OVERVIEW

This section provides an overview of the roles and responsibilities of key stakeholders impacting hospitals. The detailed description of stakeholders can assist physician leaders in understanding the relationship between their hospital and the Ontario health system.

Hospital Stakeholders

Public hospitals must take into account the interests of multiple stakeholders. These include:

- Patients and local community;
- Staff (Employees and Professional Staff);
- Volunteers;
- Community members;
- Local Health Integration Networks (LHINs);
- Ministry of Health and Long-Term Care (Ministry);
- Canadian Institute for Health Information (CIHI);
- Donors and hospital foundations;
- Academic partners;
- Donors;
- Contracting parties;
- Other health providers; and
- The health system as a whole.
Figure 1. A Hospital and its Relationships
Source: OHA Guide to Good Governance
Other important external stakeholders for Ontario hospitals include:

- **Ontario Hospital Association** (OHA);
- **Ontario Medical Association** (OMA);
- **Ontario Nurses' Association** (ONA);
- **Canadian Blood Services** (CBS);
- **Trillium Gift of Life Network** (TGLN);
- **Cancer Care Ontario** (CCO);
- **Health Quality Ontario** (HQO)

It is the role of the hospital’s board of directors and all of its leaders (including physician leaders) to act in the interests of the hospital corporation, and therefore, hospital leaders are not solely accountable to any stakeholder in particular. Hospital leaders will face challenges when they are choosing between competing demands for limited resources. However, when acting in the interests of the hospital, its leaders must ensure that they act not only in furtherance of the mission and vision of the hospital, but in a way that allows the hospital to discharge its accountability to its stakeholders.

This and other corporate governance concepts are discussed further in Module 2. This module provides further information regarding some of the key hospital-stakeholder relationships relevant to physician leaders. A more detailed discussion of hospital stakeholder relationships can be found in Chapter 2 of the OHA’s Guide to Good Governance.

**Patients and Local Community**

The interests of patients and families and the needs of the community being served are of utmost importance. Hospitals provide a vital service to the community with taxpayers’ dollars. Hospital leaders, including physician leaders, must therefore take into account the public interest when determining what is in the best interests of the corporation. The standard to which the hospital will be held accountable with respect to the scope and quality of services it provides, is that which would be expected of a similarly situated hospital (a “community standard”).
Hospital Staff

The physician leader’s relationship with hospital staff will be explored throughout this Manual. At this stage, it is important to understand that hospital staff are comprised of employees (union and non-union) as well as credentialed Professional Staff (many of the hospital’s physicians, midwives, dentists, extended class nurses), and that there are differences in the legal relationship with each group.

Community Members

Public hospitals are not-for-profit corporations, and therefore, have members instead of shareholders. Some public hospitals have community members, and others do not. For example, faith-based hospitals are governed by the religious community and, as such, they do not have community members. The role of community members in the corporate governance of hospitals is discussed in Module 2. It is important to note here that hospital members have a limited role in the corporate governance (most notably, the election of directors) and do not have the rights of a shareholder of a for-profit corporation.

Local Health Integration Network (the “LHIN”)

Ontario has implemented a model for local management of health care services based on LHINs constituted under the Local Health System Integration Act. Each LHIN is a not-for-profit corporation and agent of the government which oversees and represents health service providers in a particular geographic area. The Board of Directors of each LHIN is appointed by the government, and the Directors receive remuneration for their role (i.e., compensation for expenses and payment for time spent on authorized LHIN business).

The LHINs oversee and fund health service providers (as defined in the legislation), including public hospitals. The LHINs also engage in health system planning, system integration (including transferring, merging, amalgamating, or ceasing provision of services) and coordination, and oversee health service provider performance pursuant to service accountability agreements and performance agreements.
Each LHIN has its own website which is accessible from the general site and which contains region-specific information regarding processes and procedures employed by the particular LHINs. More information on LHINs is available here.

Ministry of Health and Long-Term Care (the Ministry)

The Local Health System Integration Act has resulted in the delegation of a number of funding functions to the LHINs, including the legislative power and authority to plan, coordinate and fund local health systems. The Ministry develops policy and provides funding to the LHINs for Ontario’s public hospitals. The Ministry retains ultimate responsibility for the health care system. In addition, pursuant to the Public Hospitals Act, the Minister has the power to intervene in the governance of a hospital through the appointment of a supervisor or an investigator in cases where the Ministry determines it is in the public interest to do so.
Academic Partners

Academic hospitals are formally affiliated with colleges and universities that have medical and other clinical programs, through written affiliation agreements. The agreement creates a contractual relationship between the hospital and the academic institution. University affiliation agreements typically outline each organization’s obligations as they relate to student placement. It may also address Professional Staff appointments at the university, adherence to university and hospital policies and procedures, placement of undergraduate and postgraduate students, and research relationships. College affiliation agreements typically govern the placement of the school’s students in a clinical setting at the hospital.

Community hospitals may also have academic affiliations with a university medical school (e.g. North York General Hospital – University of Toronto), to provide clinical rotations for medical students and residents; and with universities and community colleges to provide clinical rotations for students in other health professions.

