sector/insurance. The Board did not accept that the legislation referred to all public and private health care in Ontario.

The author sees a number of challenges with this element of the Test. One on the most challenging aspects is if the GP and or the SP do not know what actual treatment should be provided to the patient. If the medical professionals do not know the treatment, they are not able to provide domestic-out of country comparison evidence or the lack of available domestic treatment evidence. For example:

"The Respondent [OHIP] questioned how Dr. Hart [for the Appellant] could know that the treatment was not available in Canada if he did not know what the treatment was."⁴²⁴

In this respect, if the patient requires treatment but the treatment is unknown and thus not comparable to a domestic treatment, it is possible that the evidence of I/E would not be submitted and the onus not met and - as a result - the patient would not meet the requirement of s.28.4(2)(b)(i) and would not qualify for OHIP out of country coverage.

⁴²⁴ 06-HIA-0444 B.S. at12

e) Delay in Ontario

i) Definitions: Death and MSITD

The Board does not consider ‘delay’ itself to be a reason for out of country coverage by OHIP. The delay must be anticipated to result in the death of the patient or in medically significant irreversible tissue damage to the patient.

“Section 28.4(2) requires that there be not only evidence of delay but also evidence that the delay ‘would’ result in death or medically significant tissue damage.”⁴²⁵

While the definition of patient ‘death’ is not in question, the definition of what constitutes ‘MSITD’ to the patient is more difficult. The definition of MSITD is not in the legislation. It is also important to note two features of the delay causing death or MSITD definition – first, the definition is prospective. The definition requires the Appellant to project into the future that the delay would also cause D or MSITD. This may be very difficult for a medical practitioner to project. It also raises the question ‘who’ should project this outcome – the GP, the SP or the patient.

Officially, the Ontario Wait time bases its ‘delay’ for Ontario treatment from the time a SP confirms a treatment is needed to the time the treatment is received. The Ontario Wait time does not include the time period for the patient to see a GP, the time from GP appointment to appointment with the SP or the time from appointment with the SP to the

⁴²⁵ 06-HIA-0191 M.B. at 11

time a SP confirms a treatment is needed. In this respect, the ‘delay’ experienced by patients may be further broken down. Further research is needed to locate the subcomponent of delay the patients are experiencing. For example, if the majority of patients are experiencing delay between the time they see their GP and the time they are first able to secure an appointment with a SP and are therefore going out of country for diagnostics and/or out of country SP, that is a different Wait time issue than the delay from SP confirmation of treatment need to the treatment itself. In terms of diagnostics, patients may be going out of country for diagnostics in order to maintain their Ontario SP appointment. Patients also may be generating additional Ontario treatment requests if out of country diagnostics show the need for treatment.

What is not clear from the Decisions is if there is a ‘tiered delay’.⁴²⁶ In a tiered delay, patients receiving Ontario based health care may have a different delay experience than Ontario patients returning from out of country health care. Those returning from out of country care may experience delay as medical professionals may not want to follow up on non-domestic treatment. It is also unclear if patients receiving out of country treatment are in fact increasing medical requests within Ontario in the form of follow up and/or ongoing care.

One disturbing feature of the Delay-MSITD definition is the criteria of ‘tissue damage’. Tissue damage may not result from significant pain. In the case of patients experiencing pain, there is not always an objective diagnostic tool to assess the level of pain and which may not show ‘tissue damage’.

⁴²⁶ ‘tiered delay’ is the author’s term

“The Appeal Board notes that the Appellant has been in significant pain and that his ability to function has been impaired while waiting some time for surgery; however, the legislation stipulates that in order for the surgery to qualify as an insured service, it must be established that the delay would result in “medically significant irreversible tissue damage”. The Appeal Board finds there is insufficient evidence that the delay would result in medically significant tissue damage and the requirements of section 28.4(2)(b)(ii) have not been satisfied.”⁴²⁷

Pain may be severely incapacitating and - according to Decision data analyzed in Phase I - pain is a major reason for seeking out of country treatment. In such a scenario, the patient/Appellant may seek out of country treatment for pain which may be GA and I/E in Ontario but it does not meet the criteria of Delay causing MSITD. Thus, the criteria of ‘tissue damage’ may be putting a limitation on pain treatment as well as certain mental health conditions where it is difficult if not impossible for the patient/Applicant to establish ‘tissue damage’.

ii) Onus / Burden of Proof

As previously cited, the Onus is on the Appellant/Patient to prove that the delay accessing identical or equivalent treatment in Ontario would result in death or MSITD.⁴²⁸

iii) Evidence Required

427 06-HIA-0357 at12

428 06-HIA-0434 at 8 , 06-HIA-0430 at 6

The Board requires that ‘delay’ be established in order to further consider the criteria of s.28.4(2)(b)(ii) – delay causing D or MSITD:

“Finally, it is not possible to posit a causal connection between the suggested damage and the delay faced by the Applicant where there is no solid evidence of the actual delay that he faced for an urgent MRI.”⁴²⁹

It is also important to note that the evidence required by the Board is based on medical judgment of the patient’s probable future health condition as a result of the delay:

“The Health Insurance Act is a statutory scheme to provide insurance against the cost of “insured services” to insured persons. For the most part those services are medical treatments delivered in Ontario and the insured person is living in Ontario. There are a few, well-defined exceptions to that general rule, section 28.4 is one of them. The conditions set out in section 28.4 require a medical judgment about a patient’s future, in situations where it is very difficult to predict the future. Against this backdrop, we are [sp] the view that “would” does not mean “inevitable”, however, it does require some degree of certainty of the outcome. In our view, the word “would” in this context is synonymous with “probably”; thus, the question in this case is whether, in view of the Applicant’s circumstances, death or medically significant tissue damage would probably result if she had to wait a year for surgery.”⁴³⁰

429 06-HIA-0208 A.S. at 10

430 06-HIA-0191 M.B. at 11

According to several Board Decisions, the patient/Appellant must first show evidence of attempting to access I/E within Ontario before advancing a Delay causing D and/or MSITD argument:

“ As the Appellant did not attempt to proceed with the equivalent surgery with Dr. Izukawa or any other Ontario surgeon, it is impossible to determine whether there was delay.”⁴³¹

“Because the Appellant did not return to Ontario with his second opinion to try to get a surgery date in Ontario, we do not know whether a date for surgery could have been obtained earlier than the fall of 2006 ... we do not know what the Appellant’s family physician would have done for the Appellant had he or she known all of the facts. ...”⁴³²

In this latter case, it is interesting to note that approval for out of country diagnostics may also generate demand for out of country treatment.

The Board did not accept evidence obtained on the patient’s health after the out of country treatment. The Board stated:

431 06-HIA-0383 at 13 – this raises the question that if a patient/Appellant is not assessed on the sufficiency of their attempts to access I/E in Ontario, how is accessing I/E assessed?

432 06-HIA-0395 at 9 – the diagnostics may create an unexpected demand for services

“ ... Dr. Langley [OHIP representative] urged the Board not to rely on the evidence gleaned following surgery. He stated on an earlier decision of the Board¹ [WM 06-HIA-0001] in which the Panel observed:

...the provision ... To find that this question is properly answered with evidence available only after treatment has been obtained would render the language of the clause absurd, because the criterion could never be satisfied in advance, as it should be with prior approval⁴³³

We agree that it would not be appropriate to rely exclusively on evidence gleaned after the surgery ...^{434 435}

It is not clear whether a ‘delay’ experienced in accessing treatment is actually a physician’s decision making regarding medical necessity. In other words, are patients experiencing ‘real’ delay or are physicians prioritizing patient issues based on ‘real’ medical necessity. For example, a patient requesting bariatric surgery in Ontario for obesity may be told, based on their medical condition (perhaps the need to lose a portion of the weight prior to surgery or to stabilize a diabetic or mental health condition) that there will be a 3-5 year wait for bariatric surgery. The patient/Appellant’s submission to the Board is that the surgery is GA, that there is I/E in Ontario but that there is a Delay

⁴³³ Italics as reported in actual case 07-HIA-0018 at 5
434 07-HIA-0018 at 5

435 It is interesting to note that the Board preferred the evidence of the patient’s GP over the evidence of the patient’s SP “We prefer the evidence of Dr. Whishinsky [the patient’s GP not the SP]” 07-HIA-0018 at 5. Earlier in the decision, the Board states “The views of a specialist are often highly persuasive and perhaps more persuasive than those of a family physician on matters concerning surgery; however, this is not always the case. It is a question of fact whether the surgeon’s opinion has more weight than that of a family doctor.” 07-HIA-0018 at 4.

