10. Reforms

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Key messages for citizens

- The health system was reformed in 2007 to make healthcare more responsive to local needs by creating 14 Local Health Integration Networks that assumed a substantial portion of the responsibility for planning and integrating the delivery of services, and for funding the organizations (each typically overseen by its own board of directors) that deliver these services.
- Reforms have been implemented to enhance care for priority populations, such as those with complex health needs and those living with mental health and substance use problems.
- Privacy rules for personal health information were enhanced in 2004, and again in 2016.
- Planned reforms articulated in the *Patients First Act, 2016* seek to make care more patient-centred through an expansion of the role of the Local Health Integration Networks for planning and integrating primary care and home and community care.

Key messages for professionals

- The *Excellent Care for All Act, 2010* included a requirement for many types of health organizations (e.g., hospitals and Family Health Teams) to submit annual Quality Improvement Plans to Health Quality Ontario.
- Some reforms have been implemented for managing the health workforce in the province, including strengthening the nursing workforce, expanding the scope of practice for many regulated health professionals, and enhancing coordination between the education and health systems in training health professionals.
- The way that some professionals practise (e.g., as part of interprofessional teams in primary care) and are paid (e.g., using a payment mechanism called Quality-Based Procedures to reimburse hospitals based on the type and quantity of patients they treat) has been changed, and additional changes seem to be on the horizon through the *Patients First Act, 2016* (e.g., as a result of Local Health Integration Networks taking on responsibility for planning primary care) and through negotiations between the Government of Ontario and the Ontario Medical Association on the terms of a new Physician Services Agreement.

Key messages for policymakers

- The last decade and a half has been a time of many health-system changes that have moved the province towards more of a true 'system' (i.e., one that takes a coordinated approach to planning, integrating and funding care across sectors).
- The most significant changes appear to have emerged due to factors related to electoral processes, most notably a change in governing party in 2003 that led to 13 of the 31 recent reforms identified in this chapter (six of which represented significant changes), and a new leader for a majority government in 2014 that led to the *Patients First Act, 2016* that amended 20 pieces of existing legislation (and significantly expanded the role of Local Health Integration Networks in planning and integrating primary care and home and community care).
- One notable area where significant reforms have not been implemented is prescription drugs, where no changes have been made since the introduction of the Trillium Drug Program, despite prescription drugs being the second-largest health expenditure in Ontario.

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This chapter about recent health-system reforms is the first of two chapters that address change and progress, with the second focusing on assessments of the health system that can inform decisions about future reforms. Government decisions to introduce reforms are typically the result of there being: 1) agreement among key decision-makers that there is a compelling problem that needs to be addressed at the level of: risk factors, diseases or conditions; the programs, services or drugs currently being used to address risk factors, diseases or conditions; the governance, financial or delivery arrangements within which these programs, services or drugs are provided; and/or the current degree of implementation of an agreed upon course of action; 2) one or more viable solutions to address the problem (which need to target the right level(s) of the problem); and 3) a determination that the 'politics' are conducive to taking action.(1)

For this chapter we identified recent reforms to the Ontario health system (which we defined very liberally to mean reforms introduced since 2000) by summarizing policy changes that we identified and described in detail in each of the previous chapters of the book. We supplement this with an

overview of proposed reforms to the health system. We analyze recent and proposed reforms in terms of both their nature and where they have and have not happened.

To understand why larger structural reforms to the health system have happened (or may happen in future), the findings from a large empirical study of policymaking processes for a purposively selected sample of six policy issues in five different provinces (Alberta, Saskatchewan, Ontario, Quebec, and Newfoundland and Labrador) are helpful. This study found that two variables were consistently associated with 'large reforms': 1) electoral processes (new government or government leader, campaign commitment to reform during an election, appointment of a champion once in power, and a policy announcement in the first half of a mandate); and 2) presence of a perceived fiscal crisis.(2) Moreover, the study found that the Ontario case – when compared to the other four provinces – is perhaps best characterized as the tortoise in the fable of the tortoise and the hare, since the Government of Ontario took a slow-and-steady approach whereas other provincial governments at times experimented with bold policy changes such as regionalization (which Ontario ended up pursuing, in a much less dramatic form, much later than other provinces).(3) The metaphor still appears apt.