Further information regarding academic partnerships appears in Module 2.

Canadian Institute for Health Information (CIHI)

CIHI, a national, independent, not-for-profit organization, plays an important role in Canada’s health care sector. CIHI collects, analyzes, and publishes health care data provided by hospitals and other providers in a standardized fashion. This publicly available information supports leaders across the system – health providers, policy-makers, provincial governments – by providing data and information to enable more effective decision-making, and in turn, better health for Canadians.
For example, the public reporting of various patient safety indicators through CIHI, continues to help Ontario’s hospitals implement strategies to improve quality and safety within their organizations, inspire improved performance, and strengthen the public’s confidence in Ontario’s hospitals.

Since 1994, CIHI has worked with system partners to:

- Help improve the depth and breadth of Canada’s health data.
- Build and maintain 27 critical pan-Canadian databases that enable jurisdictions to compare data (e.g., the National Ambulatory Care Reporting System (“NCARS”), National Rehabilitation Reporting System (“NRSS”), National System for Incident Reporting (“NSIR”), among others).
- Produce analyses on health and health care in Canada that are relevant, timely and actionable.
- Increase the understanding and use of data through education, reporting tools and strategies.

Donors and Hospital Foundations

Many hospitals rely, to a significant extent, on charitable donations for equipment and special projects. Foundations generally do not fundraise for ongoing operations. While hospitals may fundraise directly, the most common fundraising model is the hospital foundation: a separately incorporated charitable corporation governed by an independent board of directors. Typically, there is a formalized relationship between the hospital board and the foundation board, and physician leaders will generally not deal directly with donors or the foundation as part of their day-to-day duties. Some physician leaders may hold positions on the foundation board. Physician leaders may also be asked to speak to donors to support the work of the foundation.

While hospital donors and foundations are important hospital stakeholders, as with other hospital stakeholders, it is important for physician leaders and hospital directors to always act in the best interests of the organization, which involves consideration of all stakeholders and accountabilities.
LEADERSHIP QUOTE

Our donors are key partners in the hospital strategic directions. I do my best to attend events and lend my presence as requested by the Foundation.

Dr. Nancy Merrow
Chief of Staff, Southlake Regional Health Centre

HAVE A GREAT LEADERSHIP QUOTE OR RESOURCE TO SHARE? Click Here
OVERVIEW

Physician leaders need to be familiar with the legal context of hospital operations as it relates to their administrative role and responsibilities within the organization.

This section provides an overview of the key legislation governing the Ontario health system and their implications for hospitals and physician leaders.

There are many different pieces of legislation which are relevant to the operation of Ontario hospitals. Copies of current Ontario legislation can be accessed here.

FEDERAL ROLE

The establishment, maintenance and management of hospitals is a provincial responsibility under the Federal Constitution Act, and therefore, the majority of the relevant legislation is provincial.

The few pieces of Federal legislation which impact day-to-day hospital operations include:

- The Canada Health Act, under which the Federal government contributes to provincial health funding and sets out the five principles (“pillars”) which provinces must meet in order to receive full funding from the Federal Government: public administration, comprehensiveness, universality, portability, and accessibility (funding flows are discussed in further detail later in this module);

- The Food and Drugs Act, under which the Federal government regulates pharmaceuticals and medical devices and provides narcotic control.

Health Canada is a department of the Federal government which administers funding for health care funded directly by the Federal government, such as health care for First Nations.

The Public Health Agency of Canada (PHAC) is another department of the Federal government which assists the Federal Minister of Health in exercising and performing his or her powers, duties and functions in relation to public health. PHAC works closely with provincial, territorial and municipal governments given their shared responsibility for public health. PHAC is managed by the Chief Public Health Officer of Canada, who also acts as a Deputy to the Minister of Health.
PROVINCIAL LEGISLATION

A hospital corporation is a not-for-profit corporation incorporated under the Ontario Corporations Act and approved as a public hospital under the Public Hospitals Act. Hospitals are not agents or divisions of the government, but are autonomous organizations governed by independent boards of directors.

There are many pieces of provincial legislation which impact on a hospital’s day-to-day operations. This section provides a brief overview of the legislation that is most relevant to the physician leader role. In some cases, more detailed information will be provided in upcoming Modules.

Public Hospitals Act

The Public Hospitals Act (PHA) and its regulations provide the framework within which Ontario’s public hospitals operate.

The PHA is administered and enforced by the Minister of Health and Long-Term Care. The PHA sets out the role of the Minister and Ministry with respect to oversight of public hospitals. The Minister’s approval is required with respect to a number of more significant administrative matters, including the incorporation and amalgamation of public hospitals, and with respect to the acquisition and disposal of land.

The PHA governs a number of different areas, including:

- Corporate Governance: In conjunction with the Corporations Act, the PHA and Regulation 965 (the Hospital Management Regulation, or HMR) made under the PHA, provide the framework for hospital governance. Pursuant to the HMR, the hospital is governed and managed by board of directors. The PHA and HMR provide for the establishment of corporate by-laws, Professional Staff by-laws, the Medical Advisory Committee (MAC) and Fiscal Advisory Committee, and impose requirements with respect to the composition of hospital boards of directors and the timing of annual meetings. The PHA also empowers the Ministry to appoint an investigator and/or recommend the appointment of a supervisor to manage public hospitals in certain circumstances.