that will cause MSITD in the form of weight on the joints, increased prospective risk of heart disease and uncontrolled diabetes. In this scenario, perhaps the patient is experiencing a delay as they see it but the delay is justified based on medical assessment. On the other hand, the patient may be experiencing actual delay even if the treatment is deemed medically necessary.

j) Summary of Analysis

This section sought to examine the legal aspects of the s.28.4(2) Test – specifically, the Definition of each element of the s.28.4(2) Test, the Standard of Proof, the Onus/Burden of the Proof, and the Evidence required by the Board regarding the s.28.4(2) Test for GA, I/E and D causing D and/or MSITD. The author found that how the elements of s.28.4(2) are defined had a major impact on what evidence was required to establish the given element. It is of interest that the s.28.4(2) Test definitions were not outlined in the statute or regulations. The Board had to resort to common dictionary definitions to define the element of the s.28.4(2) Test. The definition for the first element of the Test – GA s.28.4(2)(a) – was further judicially defined by the court in 2006 in the case of Flora but there were still gaps in the definition that led to different weighting of evidence by the Board.⁴³⁶ It is also of interest that the evidence of physicians is required yet physicians rarely come before the Board in person with evidence – it is the patient who brings evidence to the Board and argues the evidence against OHIP. The evidence submitted by physicians is typically based on a government issued form. The medical opinion expressed on the form is typically difficult to understand and the evidence supporting the

⁴³⁶ The author notes that in April 2011, the s.28.4(2) was further amended to include - among other aspects – the requirement for Ontario SP medical opinion as evidence to support a patient's request for of out of country treatment funded by OHIP.

medical opinion is rarely present. The substantiation of the medical opinion and the representation of that opinion by the patient and not the physician needs further exploration.

APPENDIX F: – Patient Age, Sex Residence

It became clear in the case analysis that a significant number of Board Decisions did not state the age of the patient. If age was stated, it may have been stated as of the time of a health incident or at the time of application to OHIP rather than the Board Hearing. In cases where the age was stated as of the time of the health incident, that age was added to the date of the Board Hearing to approximate the age of the patient. Given that the date of Board Hearing was not the same as the date of the Board Decision, the age of the patient is an approximation of the age at the time of the Board Hearing not the date of the Board Decision.

The data revealed a wide variation in patient age. Given this wide variation of ages, the raw data was subsequently grouped into the age categories used by the Canada Census of 2006 and Statistics Canada. As such, the seven age groupings were 0-17 years, 18-24 years, 25-44 years, 45-64 years, 65-79 years, 80 plus years or ‘Unknown’.

Age

	Frequency	Percent	Valid Percent	Cumulative Percent
Age 0-17	23	7.3	7.3	7.3
18-24	8	2.5	2.5	9.8
25-44	32	10.2	10.2	20.0
45-64	37	11.7	11.7	31.7

65-79	23	7.3	7.3	39.0
80+	7	2.2	2.2	41.3
Unknown	185	58.7	58.7	100.0
Total	315	100.0	100.0	

It is assumed that data collected by OHIP, in order to process the patient's request relative to their OHIP number, could provide this information.

There may be several reasons why only 40% of patients indicated their age. First, for privacy reasons, patients may not give their age as the Decisions become public - even though the Decisions only display the patient's initials and not by name. Second, the lack of age data may also be a function of Board Decision writing practices. The Board may have had this information but chose not include it in the Decision as it may not have been considered relevant information for the determination of the case. Third, the Board may have been influenced by provincial and federal health privacy legislation regarding the collection of personal health information. An informal look at the data indicated that early Decisions did list the age of the patient whereas later Decision typically did not list the age of the patient. Further analysis would be of interest to determine if there is a correlation between the year of the Decision not reporting age and the emergence of provincial and federal privacy legislation.

Where the patient's sex was not given but deduced, the deduction was based on information within the Board Decision. For example, the pronoun 'her' or 'she' was taken to indicate the patient was female. In rare cases, the sex of the patient was deduced

from the diagnosis or requested procedure. For example, if the patient was diagnosed with ovarian cancer or who requested a hysterectomy, it was deduced that the patient was female. A deduction could not be made if the diagnosis or treatment requested was applicable to both sexes even if the condition was more probable in one sex than the other. An example of this would be breast cancer.

Patient Sex

	Frequency	Percent	Valid Percent	Cumulative Percent
Male	151	47.9	47.9	47.9
Female	164	52.1	52.1	100.0
Total	315	100.0	100.0	

The patient's geographical residence was often not stated within the Decision. When it was clearly stated it was documented as such. In many cases, the patient's residence was not stated but the location of the patient's work and the location of the General Practitioner (GP) were stated. In such cases it was assumed that if these two factors coincided – the workplace and GP location – then they represented the residence location of the patient. However, if only the Ontario Specialist (SP) geographic location was given, the patient's residence was not assumed to be the same as the SP and the patient's residence was coded as 'Not Stated'. The reason of this coding was that a SP may have been outside the geographic area of the patient. For example, patients residing in Windsor may have been referred to SP in London, Hamilton or Toronto. Patients residing in northern Ontario may be referred to Ottawa or London, Hamilton or Toronto. The referral

location of the SP was assumed not to be specific enough to attribute it to the residence location of the patient.

There was large variability in the raw data regarding patient residence. The raw data was re categorized into 15 areas based on the 14 Local Health Integration Networks (LHIN) boundaries and one category of ‘Not Stated’. These 14 geographic LHIN based locations were then further re-categorized into 5 Ontario regions: North Ontario, East Ontario, South Ontario, West Ontario and ‘Not Stated’.

Patient Residence

LHIN		Frequency	Percent	Valid Percent	Cumulative Percent
	North	35	11.1	11.1	11.1
	East	23	7.3	7.3	7.3
	South	48	15.2	15.2	15.2
	West	46	14.6	14.6	14.6
	Unknown	163	51.7	51.7	100.0
	Total	315	100.0	100.0	

APPENDIX G: Patient Profile - Diagnosis and Pain

The patient's diagnosis and subsequent coding for this study was based on the information provided in the Decision. There was variability in the diagnosis description based on whether the patient used medical terms or lay person terms to describe the diagnosis. In several cases there was more than one diagnosis. In cases with more than one diagnosis, the predominate diagnosis was coded.

The raw data showed huge variations in diagnosis. As a result, the raw data was summarized / categorized into 10 codes for diagnosis: cancer, heart disease/circulatory disease, back pain, general pain, obesity, addictions/mental health/anorexia, joints (hips, knee, shoulder – surgery, replacement, pain, arthritis), head (eye, ear, headache, cataract, memory loss), unknown and ‘other’ (e.g. organ transplant).

Patient Diagnosis

	Frequency	Percent	Valid Percent	Cumulative Percent
Cancer	49	15.6	15.6	15.6
Heart/Circulatory	17	5.4	5.4	21.0
Back Pain	36	11.4	11.4	32.4
General Pain	22	7.0	7.0	39.4

Obesity	22	7.0	7.0	46.3
Addictions/Mental	29	9.2	9.2	55.6
Health/Anorexia				
Joints	34	10.8	10.8	66.3
Head	35	11.1	11.1	77.5
Unknown	3	1.0	1.0	78.4
Other	68	21.6	21.6	100.0
Total	315	100.0	100.0	

Pain Diagnosis:

The addition of Back Pain (11.4%) and General Pain (7.0%) equals 18.4% which is a greater percent than the leading diagnosis of Cancer (15.6%)

The ‘Other’ category included conditions not easily falling within the categories of cancer, heart disease/circulatory disease, back pain, general pain, obesity, addictions/mental health/anorexia, joints, head and ‘other’ (transplant, gastro, renal). This collection of ‘Other’ conditions included: pneumonia, CP, MS, Fabre Disease, leukemia, falls, hernia, vertigo, gynecological, asthma, reconstruction after mastectomy, birthmark infection, lymph nodes, bowel polyps, stent, multiple (health issues), neuropathy in feet, gallbladder, gastrointestinal issues, liver, kidney, urine blockage, urine fibroids, endometriosis, Menier’s Disease, carpal tunnel syndrome, lesions, abdominal complaints, hereditary condition, genetic disease, menstrual disorder, lymphoma, MRI of the breast,

nerve function, laryngeal issue, myelodysplasia, scleroderma morphea, pelvic organ prolapse, and Wegener's Granulomatosis.