Recent reforms

Since 2000, 31 reforms have been introduced to Ontario's health system. These reforms can be described in relation to the year in which they were implemented, the type and focus of reforms, and the levels of the system that they affected (which is our focus in Table 10.1) and in relation to whether they changed the ways in which the health-system building blocks are used (which is our focus on Table 10.2). We address the timing of the reforms before turning to the nature of the reforms.

In the same time period (i.e., since 2000), there have been four general elections in Ontario (2003, 2007, 2011 and 2014), with the first leading to a new governing party (Dalton McGuinty's majority Liberal government in 2003) and the last involving a new Liberal leader (Kathleen Wynne's majority Liberal government) after three years of a Liberal minority government. In addition, this time period included two significant

Table 10.1: Overview of reforms since 2000

Year	Reform[1]	Type of reform	Focus of the reform	Level of reform
2000-12	Regulation of health professions	Legislation	Enhanced regulations for healthcare providers that were implemented over a period of 12 years for eight health professions or categories of health workers (nurse practitioners, opticians, psychologists, homeopathy, naturopathy, traditional Chinese medicine, personal support workers, and physician assistants), as well as established regulations for new health professions as parts of the *Health System Improvements Act, 2007* (see below)	Profession
2000	*Bill 168, Brian's Law (Mental Health Legislative Reform)*	Legislation	Modified assessment and committal criteria for seriously mentally ill people to enable earlier intervention by their families and health professionals, and to enable their treatment in the community rather than in a psychiatric facility	Cross-sectoral
2001	*Community Care Access Corporations Act*	Legislation	Established the mandate, governance and accountabilities of Community Care Access Centres (CCACs)	Sector
2001	Good Nursing, Good Health: A Good Investment	Strategy/ recommendations/ framework	Provided eight recommendations from the Nursing Task Force focused as part of its mandate "to examine the impact of healthcare reform on both the delivery of nursing services and the nursing profession in Ontario and to recommend strategies to ensure and enhance quality of care through effective use of nursing human resources"(13)	Profession
2003	Mental Health Accountability framework ('Making it Happen')	Strategy/ recommendations/ framework	Developed a guide for mental health accountability in four areas (performance domains, transfer payments from the Ministry of Health and Long-Term Care to agencies, an operating manual for mental health and addiction agencies, and hospital accountability)	Cross-sectoral
2004	*Commitment to the Future of Medicine Act*	Legislation	Established an organization (that became what is now known as Health Quality Ontario, or HQO) to publicly report on health-system performance and support continuous quality improvement	System
2004	*Personal Health Information Protection Act*	Legislation	Enshrined patient confidentiality as an individual right by outlining rules for collecting, using and disclosing personal information about individuals that protect confidentiality while also providing effective healthcare	System

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Year	Reform[1]	Type of reform	Focus of the reform	Level of reform
2004-05	Cancer Care Ontario (CCO) restructuring	Contracts	Restructured CCO between 2004 and 2005 from a provider of a limited scope of cancer services to give it a broader role that includes overseeing the regional delivery of an expanded range of services through 14 regional cancer programs that align with the 14 Local Health Integration Networks (LHINs) (this included transferring assets to hospitals but retaining the funding levers for services delivered, as well as a model for performance accountability)	Cross-sectoral
2005	Health human resource initiatives	Program	Enhanced coordination between the education and health systems in the training of health professionals through a joint initiative between the Ministry of Health and Long-Term Care and the then Ministry of Training, Colleges and Universities	Profession
2005	Family Health Teams	Contracts	Implemented an interprofessional team-based primary care model consisting of physicians, nurse practitioners and other clinicians working in collaboration, with extended hours of care provided	Sector
2006[2]	Nurse Practitioner-led Clinics	Contracts	Implemented a primary-care model where nurse practitioners assess, diagnose, treat and monitor a wide range of health problems	Sector
2006	Program Framework for Mental Health and Court Support Services	Strategy/ recommendations/ framework	Developed a framework for guiding individuals from the criminal justice system to mental health services	Cross-sectoral
2006	*Transparent Drug System for Patients Act*	Legislation	Established the Ontario Public Drug Programs as part of the public drug system reform and includes consumer and patient engagement, transparency, and basing funding decisions on clinical and economic evidence	Cross-sectoral
2006	*Local Health Integration Network Act*	Legislation	Created 14 geographically defined LHINs that have responsibility for the planning, integration and funding of healthcare in their regions, and for ensuring that the different parts of the health system in their regions work together Reduced the number of CCACs from 43 to 14, aligned their boundaries with those of the LHINs, and established the LHINs as their funder	System