1 The Not-for-Profit Corporations Act will replace the Corporations Act when it is proclaimed in force (targeted for July 1, 2013). See discussion on governance below and Module 2 for further details.
• **Physician Appointments and Privileges**: The PHA contains a process describing how members of the Professional Staff are to be appointed and re-appointed, and how board hearings are used to resolve disputes between hospitals and members of the Professional Staff. Hospital privileges will be discussed in more detail in Module 2. For more information, refer to the OHA’s [Professional Staff Credentialing Toolkit](#).

• **Reporting**: Under the HMR, the board is responsible for ensuring that the CEO establishes a system to ensure disclosure of every critical incident to the MAC, CEO and patient or patient representative. The board is also responsible for ensuring that the CEO provides aggregated critical incident data to the hospital’s quality committee established under the [Excellent Care for All Act](#) (ECFAA) at least two times per year. It is important to note that ECFAA imposes further reporting requirements (as set out in more detail later in this Module, and in Modules 2 and 6).

For additional information on quality oversight, see the [Quality and Patient Safety Governance Toolkit](#) and the [Ontario Guide to Disclosure](#).

The CEO is also responsible for reporting to the College of Physicians and Surgeons of Ontario pursuant to the PHA with respect to any disciplinary action taken with respect to physicians.

• **Funding**: There is a general provision in the PHA which enables the Minister to fund public hospitals when it is in the public interest for it to do so. Hospital funding is discussed in detail later in this Module.

• **Patient admissions, discharge and records**: The HMR sets out in detail the requirements for admission and discharge of hospital in-patients and out-patients, and the requirements for patient records.

• **Classification of hospitals**: Under a regulation made under the PHA, public hospitals are classified as general hospitals, convalescent hospitals, hospitals for chronic patients, active treatment teaching psychiatric hospitals, active treatment hospitals for alcoholism and drug addiction and regional rehabilitation hospitals, and are designated into a number of Groups.

• **Communicable disease protocols**: Under the HMR, hospitals are required to provide for the operation of an employee health surveillance program, following the recommendations in the Communicable Disease Surveillance Protocols published jointly by the OHA and the OMA and approved by the Minister. Information regarding the Protocols is available [here](#).
Governance

Hospital corporations are not-for-profit corporations incorporated under the Ontario Corporations Act or, in some cases, incorporated by special legislation.

In October 2010, the Ontario Government passed the Not-for-Profit Corporations Act which, at the time of this Manual’s publication, has not yet been proclaimed in force. When the Not-for-Profit Corporations Act is proclaimed in force (targeted for July 1, 2013), it will replace the Corporations Act with respect to the corporate governance of hospitals.

For more information on the Not-for-Profit Corporations Act, visit the OHA’s Governance Centre of Excellence.

The corporate governance structure of public hospitals will be explored in more detail in Module 2. For more information, refer to the OHA’s Guide to Good Governance.

Charity Law

Hospitals are also charitable corporations. Charity law is outside the scope of this Manual. However, it is important for physician leaders to know that legislation such as the Federal Income Tax Act and the Ontario Charities Accounting Act may limit the business activities that may be carried on by hospitals.

Quality, Transparency, Accountability and Engagement

A number of pieces of legislation have been enacted in recent years which impose new obligations on Ontario public hospitals with respect to quality, transparency, accountability and community engagement. This section summarizes these obligations. A more detailed discussion of many of these issues can be found in Module 6.

(a) Excellent Care for All Act (ECFAA)

ECFAA was enacted in 2010 with the purpose of improving patient care and enhancing the patient experience. Under ECFAA, hospitals are mandated to conduct employee/care provider and patient satisfaction surveys, and to have in place a patient relations process. ECFAA also
requires hospitals to establish a Quality Committee that reports to the board, and to complete annual Quality Improvement Plans. ECFAA links executive compensation to performance improvement targets in the Quality Improvement Plan. For more information, see the OHA’s ECFAA page.

(b) **Broader Public Sector Accountability Act** (BPSAA)

BPSAA was enacted in response to issues raised in the Special Report from the Office of the Auditor General of Ontario in 2010, to enhance transparency and accountability with respect to public funds. BPSAA imposes a number of accountability requirements on public hospitals, including:

- Not using public funds to engage lobbyists
- Reporting on use of consultants
- Managing expense claim reporting
- Setting expense claim rules
- Setting procurement standards
- Establishing allowable perquisite rules
- Creating compliance reports
- Parameters around executive compensation

Detailed information and resources with respect to the implementation of BPSAA is available from the [MOHLTC](https://www.mohltc.gov.on.ca).