APPENDIX H: Requested Patient Procedure Global Locations

The details of the requested treatment locations are further described in the Table below:

Global Location – Detailed Chart

	Frequency	Percent	Valid Percent	Cumulative Percent
Argentina	1	.3	.3	.3
Belgium	5	1.6	1.6	1.9
Chile	1	.3	.3	2.2
China	4	1.3	1.3	3.5
France	4	1.3	1.3	4.8
Germany	8	2.5	2.5	7.3
Hong Kong	1	.3	.3	7.6
Hungary	1	.3	.3	7.9
India	9	2.9	2.9	10.8
Iran	1	.3	.3	11.1
Israel	2	.6	.6	11.7
Italy	1	.3	.3	12.1
Mexico	1	.3	.3	12.4
Pakistan	2	.6	.6	13.0
Poland	1	.3	.3	13.3
South Africa	1	.3	.3	13.7
South Korea	1	.3	.3	14.0
Sweden	1	.3	.3	14.3
Switzerland	1	.3	.3	14.6
Taiwan	1	.3	.3	14.9
UK	5	1.6	1.6	16.5
USA	263	83.5	83.5	100.0
Total	315	100.0	100.0	

APPENDIX I: Patient Requested USA Northern State and Requested Treatment

Northern State by Patients' Requested Treatment

Cross tabulation

			Patient's Requested TMT					Total
			1 Surgery	2 Treatment	4 Diagnostics	5 Assessment	6 Other	
State Code	1 Michigan	Count	32	6	5	6	0	49
		Expected	24.3	6.6	5.4	12.0	.8	49.0
		Count						
		% within State Code	65.3%	12.2%	10.2%	12.2%	.0%	100.0%
	2 Minnesota	Count	15	6	7	23	1	52
		Expected	25.8	7.0	5.7	12.7	.8	52.0
		Count						
		% within State Code	28.8%	11.5%	13.5%	44.2%	1.9%	100.0%
	3 Ohio	Count	12	3	2	1	0	18
		Expected	8.9	2.4	2.0	4.4	.3	18.0
		Count						
		% within State Code	66.7%	16.7%	11.1%	5.6%	.0%	100.0%

4 Illinois	Count	0	1	0	1	0	2
	Expected	1.0	.3	.2	.5	.0	2.0
	Count						
	% within	.0%	50.0%	.0%	50.0%	.0%	100.0%
	State Code						
5	Count	2	1	0	0	0	3
Pennsylvania	Expected	1.5	.4	.3	.7	.0	3.0
	Count						
	% within	66.7%	33.3%	.0%	.0%	.0%	100.0%
	State Code						
6 Montana	Count	0	0	0	0	1	1
	Expected	.5	.1	.1	.2	.0	1.0
	Count						
	% within	.0%	.0%	.0%	.0%	1.0E2	100.0%
	State Code					%	
7 Wisconsin	Count	1	0	0	0	0	1
	Expected	.5	.1	.1	.2	.0	1.0
	Count						
	% within	100.0%	.0%	.0%	.0%	.0%	100.0%
	State Code						
9 Not stated	Count	1	0	0	0	0	1

	Expected	.5	.1	.1	.2	.0	1.0
	Count						
	% within	100.0%	.0%	.0%	.0%	.0%	100.0%
	State Code						
Total	Count	63	17	14	31	2	127
	Expected	63.0	17.0	14.0	31.0	2.0	127.0
	Count						
	% within	49.6%	13.4%	11.0%	24.4%	1.6%	100.0%
	State Code						

APPENDIX J: File Date, Hearing Date, Decision Date

In the future, it is recommended that the File Number include a day and month code to allow for analysis of total time a case was within the Tribunal system.

Days from Hearing Date to Decision Date

	No.	Minimum	Maximum	Mean	Std. Deviation
Days	315	3.00	1220.00	159.9397	147.28111
Valid N	315				

The following table assesses this skewness of the data:

Days from Hearing Date to Decision Date

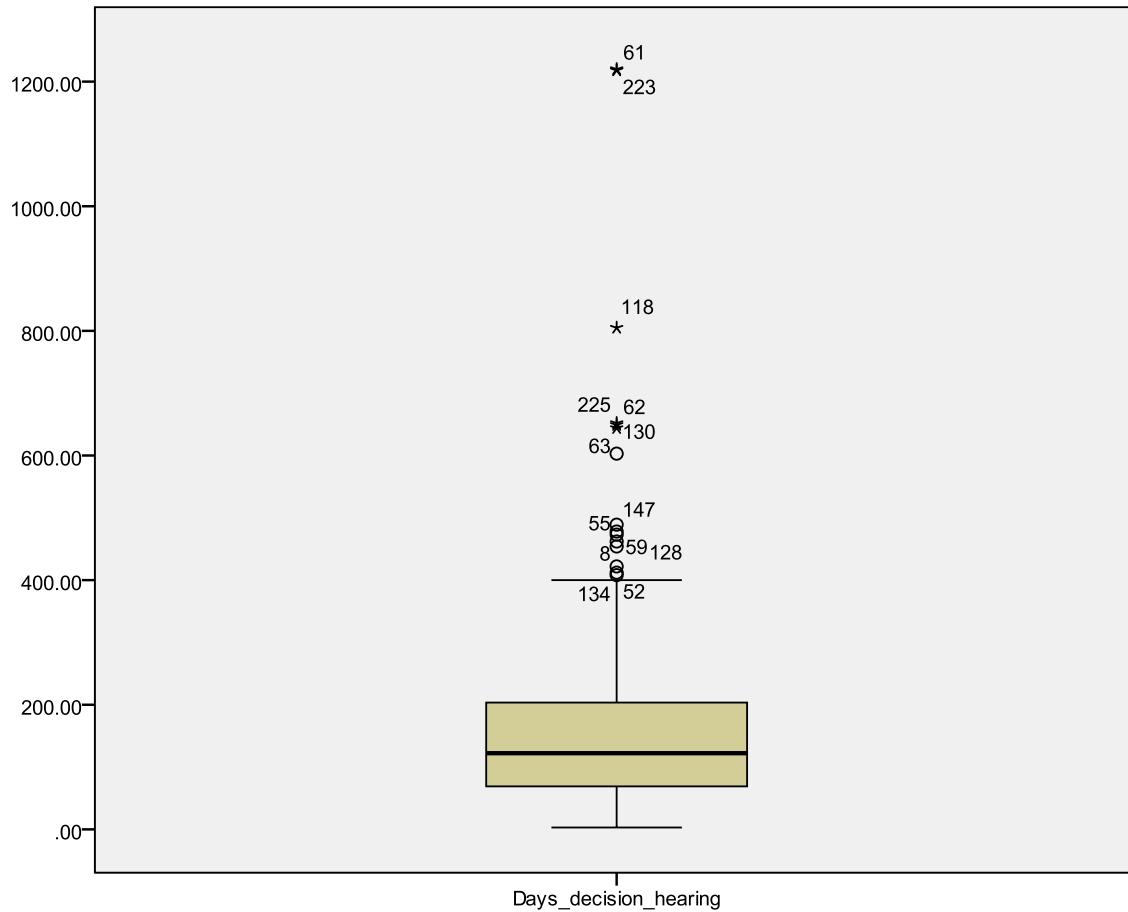
	Statistic	Std. Error
Days	Mean	8.29835
	95% Confidence Interval for Lower Bound	143.6123
	Mean Upper Bound	176.2671
	5% Trimmed Mean	142.6173
	Median	122.0000
	Variance	21691.726
	Std. Deviation	147.28111

Minimum	3.00	
Maximum	1220.00	
Range	1217.00	
Interquartile Range	135.00	
Skewness	3.305	.137
Kurtosis	17.739	.274

Mean (159.9) and median (143.6, 176.2) should be close in value – but the analysis indicates they are not. The skewness (3.3) and kurtosis (17.7) statistics should be in the range of [+1 and -1] to be considered normal. The data analysis indicates that the skewness is 3.305 and the kurtosis is 17.739 – outside the normal distribution range.