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Year	Reform[1]	Type of reform	Focus of the reform	Level of reform
2006-07	Health-Force-Ontario and Health-Force-Ontario Marketing and Recruitment Agency	Program	Developed a provincial strategy (HealthForce-Ontario) to address the supply and mix of health professionals Created the HealthForceOntario Marketing and Recruitment Agency, which focuses on the recruitment, distribution and retention of health professionals	Profession
2007	*Health System Improvements Act*	Legislation	Introduced several changes (through omnibus legislation that affected a number of existing acts) including: • four new regulated health professions (homeopathy, kinesiology, naturopathy and psychotherapy) • new requirements for regulatory colleges (e.g., to establish their own websites with mandated information such as summaries of disciplinary decisions) • allocation of responsibility for some public health activities in the province (e.g., for an enhanced approach to emergency management and for public health laboratories) to a newly created agency (Ontario Agency for Health Protection and Promotion, which was later renamed to Public Health Ontario) that provides leadership and support for all public health activities (including an enhanced approach to emergency management and public health laboratories in Ontario)	Profession Sector
2007	*Long-Term Care Homes Act*	Legislation	Expanded the Residents' Bill of Rights, updated regulations and strengthened the inspection process (including rules for inspectors to enforce compliance)	Sector
2010 (renewed original 1994 strategy)	Aboriginal Healing and Wellness Strategy	Strategy/ recommendations/ framework	The largest provincially funded Indigenous health initiative in the country, which brings together traditional and western programs and services with the aim of providing culturally and linguistically appropriate care to improve Indigenous health, and support Indigenous healing and wellness, while reducing family violence and violence against Indigenous women and children (14)	Cross-sectoral
2010	*Excellent Care for All Act*	Legislation	Created the requirement for many types of health organizations to submit annual Quality Improvement Plans to HQO, and for research evidence to be used to inform policy decisions about the health system	System

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Year	Reform[1]	Type of reform	Focus of the reform	Level of reform
2010	*Narcotics Safety and Awareness Act*	Legislation	Established a monitoring system for the prescribing and dispensing of narcotics and other monitored drugs, in order to reduce the misuse and abuse of these types of drugs (15)	Cross-sectoral
2011	*Health Protection and Promotion Amendment Act*	Legislation	Established the authority of the provincial chief medical officer of health to direct boards of health and their medical officers of health in cases of a pandemic, public health event or emergency with health impacts	Sector
2011	Open Minds, Healthy Minds	Strategy/ recommendations/ framework	Developed a strategy focused on supporting mental health and addictions throughout the life span	Cross-sectoral
2012	Community Health Links	Contracts	Support the delivery of coordinated care in the community for those with complex health needs	Cross-sectoral
2012	Health system funding reform	Contracts	As of 2015-16 two new funding approaches make up 70% of the total funding provided to hospitals: 1) Health-Based Allocation Model (40% of total funding to hospitals) that allocates funding based on a number of inputs that can be used to predict how many services will be needed each year and the costs of those services (e.g., historical service volumes, expected population growth, and healthcare access patterns in a specific region); and 2) Quality-Based Procedures (30% of total funding to hospitals) that allocates funding based on the costs of all of the services required as part of an optimal clinical pathway for an episode of care (or for a discrete part of the clinical pathway) A similar approach is now being used for CCACs	Sector
2012	Moving on Mental Health: A System that Makes Sense for Children and Youth	Strategy/ recommendations/ framework	Created the action plan for community-based mental health for care for children and youth	Cross-sectoral
2013	Make No Little Plans	Strategy/ recommendations/ framework	Developed a strategic plan for restructuring the public health sector with a focus on addressing early childhood development, infectious diseases, prevention, healthy environments, and infrastructure and emergency preparedness	Sector