(c) **Local Health System Integration Act** (LHSIA)

Under LHSIA, hospitals are required to conduct community engagement “when developing plans and setting priorities for the delivery of health services”. For more information on stakeholder engagement, refer to [EPIC – Engaging People, Improving Care](https://www.epic.ca).
(d) **Public Sector Salary Disclosure Act** (PSSDA)

Under PSSDA, hospitals are required to publicly disclose employee salaries which exceed $100,000. The list of public salaries is commonly referred to as the “Sunshine List”.

(e) **Quality of Care Information Protection Act** (QCIPA)

QCIPA addresses the public interest in facilities engaging in quality of care and peer review activities by prohibiting disclosure of quality of care information generated for the purposes of a designated “quality of care committee”. For more information, consult the OHA’s [QCIPA Toolkit](#).

There are also a number of voluntary processes not prescribed by legislation which contribute to or demonstrate hospital accountability, transparency and engagement. Typical forums for engagement include community advisory committees or councils, “town hall” style meetings and other presentations to community groups and stakeholder entities, patient feedback and surveys, and the hospital website.
HOSPITAL RECORDS AND PRIVACY

Physician leaders should be familiar with the system of patient record-keeping in their institutions from experience with their clinical practices.

Minimum requirements for patient record-keeping by hospitals are contained in the HMR – e.g., all orders for treatment must be dated, in writing, and signed by the Professional Staff member giving the order.

There are also requirements with respect to patient record-keeping in the statutes which govern self-governing health professions, as well as in their policies and procedures and in the policies and procedures of the hospital. For example, rules made under the General Regulation of the Medicine Act set out minimum requirements for patient record-keeping by physicians.

In 2004, the Ontario government enacted the Health Information Protection Act, which introduced two significant new pieces of legislation governing health information in the province: the Personal Health Information Protection Act (PHIPA) and the Quality of Care Information Protection Act (discussed in the previous section).

PHIPA governs the collection, use and disclosure of individuals' personal health information by health information custodians such as public hospitals. PHIPA also addresses the right of patients to access their own personal health information.

For more information, consult the OHA's Hospital Privacy Toolkit.

As of January 1, 2012, the Freedom of Information and Protection of Privacy Act (FIPPA) applies to public hospitals in Ontario. Under FIPPA, members of the general public have a right of access to all records in the custody or under the control of a hospital from on or after January 1, 2007, unless the records are excluded from the right of access or subject to an exemption. The application of FIPPA represents a significant change for hospitals. Whereas previously, the only right of access to information was by individuals to their own personal health information under PHIPA, many other hospital records are now accessible by the general public under FIPPA. Most hospitals have assigned administrative responsibilities for FIPPA to a Freedom of Information Office or Co-ordinator, and have implemented an administrative, reporting and decision-making structure to ensure compliance with FIPPA. For more information, consult the OHA’s Hospital Freedom of Information Toolkit.

Retention of hospital records, including patient records, is a complex issue which requires reference to a large number of relevant pieces of legislation. The OHA’s Records Retention Toolkit provides a summary of and guidance on this issue.
Inquests and Inquiries

It is important that physician leaders be aware of recommendations with respect to inquiries and inquests as they relate to the provision of care at their hospital.

Under the Coroner’s Act, it is mandatory to report unusual or unexplained deaths to the coroner, who is then required to investigate. In some cases, the coroner’s investigation leads to recommendations, and in other cases, the coroner may decide that an inquest is necessary in order to complete an investigation.

An inquest is a public hearing into an unexplained or suspicious death, presided over by the coroner. Inquests are not intended to adjudicate liability or make any findings of fault; the main function is to determine the facts and circumstances of the death and to make recommendations aimed at avoiding or reducing the risk of a death occurring in similar circumstances in the future. The coroner has broad powers to regulate the proceedings.

Under the Public Inquiries Act, the Lieutenant-Governor-in-Council has the authority to appoint a commissioner to conduct a public inquiry concerning any matter connected with the good government of the province. On a number of occasions, inquiries in the province have been given terms of reference that relate directly to health care. These typically involve high-profile, system-wide issues or concerns.
For example:

- The *Inquiry into Pediatric Forensic Pathology in Ontario* (the Goudge Inquiry) was created to address serious concerns over the way criminally suspicious deaths involving children are handled by the Province.

- The *Commission to Investigate the Introduction and Spread of SARS in Ontario* (SARS Commission) was struck to investigate the SARS virus that killed 44 people in Ontario in 2003.

In February 2012, the Drummond Commission on the Reform of Ontario’s Public Services released its report, which contains a number of recommendations with respect to health care reform in the province, including a focus on patient-centered care, non-acute care, home-based care, and spending reform. The executive summary can be accessed on the Ministry of Finance’s website.

Reports sent to the OHA from the Office of the Chief Coroner contain details of the investigation and a review of deaths that occurred in hospitals. They include recommendations to hospitals and other related organizations made by either a specialized Committee of the Coroner’s office, or by the coroner’s jury serving on the inquest of the case. These recommendations are intended to prevent deaths in the future that are of a similar nature. An archive of reports can be found on the OHA’s website.