The data was also analyzed according to a box-plot where the line in the box is the median value and the box is drawn at 25 and 75 percentile points. Anything outside the box can be regarded as outliers, i.e. those very unusual cases in terms of days from the number of days from Hearing Date to Decision Date. The data clearly indicates that the extreme higher values – those cases incurring more days between the Hearing Date and the Decision Date – affect the distribution - not the shorter day lengths.

The case numbers for these extreme high values were identified - cases 88, 223 and 279. These are “unique” cases from the point of view of number of days spent in the system. Further analysis is required to determine why these three cases were ‘unique’.



Although data comparisons were based on the case day, month and year, only the year existed in the File Date. Therefore, comparisons could only be based on the File Date year. The relationship between File Date year and the Hearing Date year is very strong but suffers from the 'year end' problem meaning that the File Date only gave the year date not the month and day date. If, hypothetically, a File Date year was 2005, that could mean the file came into the office as early as January 1, 2005 or as late as December 31, 2005. If the File came into the office December 31, 2005 and the Hearing Date was scheduled for January 1, 2006, it will appear as though the File Date of 2005 was heard

one year later in 2006. Thus the usefulness of the File Date as a start date to estimate time a case is within the Board's system is very limited.

In terms of analyzing the data for File Date year to Hearing Date year, a “perfect” system would have most cases falling within the diagonal of the table below. This appears to be the case except for File Date year 2005 (values 53, 47) and 2006 (values 55, 20). This signals that something is different for File Date years 2005 and 2006.

File Year by Hearing Year Cross tabulation

Count

	2	3	4	5	6	7	Total
File Year	2	8	9	1	0	0	18
	3	0	17	8	1	0	26
	4	0	0	29	16	1	46
	5	0	0	1	44	53	102
	6	0	0	0	1	47	55
	7	0	0	0	0	0	20
Total		8	26	39	62	101	79
							315

This could have been explored more but given the challenges of ‘year end’ problems with File Date, the focus of this study continued on the Hearing Date and Decision Date variables.

With this focus, an analysis was undertaken to determine if the Hearing Date year and the Decision Date year matched – in other words, did the date a case was heard coincide with the date a Decision was released:

Hearing Date Year by Decision Date Year: Cross tabulation

Count

	Decision Date Year						Total	
	3	4	5	6	7	8		
Hearing Date Year	2	7	0	0	1	0	0	8
	3	10	12	4	0	0	0	26
	4	0	15	22	1	0	1	39
	5	0	0	27	35	0	0	62
	6	0	0	0	63	36	2	101
	7	0	0	0	0	65	14	79
Total		17	27	53	100	101	17	315

In a “perfect” system, most cases would fall within the diagonal on the table below. From the data, it appears that all of these associations are highly significant, perhaps indicating that on a broad year-by-year basis, Hearing year and Decision Date year were associated. In other words, the Hearing Date year appears to be within the Decision Date year.

Analysis was then done to determine the number of days a case was within the system – from Hearing Date to Decision Date - by year. In other words, did the number of days a case was within the system vary by year of Decision Date?

Number of Days by Year: Hearing Date to Decision Date

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
3	17	183.0588	133.47728	32.37300	114.4311	251.6865	11.00	422.00
4	27	162.0370	127.59566	24.55580	111.5619	212.5122	37.00	473.00
5	53	182.8679	167.58546	23.01963	136.6757	229.0602	8.00	805.00
6	100	136.8700	147.40816	14.74082	107.6210	166.1190	3.00	1218.00
7	101	144.6139	88.35858	8.79201	127.1708	162.0570	17.00	454.00
8	17	288.7647	286.61593	69.51457	141.4004	436.1290	59.00	1220.00
Total	315	159.9397	147.28111	8.29835	143.6123	176.2671	3.00	1220.00

37.

ANOVA

Days – Year: Hearing to Decision Date

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	396141.565	5	79228.313	3.816	.002
Within Groups	6415060.289	309	20760.713		
Total	6811201.854	314			

According to the table above, the Decision Date Year is significant (.002) in terms of the amount of time a case was in the system ('Between Groups'). As such, which years are more important with respect to how long a case takes from the Hearing Date to the Decision Date? If the data was less than or equal to .05, the year was significant. The following table shows how the differences that 2008 contribute to the strength of this year effect:

Multiple Comparisons

Days: Hearing - Decision

(I) Decision Year	(J) Decision Year	Mean Difference (I-J)	Std. Error	Significance	95% Confidence Interval	
					Lower Bound	Upper Bound
2003	4	21.02179	44.61091	1.000	-110.9462	152.99
	5	.19090	40.16130	1.000	-118.6142	118.99
	6	46.18882	37.79981	1.000	-65.6305	158.00
	7	38.44496	37.77261	1.000	-73.2939	150.19
	8	-105.70588	49.42102	.498	-251.9031	40.44
2004	3	-21.02179	44.61091	1.000	-152.9897	110.99
	5	-20.83089	34.06797	1.000	-121.6107	79.99
	6	25.16704	31.24936	1.000	-67.2748	117.00
	7	17.42318	31.21645	1.000	-74.9213	109.19
	8	-126.72767	44.61091	.072	-258.6956	5.20
2005	3	-.19090	40.16130	1.000	-118.9960	118.00
	4	20.83089	34.06797	1.000	-79.9489	121.00
	6	45.99792	24.48099	.918	-26.4217	118.40
	7	38.25406	24.43897	1.000	-34.0413	110.59
	8	-105.89678	40.16130	.132	-224.7019	12.90
2006	3	-46.18882	37.79981	1.000	-158.0082	65.60
	4	-25.16704	31.24936	1.000	-117.6088	67.20
	5	-45.99792	24.48099	.918	-118.4175	26.40
	7	-7.74386	20.32631	1.000	-67.8731	52.30
	8	-151.89471	37.79981	.001	-263.7140	-40.00
2007	3	-38.44496	37.77261	1.000	-150.1838	73.20
	4	-17.42318	31.21645	1.000	-109.7676	74.90
	5	-38.25406	24.43897	1.000	-110.5494	34.00
	6	7.74386	20.32631	1.000	-52.3854	67.80

	8	-144.15084	37.77261	.002	-255.8897	-32.4
2008	3	105.70588	49.42102	.498	-40.4913	251.9
	4	126.72767	44.61091	.072	-5.2403	258.0
	5	105.89678	40.16130	.132	-12.9083	224.1
	6	151.89471	37.79981	.001	40.0754	263.1
	7	144.15084	37.77261	.002	32.4120	255.8

*. The mean difference is significant at the 0.05 level.

In this respect, it may be helpful to have benchmarks for Tribunal procedural fairness in order to assist with internal tribunal processes. For example, a legislated period of time between receipt of a file (File Date) and the final Decision (Decision Date) may assist in designating existing and/or new tribunal staff and panel members to cases.

It is important to note that the Hearing Date code does not indicate how many days the case was actually argued. While Hearings lasting more than one day are not the norm, it is possible that a case could be heard over several days. For example, a case may have been argued 3 hours or three days but would have been coded as of the first day of the Hearing. For example, case 02-HIA-0040 JD was argued October 13 and 14th, 2004 as well as August 11, 2005. In the case just referenced, the Hearing Date to Decision Date would have been estimated from the first Hearing Date of October 13th, 2004 rather than August 11, 2005. If, hypothetically, the end of the Hearing was August 11, 2005 and the Decision was released September 1, 2005, it would appear that the case took 10 months

rather than half a month between hearing and Decision. Thus the time between Hearing Date and Decision Date is just a rough estimate of the days a case was within the system.

Further analysis should also be done to determine whether case time within the system was significantly related to the ultimate outcome of Granting or Denying the appeal. A cross tabulation regarding the substantive legal argument and patient profile may also render interesting data with respect to the time a case is within the system.