**LEADERSHIP QUOTE**

“Coroner’s reports are reviewed by the Quality Council, a subcommittee of the MAC and the Senior Leadership Team, to understand the application to the care provided within the organization.”

Dr. Gillian Kernaghan
President and CEO, St. Joseph’s Health Care London
Consent to Treatment

All physician leaders should be familiar with consent to treatment from their clinical practice. Physician leaders should also be aware of the legal requirements with respect to consent.

The principle of informed consent to medical treatment is codified in Ontario’s Health Care Consent Act (HCCA). The HCCA provides that consent to treatment is informed if the individual receives the information that a reasonable person in the same circumstances would require to make the treatment decision. The information provided must include the following:

- The nature of the treatment;
- The expected benefits of the treatment;
- The material risks of the treatment;
- The material side effects of the treatment;
- Alternative courses of action; and
- The likely consequences of not undergoing the treatment.

The extent of disclosure will depend on the particular circumstances of each patient’s case and needs to be related to the patient’s own situation and the nature of the proposed treatment.

Where there is an urgent need for treatment, and obtaining consent is not possible, a provider may be exempt from the requirement to obtain it. The HCCA stipulates that an emergency exists only "if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm".

Both the HCCA and the Substitute Decisions Act provide a mechanism for obtaining consent from substitute decision-makers in circumstances where the patient is incapable of providing informed consent for a specific treatment (see below). The HCCA also provides for the review of findings of incapacity by a provincial administrative tribunal, the Consent and Capacity Board (CCB).
Mental Health Law

Physician leaders should be aware of the legislative scheme governing mental health issues, as the treatment of patients with severe mental disorders raises legal issues that often do not arise in the treatment of other illnesses, and all clinical decisions will be subject to a high degree of scrutiny from review tribunals, particularly with respect to whether treatment was authorized. In brief:

- **Mental Health Act** (MHA): governs hospitalization and provides authority for detention in a “psychiatric facility”. Many large public hospitals with a psychiatric department are classified as “psychiatric facilities” pursuant to the MHA. There are approximately 70 Schedule 1 facilities which provide comprehensive general psychiatric services. Psychiatric facilities designated under Schedules 2 through 6 provide more limited or specialized services.

- **Health Care Consent Act**: Governs patient/clinician relations, informed consent, and assessment of capacity and substitute decisions, and provides for the review of findings of incapacity by a provincial administrative tribunal, the Consent and Capacity Board (CCB).

- **Substitute Decisions Act**: Defines and governs Powers of Attorney for personal care and property.

More information on Mental Health Law is available in the OHA’s Mental Health Toolkit.
Workplace Issues

Issues relating to Professional Staff will be dealt with elsewhere in this Manual. This section provides a summary of some of the key legislation relating to workplace issues.

There are two types of hospital employees:

- Non-Unionized Employees - Non-unionized employees have traditional employment contracts, subject to minimum employment standards set out in the Employment Standards Act (ESA) (e.g., minimum age requirement, maximum hours for full-time employment, entitlement to overtime). Insofar as these standard employment contracts contain benefits which exceed the minimum standards, they will be governed by the common law (judge-made case law) with respect to matters such as wrongful dismissal.

- Unionized Employees - The hospital's employment relationship with unionized employees will be governed by the applicable collective bargaining agreement. Collective agreements are negotiated between an employer and a union representing the interests of a particular group of employees. In Ontario, collective bargaining is regulated by the Labour Relations Act, which contains a code of rights and procedures, including how employees become unionized, guidelines for collective agreement negotiations, and procedures for arbitration when differences arise. In the hospital sector, labour relations are also governed by the Hospital Labour Disputes Arbitration Act (HLDAA). HLDAA removes the right of hospital employees to strike and the right of hospitals to lock out their employees in situations where the parties cannot conclude a collective agreement. The right to strike and the right to lock out are replaced with mandatory binding arbitration. The most common unions in the hospital sector are the Ontario Nurses’ Association (ONA), the Canadian Union of Public Employees (CUPE), the Service Employees’ International Union (SEIU), and the Ontario Public Service Employees’ Union (OPSEU).
The biggest difference between non-unionized and unionized employees is that unionized employees have access to a grievance arbitration process, to challenge employer decisions made in the employment relationship. Generally, unionized employees cannot have their employment terminated without the use of progressive discipline and demonstrated just cause. In contrast, non-unionized employees can have their employment terminated by providing ESA notice of termination or payment in lieu of notice and, if applicable, severance pay under the ESA and notice at common law.

The following pieces of legislation are applicable to both unionized and non-unionized employees:

- The ESA provides minimum standards of employment. This legislation deals with such issues as maximum hours of work, vacation entitlements, public holidays, overtime, and minimum wages. Employment contracts and collective agreements cannot contract out of any of the minimum standards, but can, and often do, provide for more than the minimum requirements.

- Under Ontario’s Human Rights Code, hospitals may not discriminate on the basis of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability, in the context of employment or provision of health care services.