APPENDIX K: Type of Hearing (oral/written/teleconference/combination) relative to Disposition

Percent of Oral Hearings

Oral

	Frequency	Percent	Valid Percent	Cumulative Percent
No	123	39.0	39.0	39.0
Yes	192	61.0	61.0	100.0
Total	315	100.0	100.0	

Percent of Teleconference Hearings

Teleconference

	Frequency	Percent	Valid Percent	Cumulative Percent
No	259	82.2	82.2	82.2
Yes	56	17.8	17.8	100.0
Total	315	100.0	100.0	

Percent of Written Hearings

Written

	Frequency	Percent	Valid Percent	Cumulative Percent
No	230	73.0	73.0	73.0
Yes	85	27.0	27.0	100.0
Total	315	100.0	100.0	

Percent of Combination Hearings

Oral – Teleconference Hearings

Cross tabulation

			Teleconference		Total
			No	Yes	
Oral	No	Count	78	45	123
		Expected	101.1	21.9	123.0
		Count			
Yes	Count	181	11	192	
		Expected	157.9	34.1	192.0
		Count			
Total	Count	259	56	315	

Oral – Teleconference Hearings

Cross tabulation

			Teleconference		Total
			No	Yes	
Oral	No	Count	78	45	123
		Expected	101.1	21.9	123.0
		Count			
	Yes	Count	181	11	192
		Expected	157.9	34.1	192.0
		Count			
	Total	Count	259	56	315
		Expected	259.0	56.0	315.0
		Count			

Oral – Written Hearings

Cross tabulation

			Written		Total
			No	Yes	
Oral	No	Count	42	81	123
		Expected	89.8	33.2	123.0
		Count			

Yes	Count	188	4	192
	Expected	140.2	51.8	192.0
	Count			
Total	Count	230	85	315
	Expected	230.0	85.0	315.0
	Count			

Teleconference - Written Hearings

Cross tabulation

			Written		Total
			No	Yes	
Teleconference	No	Count	177	82	259
		Expected	189.1	69.9	259.0
		Count			
	Yes	Count	53	3	56
		Expected	40.9	15.1	56.0
		Count			
Total	Count	230	85	315	
	Expected	230.0	85.0	315.0	
	Count				

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.925 ^a	1	.003		
Continuity Correction	8.078	1	.004		
Likelihood Ratio	9.472	1	.002		
Fisher's Exact Test				.003	.002
Linear-by-Linear Association	8.896	1	.003		
N of Valid Cases	314				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 24.29.

b. Computed only for a 2x2 table

Format of Hearing relative to Disposition

Year 2004: NOT significant

Board-Grant of Appeal vs. Oral Hearing

Cross tabulation

Board-Grant	No	Count	Oral		Total
			No	Yes	
Board-Grant	No	Count	10	13	23

	Expected Count	9.4	13.6	23.0
	% Board-Grant	43.5%	56.5%	100.0%
Yes	Count	1	3	4
	Expected Count	1.6	2.4	4.0
	% within Board-Grant	25.0%	75.0%	100.0%
Total	Count	11	16	27
	Expected Count	11.0	16.0	27.0
	% within Board-Grant	40.7%	59.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.482 ^a	1	.488		
Continuity Correction	.020	1	.886		
Likelihood Ratio	.508	1	.476		
Fisher's Exact Test				.624	.455
Linear-by-Linear Association	.464	1	.496		
N of Valid Cases	27				

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.482 ^a	1	.488		
Continuity Correction	.020	1	.886		
Likelihood Ratio	.508	1	.476		
Fisher's Exact Test				.624	.455
Linear-by-Linear	.464	1	.496		
Association					
N of Valid Cases	27				

a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.63.

b. Computed only for a 2x2 table

Format of Hearing relative to Disposition

BUT for 2006 the association was significant:

Board-Grant of Appeal vs. Oral Hearing

Cross tabulation

Board-Grant	No	Count	Oral		Total
			No	Yes	
Board-Grant	No	Count	36	45	81

	Expected Count	31.3	49.7	81.0
	% within Board-Grant	44.4%	55.6%	100.0%
Yes	Count	3	17	20
	Expected Count	7.7	12.3	20.0
	% within Board-Grant	15.0%	85.0%	100.0%
Total	Count	39	62	101
	Expected Count	39.0	62.0	101.0
	% within Board-Grant	38.6%	61.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.867 ^a	1	.015		
Continuity Correction	4.690	1	.030		
Likelihood Ratio	6.536	1	.011		
Fisher's Exact Test				.020	.012
Linear-by-Linear Association	5.809	1	.016		
N of Valid Cases	101				

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.867 ^a	1	.015		
Continuity Correction	4.690	1	.030		
Likelihood Ratio	6.536	1	.011		
Fisher's Exact Test				.020	.012
Linear-by-Linear Association	5.809	1	.016		
N of Valid Cases	101				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.72.

b. Computed only for a 2x2 table

APPENDIX L – Procedures – Self Represented / Lawyer Represented Results

Introduction

Patients were often accompanied by friends or relatives who may or may not have had legal training. The level of legal training was not identified in the Decision. Patients who were represented by ‘agents’ were coded as not being represented by a ‘lawyer’ because determinations could not be made as to the level of legal training of the “agent”. Only licensed lawyers were coded as ‘represented’. To be coded as a ‘lawyer’ the party had to be identified as ‘Counsel’ in the Decision section of ‘Appearances’. In the case of minors, deceased parties, or other factors such as ill health, patients were typically represented by a guardian, the estate or a ‘friend’. While it is possible that any party could have been a ‘lawyer’, they were only coded as being a lawyer if identified as such. It is also possible that patients received legal advice or had their written submissions to the Board vetted through a lawyer. This was information not available in the Decision.

Representation

Patient Represented by a Lawyer:

Patient Representation

	Frequency	Percent	Valid Percent	Cumulative Percent
Not Represented	282	89.5	89.5	89.5

Represented	32	10.2	10.2	99.7
Unknown	1	.3	.3	100.0
Total	315	100.0	100.0	

OHIP Represented by a Lawyer:

OHIP Represented

	Frequency	Percent	Valid Percent	Cumulative Percent
Not Represented	273	86.7	86.7	86.7
Represented	42	13.3	13.3	100.0
Total	315	100.0	100.0	

Cases where both the Patient and OHIP were Both Represented by Lawyers:

Patient+OHIP Represented: Cross Tabulation

Count

		OHIP Represented		Total
		No	Yes	
Patient	No	268	14	282
Represente d	Yes	4	28	32
	Unknow	1	0	1
Total		273	42	315

Details regarding Patient Representation Cases

While beyond the scope of this study, the 28 cases having a grant rate of 32% were identified for further future analysis in order to determine the substantive arguments made by the parties and the Board's resulting position.

The table below lists the 28 cases and whether they resulted in a grant or denial of the patient's appeal:

Case Summaries

	Unique _ID	V1 Case number	Patient Rep.	OHIP Rep.	HSARB- Grant
1	4.00	6	1	1	0

2	9.00	20	1	1	1
3	15.00	32	1	1	0
4	21.00	39	1	1	0
5	23.00	44	1	1	1
6	47.00	70	1	1	0
7	55.00	78	1	1	0
8	67.00	94	1	1	0
9	104.00	134	1	1	0
10	128.00	169	1	1	0
11	129.00	173	1	1	0
12	132.00	178	1	1	0
13	144.00	198	1	1	0
14	153.00	207	1	1	0
15	154.00	208	1	1	1
16	174.00	228	1	1	0
17	188.00	242	1	1	1
18	207.00	263	1	1	0
19	218.00	274	1	1	1
20	219.00	275	1	1	0
21	223.00	279	1	1	0
22	224.00	280	1	1	0
23	228.00	285	1	1	1

24	236.00	293	1	1	1
25	238.00	297	1	1	0
26	265.00	328	1	1	9
27	278.00	342	1	1	1
28	315.00	382	1	1	1
Total	N	28	28	28	28

a. Limited to first 100 cases.

APPENDIX M: Cross Tabulation Generally Acceptable Procedure for the Patient (GA) with Identical/Equivalent (I/E) and Delay-Death (D) or Medically Significant Irreversible Tissue Damage (MSITD)

Section 28.4(2) Elements

To examine s.28.4(2) further, patients requesting GA were cross tabulated with patients requesting I/E across the 50 cases. There was Team Patient agreement for both GA and I/E in 21 cases and Team Patient discrepancies for both GA and I/E 4 cases. There was Team Patient agreement on GA but discrepancies on I/E in 11 cases. Interestingly, there was discrepancies on GA and agreement on I/E 14 cases.