- The Accessibility for Ontarians with Disabilities Act (AODA), and the regulations thereunder, provide for the development and implementation of accessibility standards to assist in breaking down barriers for people with disabilities. These accessibility standards, established by regulations to the AODA, cover five areas of daily living: customer service, information and communications, employment, transportation and built environment. There are a number of detailed standards with which hospitals have an obligation to comply, and new standards will continue to be developed through 2025.
For assistance in meeting obligations under the AODA, refer to the OHA’s online accessibility resource.

- The Workplace Safety and Insurance Act offers through the Workplace Safety and Insurance Board (WSIB), a no-fault insurance system to provide compensation to employees injured in the course of employment. Physicians, who are not typically employees of the hospital, are usually not eligible for compensation through the WSIB. As employers, hospitals are required to pay an insurance premium to the WSIB. The hospital is also required to facilitate and cooperate with the WSIB in the safe and early return to work of injured employees. Injured employees may be entitled for compensation during a period of disablement, and re-employment on rehabilitation, if their claim is accepted by the WSIB.

- Ontario regulates occupational health and safety under the Occupational Health and Safety Act (OHSA). Under OHSA, employers must take “every precaution reasonable in the circumstances for the protection of a worker.” Directors and officers (which may include physician leaders) have a duty to take all reasonable care to ensure compliance with the OHSA and any orders made thereunder. Employees (workers) must work in compliance with OHSA and employers must also maintain workplaces that meet the health and safety standards established by OHSA. Physician leaders may fall within the definition of “supervisor” under the OHSA, and if so, they will owe the duties set out within s. 27 of the OHSA. Hospitals have additional prescribed requirements (e.g., reporting requirements) pursuant to the Health Care and Residential Facilities Regulation made under OHSA.

  - With recent amendments to OHSA, employers have a duty to address workplace violence and harassment, as well as domestic violence, when it intrudes into the workplace. OHSA requires a written policy, a workplace risk assessment and training in the measures and procedures for mitigation or prevention of workplace violence and harassment. This will be discussed in further detail in Module 4. For more information on OHSA, please consult the Ministry of Labour website.

It is important to note that hospitals may be required to report a health care worker’s exposure to communicable diseases, pursuant to OHSA and/or WSIB policy. Physician leaders should consult the hospital’s human resources department and/or the occupational health and safety department for more details.

There are also occasions when physicians will employ staff in their offices who are based within the hospital. It is the obligation of the employing physician to ensure that applicable labour legislation is adhered to in the context of this employment relationship, and that their employees conduct themselves in accordance with relevant hospital policies and codes of conduct.
PROFESSIONAL REGULATION

Legislation governing the conduct of health professionals is a matter of provincial jurisdiction.

The *Regulated Health Professions Act* (RHPA) is “umbrella legislation” in Ontario which contains general provisions pertaining to all regulated health professions in the province.

Additionally, accompanying legislation relating to each profession details their scope of practice, controlled acts and issues relating to delegation. Examples of regulated health professions in Ontario include physicians, nurses, midwives, dentists, and optometrists. A list of the regulated health professions and their associated legislation is contained in Appendix 3 of this Module.

Once designated, the health profession is bound by the provisions of RHPA which require that a “College” be established which, in turn, passes by-laws that outlines requirements for registration and standards, limits or conditions of practice, among other things. Matters of professional discipline are handled by individual colleges according to the *Health Professions Procedural Code*, a Schedule to RHPA. The Code also creates obligations for public hospitals with respect to matters such as reporting (e.g., revocation of hospital privileges, sexual assault).

RHPA designates a number of treatments as “controlled acts” which can only be performed by certain specified professionals. However, RHPA does allow for a health professional who is authorized to perform a controlled act to delegate the performance of some of the controlled acts to a specified individual who is not otherwise authorized to perform the act. RHPA contains detailed regulations setting out the circumstances under which a controlled act can be delegated.

Another form of delegation is by way of medical directives, which are orders that may be performed for a range of patients whose condition meets the specific conditions set out in the order. For more information on delegation, please see the online toolkit from the *Federation of Health Regulatory Colleges of Ontario*. More information on the Regulated Health Colleges is contained in Module 2.
An example of non-regulated staff is physician assistants. In recent years, a number of physician assistants have begun working in Ontario hospitals, in some cases, pursuant to a pilot project of the Ministry of Health and Long-term Care. Physician assistants are non-regulated health professionals who practice under the supervision of qualified physicians and who receive their authority to perform controlled acts by delegation. More information is available in this [Scope of Practice Statement](#) released by HealthForceOntario.
OVERVIEW

It is important for physician leaders to understand the sources of hospital funding, the applicable legislation, and the key players in the funding relationship.

LEADERSHIP QUOTE

“Physicians generally have little knowledge of the legal processes that bind how hospitals acquire goods and services. There are pitfalls to be aware of.”

Dr. Nancy Merrow

Chief of Staff, Southlake Regional Health Centre

The manner by which Ontario hospitals receive funding is complicated and, at the time of publication of this Manual, is in a state of transformation.