GA versus I/E

Cross tabulation

			Patient Request- I/E in Ontario		
			No Discrepancie	Discrepancie	Total
Patient Request-GA	No Discrepancies	Count	21	11	32
		Expected Count	22.4	9.6	32.0
		% within Patient GA	65.6%	34.4%	100.0%
	Discrepancies	Count	14	4	18

	Expected Count	12.6	5.4	18.0
	% within Patient GA	77.8%	22.2%	100.0%
Total	Count	35	15	50
	Expected Count	35.0	15.0	50.0
	% within Patient GA	70%	30%	100%

From this data of 50 Team Patient discrepancies, in less than half the cases (n=21) there was agreement within Team Patient. However, there was some level of non-agreement in Team Patient regarding GA and I/E in 29 cases.

The Patients' argument for GA was then cross tabulated with the Patient's argument for Delay causing Death and Delay causing MSITD. In Delay causing Death, 13 cases had agreement within Team Patient regarding both GA and Delay causing Death while 6 cases discrepancies within both GA and Delay causing Death. Nineteen cases agreed on GA but disagreed on Delay causing Death. Six cases disagreed on GA but agreed on Delay causing Death.

A similar pattern was seen regarding GA and Delay causing MSITD: 13 cases had no disagreement within Team Patient regarding both GA and Delay causing MSITD while 8 cases discrepancies within both GA and Delay causing MSITD. Nineteen cases agreed on GA but disagreed on Delay causing MSITD. Ten cases disagreed on GA but agreed on Delay causing MSITD.

Patient Request-GA versus Patient Request b/c Delay causing Death

Cross tabulation

		Patient Request- Delay=Death		Total
		No Discrepancy	Discrepancy	
Patient Request- GA	No Discrepancy	Count	13	19
	Discrepancy	Expected Count	16.0	16.0
		% within Patient	40.6%	59.4%
	Request GA			100.0%
Total	Discrepancy	Count	12	6
		Expected Count	9.0	9.0
		% within Patient	66.7%	33.3%
	Request GA			100.0%

Patient Request-GA versus Patient Request b/c Delay causing MSITD

Cross tabulation

		Patient Request-Delay=MSITD		
		No Discrepancy	Discrepancy	Total
Patient	No Discrepancy Count	13	19	32
Request-GA	Expected Count	14.7	17.3	32.0
	% within Patient	40.6%	59.4%	100.0%
	Request GA			
Discrepancy	Count	10	8	18
	Expected Count	8.3	9.7	18.0
	% within Patient	55.6%	44.4%	100.0%
	Request GA			
Total	Count	23	27	50
	Expected Count	23.0	27.0	50.0
	% within Patient	46.0%	54.0%	100.0%
	Request GA			

APPENDIX N: Substantive Argument – Team Patient Discrepancies

Introduction

Discrepancies in the patients' argument were not expected at the start of the study. Once identified as a trend, the discrepancies in the patients' s.28.4(2) argument were analysed relative to the determination of the Board whether or not to grant OHIP coverage for OCCNEIHS

Discrepancies

In Year 5 (2007/08), one hundred and six s.28.4(2) cases came before the Board. The patient and OHIP each presented their argument for and against the out of country treatment request. However, the patients' argument for s.28.4(2) out of country treatment in these Year 5 cases was not always cohesive in terms of medical necessity.

Approximately 50 of the 106 cases showed discrepancy within the patient's s.28.4(2) argument – even before the counter argument of OHIP was presented and the subsequent determination of the Board. The author refers to these discrepancies as argument 'discrepancies within Team Patient'. These discrepancies within Team Patient were found in every area of the s.28.4(2) test⁴³⁷ - s.28.4(2)(a) generally accepted as appropriate for the patient (GA), s.28.4(2)(b)(i) identical or equivalent treatment available in Ontario (I/E) and s.28.4(b)(ii) delay causing death (DD) or delay causing irreversible significant tissue damage (DM).

⁴³⁷ Discrepancies within the 'Experimental' screening element were not analyzed for the purpose of this paper but are available for future analysis

It is important to note that discrepancies within Team Patient may not have been referenced in the Decision in all cases across the five years of study. In other words, the Board may have not recorded the medical opinion differences in Team Patient's argument and/or the Board may have weighted the evidence to that evidence presented by the patient and not the medical opinions. If this was the case, there may have been more discrepancies within Team Patient than recorded in the Board's Decisions. The patient may also have appeared to have had no discrepancies within their argument as they may only have been presenting medical support evidence and not evidence where there was not medical support for the patient's position. These issues are not known based on the cases reviewed for the study.

Discrepancies within Team Patient

While Team Patient discrepancies may have occurred in Years 1 through 4, they were not coded as such for one main reason - the author had made the assumption in designing this research study and Code Book that if the patient appeared before the Board there was medical endorsement for the patient's request for out of country treatment – given that the Board's jurisdiction was not to assess medical costs or human compassion arguments but rather to assess medical necessity for the patient's treatment. In this respect, it was assumed that there were no discrepancies within Team Patient – in other words, that the patients and the physicians were in agreement regarding s.28.4(2) - that the (a) the treatment was generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person; and (b) either,(i) that kind of treatment that was not performed in Ontario by an identical

or equivalent procedure, or (ii) that kind of treatment was performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage.

It became clear, while analyzing the cases, that this was not the case. By Year 5 cases, the author was attuned to these discrepancies and the discrepancies were well documented in the Board's written Decisions. The voided assumption of 'no Team Patient discrepancies' plus the clear documentation in Year 5 Decisions lead to the development of a more detailed coding system for Year 5 patient arguments.

While there may also have been discrepancies within OHIP argument and dissent in the Board's determination, these were not recorded in the written Decision – only Team Patient discrepancies were reported and thus coded. In hindsight, this more detailed coding system should have been applied to Years 1 to 4 – but in the interest of time and exploratory nature of this study, only Year 5 was analyzed using the more detailed coding system.

All s.28.4(2) Test Elements of Patients' Argument Assessed

While initially an analysis of the first element of the s.28.4(2) test – GA - was assessed,⁴³⁸ this only represented 17 of the 50 cases. GA cases were analyzed for the type of discrepancy. Given the small sample size of 17 cases and the number of possible discrepancies, it was not possible to have significant findings. As a result, all 50 GA, I/E,

⁴³⁸ the element s.28.4(2)(a) requiring the treatment is generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person

and Delay cases were analyzed in order to increase the sample size and determine if any patterns could be seen. The results for each of the four elements of s.28.4(2) are listed below. Of the 50 cases, there were only 4 Grants of out of country coverage.⁴³⁹ The remaining 46 cases that had discrepancies within Team Patient were Denied by the Board. In hindsight, Year 1 to 5 cases should have been included in the analysis or – at a minimum – all 106 cases – not just the 50 cases for Year 5.

Of the cases in Year 5, 41 (82%) were in 2007 Decisions and 9 (18%) were 2008 Decisions. The 4 Granted Decisions were issued in 2007.

HSARB Decision-Year

	Frequency	Percent	Valid Percent	Cumulative Percent
2007	41	82.0	82.0	82.0
2008	9	18.0	18.0	100.0
Total	50	100.0	100.0	

But if one looks at the file date of each of these 4 cases, 3 of the cases entered the Board system in 2006 and 1 in 2007. Why is this important? It is important because the patient's medical condition, the state of the comparable identical or equivalent treatment in

⁴³⁹ Cases #292 (06-HIA-0047 L.S.), Case #322 (06-HIA-0265 D.A.M.), Case #329 (06-HIA-0293 D.K.), Case #362 (07-HIA-0018 S.F.)

Ontario and the delay experienced in the eyes of the patient must be, in the majority of Granted cases, seen as of 2006 and not 2007. At the end of 2005, the Ontario government began operationalizing its Wait Time Strategy (WTS) for five treatments/operations⁴⁴⁰ in an effort to decrease the delay patients were experiencing. For surgical wait times, the time is tracked between when a surgery is ordered and when the surgery is performed.⁴⁴¹ Standards were put in place as to how long a patient should have to wait, based on their medical condition, from the time surgery was ordered until the time surgery took place.

The file date 2006 cases before the Board may not have had a chance to experience the decreased Wait Times as the policy came into effect in late 2005. On the other hand, even if it effectively reduced a delay between the order for surgery and the surgery itself, the Wait Time Strategy may not have been addressing the type of “Delay” patients were experiencing. The concept of “Delay” needs to be further broken down to determine where the delay is happening and why it is happening. It is unknown at this time if the implementation of Ontario’s WTS lead to an increase in the number of patient experiencing delays in non-WTS procedures. This is a area for potential research.

Out-of-Country “Grants” by the Board

In cross tabulation analysis table below of GA versus the Board’s Grant of the out of country request by the patient, it can be seen that when there was a discrepancy in the argument of Team Patient, the Board did not Grant the patient’s out of country request (in all 4 cases or 0%). If there was no discrepancy in the argument of Team Patient, the

⁴⁴⁰ cancer, cataract, hip, knee surgery and angiography, angioplasty and CT Scans.

⁴⁴¹ <http://news.ontario.ca/mohltc/en/2010/06/ontarios-wait-time-strategy.html>

Board did Grant the patient's out of country request (in all 4 cases or 100%). Thus, even though the presence of Team Patient discrepancies resulted in denials, the only time the Board granted out of country coverage was if there was no Team Patient discrepancies.

HSARB-Grant versus Patient-GA

Cross tabulation

		Patient Request GA as appropriate		Total
		No Discrepancy		
HSARB-Grant	Deny	Count	27	18
		Expected Count	28.5	16.5
		% within HSARB	60.0%	40.0%
	Grant			100.0%
Grant	Deny	Count	4	0
		Expected Count	2.5	1.5
		% within HSARB	100.0%	.0%
	Grant			100.0%
Total	Deny	Count	31	18
		Expected Count	31.0	18.0
		% within HSARB	63.3%	36.7%
	Grant			100.0%

In cross tabulation analysis table below of I/E versus the Board's Grant of the out of country request by the patient, it can be seen that when there was a discrepancy in the argument of Team Patient, the Board did not Grant the patient's out of country request (in all 4 cases or 0%). If there was no discrepancy in the argument of Team Patient, the Board did Grant the patient's out of country request (in all 4 cases or 100%). Thus, as with GA, even though the presence of Team Patient discrepancies resulted in denials, the only time the Board granted out of country coverage was if there was no Team Patient discrepancies.

HSARB-Grant versus Patient Request- I/E in Ontario

Cross tabulation

		Patient Request- I/E in Ontario			
		No Discrepancy	Discrepancy	Total	
HSARB-	Deny	Count	30	15	45
	Grant	Expected Count	31.2	13.8	45.0
		% within HSARB	66.7%	33.3%	100.0%
	Grant				
	Grant	Count	4	0	4
		Expected Count	2.8	1.2	4.0

	% within HSARB	100.0%	.0%	100.0%
	Grant			
Total	Count	34	15	49
	Expected Count	34.0	15.0	49.0
	% within HSARB	69.4%	30.6%	100.0%
	Grant			

This is the same pattern for GA (s.28.4(2)(a)) and I/E (s.28.4(2)(b)(i)) in terms of the Board Granting if there is no discrepancies in Team Patient's argument and not Granting if there is a discrepancy. The pattern is not significant given the sample size of 4 Grants. A larger sample size should be included to assess if this pattern is significant. Given that the focus at this point is on 'patterns' as opposed to significance given the sample size, it is interesting to note that the pattern changes when analyzing Delay (s.28.4(2)(b)(ii)).

Delay causing Death and Delay causing MSITD (s.28.4(2)(b)(ii)) both show the same pattern to each other which is different from the pattern shown in GA (s.28.4(2)(a)) and I/E (s.28.4(2)(b)(i)). With Delay causing Death, the Board Grants or Denies the patient's request for out of country coverage approximately equally if there is agreement in within Team Patient or if there is discrepancies within Team Patient. In the Table below, 50% (n=2) the Board Granted if there was no discrepancy in Team Patient argument and 50% (n=2) the Board Granted if there was a discrepancy in Team Patient's argument.

HSARB-Grant versus Patient Request b/c Delay causing Death

Cross tabulation

		Patient Request- Delay=Death		Total
		No Discrepancy	Discrepancy	
HSARB-	Deny	Count	22	23
	Grant	Expected Count	22.0	23.0
		% within HSARB	48.9%	51.1% 100.0%
	Grant			
	Grant	Count	2	2
		Expected Count	2.0	2.0
		% within HSARB	50.0%	50.0% 100.0%
	Grant			
Total	Count	24	25	49
	Expected Count	24.0	25.0	49.0
	% within HSARB	49.0%	51.0%	100.0%
	Grant			

The same pattern can be seen with Delay causing MSITD. The Table below shows that the Board Grants or Denies the patient's request for out of country coverage approximately equally if there is agreement in within Team Patient or if there is discrepancies within Team Patient. In the Table below, 50% (n=2) the Board Granted if

there was no discrepancy in Team Patient argument and 50% (n=2) the Board Granted if there was a discrepancy in Team Patient's argument.

HSARB-Grant versus Patient Request b/c Delay causing MSITD

Cross tabulation

		Patient Request- Delay=MSITD		Total
		No Discrepancy	Discrepancy	
HSARB-	Deny	Count	20	25
Grant		Expected Count	20.2	24.8
		% within HSARB	44.4%	55.6%
	Grant			100.0%
	Grant	Count	2	2
		Expected Count	1.8	2.2
		% within HSARB	50.0%	50.0%
	Grant			100.0%
Total		Count	22	27
		Expected Count	22.0	27.0
		% within HSARB	44.9%	55.1%
	Grant			100.0%

Granted Cases Year 5

The following 4 cases were Granted by the Board. Each case is reviewed in more detail to determine where the discrepancy within Team Patient lied and over what element of s.28.4(2):

1. Case 292 (06-HI-0047 L.S.) involved a second opinion regarding an eye condition. The discrepancy within Team Patient arose between the patient and the SP regarding the Delay causing MSITD element of s.28.4(2).

The patient requested reimbursement for a consultation at the Cleveland Clinic in Ohio, USA. The patient had undergone various treatments and surgeries in Toronto and was under the care of a SP at Toronto Western Hospital. The patient's condition worsened and she, at her own expense, visited the Cleveland Clinic for a consult where immediate surgery was recommended. The patient returned to Ontario where SP then attempted surgery but it was unsuccessful. The SP 'recommended' the patient return to the Cleveland Clinic – which she did – but the Cleveland Clinic would not operate 'because it was too late' because 'he [the Cleveland Clinic SP] found irreversible tissue damage due to months of low intraocular pressure.'

The patient wanted to be reimbursed for her consult at the Cleveland Clinic. The patient and OHIP agreed on GA and I/E but disagreed on Delay causing MSITD. The patient's SP initially stated a delay would cause MSITD but then reversed his agreement with the

patient – not telling the patient - and stated to OHIP that a delay would not cause MSITD. The SP then became a proposed witness for OHIP but was not called at the Hearing.

The Board stated it

“... had the benefit of observing and hearing the Applicant [the patient] as she testified. She was forthright and entirely credible.... OHIP pointed out that the form was completed in two different handwritings, and questioned whether the Applicant had written some of the statements on the form. The Applicant testified that the information on the form was completed when she received it from Dr. Lam [patient’s Ontario SP].

Since Dr. Lam did not testify, the inconsistent and contradictory information remains unexplained. ...”⁴⁴²

The Board concluded that it was too late for surgery – delay causing MSITD – but it was not too late for a consult out of country regarding the patient’s condition. The Board also stated that the Prior Approval Form must be completed before the health care service out of country is received. However, in this case, the patient submitted the form to her SP but the SP did not complete the form before the consult despite the SP’s endorsement that the patient should seek the consult. Thus, according to the Board, the patient had to wait for the SP to complete the form in order to qualify for s.28.4(5) Prior Approval by OHIP.

The Board granted the out of country coverage on the basis of Delay causing MSITD.

⁴⁴² 06-HIA-0047 L.S. at10.

2. Case 322 (06-HIA-0265 D.A.M.) dealt with consultation and biopsies for foot pain at John Hopkins Hospital (JHH) in Baltimore, Maryland. The discrepancy within Team Patient arose between the P and the SP regarding the ‘experimental’ element of the pretest to s.28.4(2).