Physician leaders are advised to meet with the CFO in their organization to understand the specifics of the funding streams for their organization.
The public funding of health care in Ontario is depicted in the following diagram:

Figure 2. The Structure of Healthcare Funding in Ontario and Relevant Legislation
LEGISLATION

The Canada Health Act sets out five principles ("pillars") which the provinces must meet as a condition of receiving full health care funding from the Federal government: public administration, comprehensiveness, universality, portability, and accessibility.

Under the Health Insurance Act (HIA) physicians receive funding for insured, medically necessary services directly from the Ontario Health Insurance Plan (OHIP), on a "fee-for-service" basis. This is the standard manner in which physicians are paid, both for their private office practice and for the hospital component of their practice. There are also other physician funding flows which are becoming more common; for example, some hospitals receive funding for physician services under various alternative funding arrangements with the Ministry, and the Hospital On-Call Coverage (HOCC) Program, administered by the Ministry, provides funding for hospital on-call coverage to offset coverage expenditures previously borne by hospital operating budgets. In some cases, physicians are employed and remunerated by the hospital, for example, through arrangements whereby the hospital bills OHIP on their behalf, using the alternative funding referred to above, or out of the hospital's global budget.

The HIA also defines the scope of insured hospital services. The hospital services to which Ontario residents are entitled without charge is very broad, and includes all laboratory, radiological and other diagnostic procedures, together with the necessary interpretations.

Under the Commitment to the Future of Medicare Act (CFMA), it is prohibited to charge or receive payment for insured services or for preferential access to insured services.

Hospital services are funded by the Ministry, and funding is administered by the LHINs.
ACCOUNTABILITY AGREEMENTS

Hospital funding flows from the Ministry to the LHIN under Ministry-LHIN Accountability Agreements (MLAA). More recently, MLAAs have been replaced by Ministry-LHIN Performance Agreements (MLPA). MLPAs for each LHIN are posted on the LHIN website.

Hospitals are accountable for funding through agreements with the LHIN – Hospital Service Accountability Agreements (HSAA) – which require hospitals to be accountable for explicit performance outcomes (e.g., a minimum number of admissions per year). CFMA establishes a process for HSAAAs to be negotiated with the LHIN. The HSAA is then executed by the Hospital and the LHIN. The HSAA contains financial performance obligations based on data from the Hospital Accountability Planning Submissions (HAPS, formerly known as Hospital Annual Planning Submissions).

The HSAA may also require that a performance agreement be entered into between a hospital and its CEO. The content of and process for entering into service accountability agreements and performance agreements is governed by CFMA. Refer to the LHIN Collaborative for more information about service accountability agreements.

Sources of Hospital Funding

The Ministry, through the LHIN, is the major source of hospital revenue, accounting for about 85-100% of operating revenues for most hospitals. Other sources of revenue include revenue-generating activities (e.g., cafeteria and parking income), funding from other government sources (e.g., Federal funding for veterans’ health care, provincial funding for workplace accidents through WSIB), grants, donations and charitable giving. As set out above, donors are a vital source of hospital funding and important hospital stakeholders.
Hospitals receive funding in a variety of ways. The most significant source of government funding is the hospital’s global budget, which flows from the Ministry through the LHIN and covers the majority of in-patient and out-patient funding. Hospitals have flexibility in allocating their global budget within the terms of their service accountability agreements. Global funding is earned based on formulas – historically, global funding has been based on past funding.
requirements rather than patient volumes or performance (see the next section for a discussion of the Ministry’s new patient-centered approach).

Other Ministry/LHIN funding includes priority services funding for designated programs (e.g., chronic kidney disease), funding to support expansion of services following expansion of hospital facilities, and hospital on-call (HOCC) funding.

Capital Projects may be funded in part by the Ministry, which requires that a significant portion be funded by the hospital through a “local share” (local community giving). Hospitals may also fund capital projects fully from their own revenue-generating activities (e.g., parking revenues). A copy of the Ministry-LHIN toolkit on capital planning is available here.

Potential Changes to Funding Formula

Hospital funding is a complex area which continues to be subject to change. The underlying legislation, policies of the Ministry and the LHINs, local implementation and hospital-specific issues are in a constant state of transformation.

In 2012, the Ministry announced a change in the funding formula which underlies Hospital-LHIN Accountability Agreements (referred to as Health System Funding Reform, HSFR), shifting from global, provider-based funding to patient-focused funding (referred to as Patient-Based Funding, PBF). A Health-Based Allocation Model (HBAM) now distributes funding based on the volume and type of patients, and, in addition, hospitals will receive funding for the number of patients treated for certain procedures (e.g., hip and knee replacements) via Quality-Based Procedures (QBP) funding. HBAM and QBP will be phased in over a number of years. The Ministry’s intention is that, for most hospitals, the global budget will eventually account for approximately 30% of funding, while HBAM will account for 40%, and QBP for 30%.
DECISION-MAKING AT THE MINISTRY

The role of the physician leader with respect to hospital funding will focus on awareness of the general framework and knowledge of the hospital’s approach and relationships with funders. It has been the OHA's practice to provide access to timely webcasts which provide updates with respect to hospital funding in the province. Archived webcasts are available through the OHA's Discovery Campus and provide a comprehensive overview of the current scheme.

The Ministry’s responsibilities are divided into a number of different divisions which deal with the development, implementation and oversight of different pieces of policy and legislation. For example, at the time of publication, the Deputy Minister’s office is responsible for various branches and initiatives, such as the Public Health Division, the Health System Accountability and Performance Division, and the Health System Strategy Division. The Ministry provides an overview and an organization chart for future reference.
HOSPITAL LIABILITY

Hospital liability is governed by the common law (“judge-made law”) rather than by legislation.

Negligence in the course of administering care and treatment to a patient constitutes malpractice. In order to succeed in such a claim, the patient must demonstrate (1) a relationship that gave rise to a “duty of care”, (2) the duty of care was breached, (3) the breach caused damage to the patient, and (4) through proof, that damages were suffered.

Ordinarily, in a malpractice case, the patient’s direct relationship is with a health care professional for whose conduct the facility may or may not have a direct legal responsibility (discussed in more detail below). The standard to which the hospital and medical professionals will be held is the “reasonable standard” in the particular circumstances of the case.

A hospital has direct liability for its equipment, premises and facilities, patient safety and protection, safe operation of hospital systems, processes and protocols, staff appointments (credentialing), and the monitoring of staff competence. A hospital is also vicariously liable for the negligence of its employees, which may include some physicians who are employees. The majority of physicians are not employees but are independent contractors with privileges at the hospital. Hospitals are not generally vicariously liable for clinical care provided by credentialed physicians, but are responsible for due diligence in the credentialing process. For more information, refer to the OHA’s Professional Staff Credentialing Toolkit.

Physician leaders will typically be provided with liability coverage by the hospital in respect of their leadership role. Physicians are required to maintain individual malpractice insurance in respect of their clinical care.

Hospital liability is addressed in more detail in Module 2. Risk management is discussed in Module 5. For more information on hospital liability, see Morris and Clarke, Law for Canadian Health Care Administrators.
LEADERSHIP QUOTE

“Get to know your risk manager and use them as a resource.”

Dr. Nancy Merrow
Chief of Staff, Southlake Regional Health Centre
APPENDIX 1

Key Sources

OHA Resources

- OHA *Guide to Good Governance*
- OHA *Professional Staff Credentialing Toolkit*
- OHA *Quality and Patient Safety Governance Toolkit*
- OHA *Personal Health Information Protection Act Toolkit*
- OHA *Quality of Care Information Protection Act Toolkit*
- OHA *Freedom of Information and Protection of Privacy Act Toolkit*
- OHA *Records Retention Toolkit*

Additional Resources

- **EPIC** – *Engaging People, Improving Care*
- Information and Privacy Commissioner
- Drummond Commission on the Reform of Ontario’s Public Services
- Ontario LHINS
- Ministry-LHIN Toolkit on Capital Planning
- Ministry Organization
- Law for Canadian Health Care Administrators
APPENDIX 2

Key Legislation

- Constitution Act
- Canada Health Act
- Food and Drugs Act
- Public Hospitals Act
- Corporations Act
- Not-for-Profit Corporations Act
- Income Tax Act
- Charities Accounting Act
- Excellent Care for All Act
- Broader Public Sector Accountability Act
- Local Health System Integration Act
- Personal Health Information Protection Act
- Freedom of Information and Protection of Privacy Act
- Quality of Care Information Protection Act
- Public Inquiries Act
- Coroner’s Act
- Mental Health Act
- Health Care Consent Act
- Substitute Decisions Act
- Ontario Human Rights Code
- Employment Standards Act
- Labour Relations Act
- Workplace Safety and Insurance Act
- Occupational Health and Safety Act
- Accessibility for Ontarians with Disabilities Act
- Regulated Health Professions Act
- Health Insurance Act
- Commitment to the Future of Medicare Act
- Local Health System Integration Act
APPENDIX 3

Regulated Health Professions Legislation

- **Audiology and Speech-Language Pathology Act**, 1991
- **Chiropody Act**, 1991
- **Chiropractic Act**, 1991
- **Dental Hygiene Act**, 1991
- **Dental Technology Act**, 1991
- **Dentistry Act**, 1991
- **Denturism Act**, 1991
- **Dietetics Act**, 1991
- **Drugless Practitioners Act**, 1991
- **Homeopathy Act**, 2007
- **Kinesiology Act**, 2007
- **Massage Therapy Act**, 1991
- **Medical Laboratory Technology Act**, 1991
- **Medical Radiation Technology Act**, 1991
- **Medicine Act**, 1991
- **Midwifery Act**, 1991
- **Naturopathy Act**, 2007
- **Nursing Act**, 1991
- **Occupational Therapy Act**, 1991
- **Opticianry Act**, 1991
- **Optometry Act**, 1991
- **Pharmacy Act**, 1991
- **Physiotherapy Act**, 1991
- **Psychology Act**, 1991
- **Psychotherapy Act**, 1991
- **Regulated Health Professions Act**, 1991
- **Traditional Chinese Medicine Act**, 2006