The patient’s SP referred her to JHH. The Board admitted evidence that was submitted by the patient following the close of the Hearing. Recognizing that it was not the ordinary practice to file evidence after the conclusion of a Hearing, the Board found the evidence – a letter from a Professor of Neurology supporting the patient – to be relevant to the issue on appeal. Under the authority of the SPPS to control its own process, the Board stated it had the jurisdiction to admit the evidence. OHIP responded to the letter in submissions to the Board.⁴⁴³

Initially, the patient’s SP on the Prior Approval Form stated that the treatment was ‘experimental’. In a subsequent letter after OHIP had made its decision not to fund the request, the patient’s SP stated:

“In your application, I indeed indicated that the procedure is considered experimental in Ontario. At the time, I meant to indicate that this procedure is not offered as a regular diagnostic service. I indicated that the investigation is generally appropriate for a person in these medical circumstances.”⁴⁴⁴

⁴⁴³ 06-HIA-0265 D.A.M. at 2

⁴⁴⁴ 06-HIA-0265 D.A.M. at 8

In a second subsequent letter, the SP confirms he sent the patient on a referral to JHH but the diagnostic “...is recognized worldwide as a reliable diagnostic procedure if done in a centre with expertise. ...”⁴⁴⁵ OHIP agreed with the SP’s initial position that the procedure was experimental and stated:

“It is the General Manager’s position that the continued evidence from an Ontario expert shows that the procedure being requested out-of-country is considered experimental by Ontario standards and, in accordance with the previously noted sections of the Health Insurance Act, of Ontario, funding cannot be considered by the Ontario Health Insurance Plan for this form of investigation and testing.”⁴⁴⁶

Based on the evidence, the Board determined that the treatment was not experimental and thus within the jurisdiction of OHIP to fund. The patient and OHIP agreed on GA and no I/E in Ontario existed. It is interesting to note that the evidence for no I/E from the patient was a simple indication on the Prior Approval Form and a letter from the SP, uncontested by OHIP, which stated:

“The technique of cutaneous nerve biopsy is not offered in Canada.”⁴⁴⁷

The Board stated that if the procedure is GA and not performed in Ontario, OHIP was to insure the out of country service. The Board stated that delay need not be considered:

⁴⁴⁵ 06-HIA-0265 D.A.M. at 8

⁴⁴⁶ 06-HIA-0265 D.A.M. at 8

⁴⁴⁷ 06-HIA-0265 D.A.M. at 10

“Having found that the requested treatment, cutaneous nerve biopsy, is not performed in Ontario by an identical or equivalent procedure, the Appeal Board need not consider this issue [whether Delay would cause death or MSITD]”.

3. Case 329 (06-HIA-0293 D.K.) dealt with reimbursement for back surgery at the Cleveland Clinic in the USA. The discrepancy within Team Patient arose between the P and the SP regarding the Delay causing M element of s.28.4(2).

The patient and OHIP agreed on GA and I/E but not Delay causing MSITD. In addition to his GP, the patient contacted a number of SP in Ontario. One SP – Dr. D - gave a wait time for surgery consultation and another wait time for the actual surgery. The patient, patient’s family and physicians explored surgery in Toronto, Hamilton, Windsor and Timmins but found a wait list of at least 6 months. The patient proceeded to have surgery at the Cleveland Clinic. The patient argued Delay causing MSITD. OHIP argued the Delay did not cause MSITD based on OHIP’s conversation with Dr. D. - one of the patient’s SP – who did not examine the patient. OHIP had contacted Dr. D’s office and Dr. D’s secretary reported that Dr. D had reviewed the patient’s chart and the patient could wait for his appointment. The Board was not persuaded by this evidence and called it Hearsay.

The Board took into account the evidence of Delay causing MSITD by one of the patient’s Ontario treating SP, and its consistency of the Cleveland neurosurgeon, the

patient's attempts to contact surgeons for surgery and subsequently Granted out of country coverage.

4. Case 362 (07-HIA-0018 S.F.) dealt with a diagnosis of pancreatic cancer. The patient, a physician himself, was referred to 4 surgeons for a consult with one surgeon proposing surgery 6 weeks later. The discrepancy within Team Patient arose between the P and the SP regarding the Delay causing MSITD element of s.28.4(2).

The patient investigated and pursued surgery in the USA and submitted a reimbursement request for surgery that had taken place at John Hopkins Hospital in Baltimore, USA in Dec of 2006. The patient and OHIP agreed on GA and I/E but disagreed on Delay. The patient argued that a 6 week delay for Ontario surgery would be a Delay causing MSITD. The patient's Ontario GP agreed but the patient's Ontario surgeon did not agree and felt that the 6 week delay would not have affected the tumor. Thus, there was conflicting views from Ontario physicians who had examined the patient. The Board stated:

“The views of a specialist are often persuasive and perhaps more persuasive than those of a family physician on matters concerning surgery; however, this is not always the case. It is a question of fact whether the surgeon’s opinion has more weight than that of the family doctor.”⁴⁴⁸

⁴⁴⁸ 07-HIA-0018 at 4

The patient argued that little weight should be given to his specialist's opinion but instead the Board should weigh the observations of the USA surgeon conducting the operation and the recurrence of the cancer following the USA surgery.

OHIP did not argue against the patient's statement that the cancer was 'aggressive' but argued that the Board should not rely on evidence gleaned following the surgery.⁴⁴⁹ OHIP cited a previous Board case⁴⁵⁰ regarding evidence gleaned after a surgery:

"... the provision is one of the criteria for funding of services obtained with prior approval. This also indicates that the question raised by the provision is whether at the time of the application for prior approval, there is evidence that it is necessary for a insured person to travel outside Canada to avoid a delay that would result in medically significant irreversible tissue damage. To find that this question is properly answered with evidence available only after treatment has been obtained would render the language of the clause absurd, because the criterion could never be satisfied in advance, as it should be with prior approval. Similarly, to find that one can satisfy a forward-looking criterion with hindsight presents an untenable proposition in terms of the medical assessment that must be performed to answer the question. A medical assessment of the necessity of obtaining early treatment to avoid tissue damage or death is not properly an

⁴⁴⁹ 07-HIA-0018 at 5

⁴⁵⁰ 06-HIA-0001

assessment, but rather a self-fulfilling prophecy if based solely on knowledge of, and pronounced following, the outcome of the treatment. (emphasis added).⁴⁵¹

The Board agreed that it would not rely exclusively on evidence gleaned after surgery to determine Delay.

It is important to note the role of the SP in these 4 cases granted in Year 5. In each case, the SP was acting as a ‘gatekeeper’ and in 3 or the 4 cases where there was a discrepancy between the P and the SP regarding Delay causing MSITD – s.28.4(2)(b)(ii). It is also interesting to note that the SP was not present at the Hearing to answer questions from the parties or the Board.

Summary

The discrepancies in the patients’ s.28.4(2) argument were analysed relative to the determination of the Board whether or not to grant OHIP coverage for OCCNEIHS. In summary, of the 106 Year 5 cases, 50 cases showed discrepancies within Team Patient of which 4 cases were granted OHIP coverage. The rate of discrepancies within Team Patient is remarkable because of grounds for granting out of country coverage are based on medical opinion for medically necessary services. If there is a disagreement, it is between the patient and their medical professional(s) whether or not the criteria of s.28.4(2) are met. The Team Patient discrepancies could be GA, I/E or Delay causing D and/or M elements of s.28.4(2). The question becomes whether the discrepancies had an

⁴⁵¹ 07-HIA-0018 at 5

effect on the Board's Granting or Denying of out of country coverage. The study is very limited in that only 4 cases out of 50 Team Patient discrepancy cases were granted. The remaining 46 Team Patient discrepancy cases were Denied by the Board. Of those 4 Team Patient discrepancy cases granted, if the discrepancy was within the GA element or the I/E element of s.28.4(2) test, the Board appears to not grant the out of country coverage. If, however, there is a Team Patient discrepancy in Delay causing death and or MSITD, a different pattern emerges such that the Board still Granted the out of country coverage 50% of the time. Although this is preliminary, exploratory data, the difference of patterns warrants more investigation beyond this study.

It is important to note that the s.28.4(2) elements of GA and Delay both apply directly to the patient's medical condition. In s.28.4(2), the element of I/E applies is a non-patient specific element as it assesses the availability of treatment in Ontario rather than any medical condition of the patient.