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Year	Reform[1]	Type of reform	Focus of the reform	Level of reform
2013	Community-based specialty clinics	Contracts	Formalized the process for shifting the site of service delivery from hospitals to community-based specialty clinics for low-risk diagnostic and therapeutic procedures that do not require an overnight hospital stay	Sector
2014	Midwifery-led birth centres	Contracts	Launched two new community-based birth centres with one located in Ottawa (Ottawa Birth and Wellness Centre) and the other in Toronto (Toronto Birth Centre)	Sector
2015 (updated from 2012)	Action plan for health care	Strategy/ recommendations/ framework	Focused on patient-centred care in the most recent version, and provided four overarching goals for the health system that have been used to shape subsequent reforms: 1) improving access; 2) connecting services; 3) informing people and patients; and 4) protecting the universal public health system	System
2016	Ontario Palliative Care Network	Program	Committed in the March 2016 budget to establish the Ontario Palliative Care Network, a partnership among CCO, LHINs, HQO and other partners (e.g., patients, caregivers and clinical representatives) to develop provincial end-of-life care standards, and to support the regionally focused networks that already exist	Cross-sectoral
2016	*Health Information Protection Act*	Legislation	Amended the *Personal Health Information Protection Act, 2004*, and other acts to establish a framework for the electronic health record, and provide increased accountability, transparency and privacy protection for personal health information	System

Sources: 16-40

Notes:
[1] This table does not include legislation that has been proposed or recently passed, the most noteworthy of which is the *Patients First Act, 2016*
[2] The first Nurse Practitioner-led Clinic was approved in Sudbury in 2006 and implemented in 2007. This was followed by the approval of 25 Nurse Practitioner-led Clinics between February 2009 and August 2010.

Table 10.2: Analysis of where reforms did and did not change the ways in which the health-system building blocks are used

Sector, treatment or population	Where did reform happen?	Nature of changes to health-system building blocks			Where did reform not happen?
		Governance	Financial	Delivery	
Care by sector (Chapter 6)					
Home and community care	• Responsibility for planning, integration and funding shifted to the Local Health Integration Networks (LHINs) • Regulation of and increased funding for personal support workers • Shift in approach to funding Community Care Access Centres (e.g., Health-Based Allocation Model) • Coordinated delivery of care for people with complex conditions in their communities (Health Links)	✓	✓	✓	• First-dollar coverage as is provided for hospital-based and physician-provided care (although additional investments have been made)
Primary care	• Enhanced accountability for providers working in Family Health Teams • Introduction of interprofessional team-based care (Family Health Teams) that included alternative remuneration models • Expanded role for nurse practitioners and pharmacists (e.g., through prescribing), and midwives (e.g., through the introduction of birth centres) in primary care	✓	✓	✓	• Accountability for providing primary care to a geographically defined population as opposed to patients on the roster of primary-care clinics (although this is called for in the *Patients First Act, 2016*) • Broader roll-out of alternative remuneration models (most family physicians still work in traditional fee-for-service models) • Requirement for physicians not in Family Health Teams to submit Quality Improvement Plans to Health Quality Ontario (HQO)

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Sector, treatment or population	Where did reform happen?	Nature of changes to health-system building blocks			Where did reform not happen?
		Governance	Financial	Delivery	
Care by sector (Chapter 6) – continued					
Specialty care	• Responsibility for planning, integration and funding shifted to the LHINs • Requirement to submit annual Quality Improvement Plans to HQO • Shift in approach to hospital funding (e.g., Health-Based Allocation Model and Quality-Based Procedures) • Some low-risk procedures shifted to community-based speciality clinics	✓	✓	✓	• Removal of hospital boards of directors as has been done in other provinces
Rehabilitation care	• Expansion of Ontario Health Insurance Plan coverage for physiotherapy clinics		✓		• First-dollar coverage for all medically necessary rehabilitation services
Long-term care	• Responsibility for planning, integration and funding for some long-term care homes shifted to the LHINs • Implementation of the *Long-Term Care Act, 2007* that strengthened regulations and enhanced the patients' bill of rights	✓			• None identified
Public health	• Creation of a new public health agency	✓			• Connecting local public health agencies to the LHINs and to primary care (although this had been included in an early draft of the *Patients First Act, 2016*) • Needs-based funding of public health agencies

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Sector, treatment or population	Where did reform happen?	Nature of changes to health-system building blocks			Where did reform not happen?
		Governance	Financial	Delivery	
Care for select conditions (Chapter 7)					
Mental health and addictions	• Enhanced accountability • Development of assessment and committal criteria for seriously mentally ill individuals • Increased collaboration between the criminal justice system and mental health services • Monitoring for prescribing and dispensing narcotics • Development of a strategy focused on supports over the life span	✓		✓	• Mental health and addictions continues to be treated separately from 'physical health' • Defining core services to be available to adults in communities across the province, establishing a lead agency that can serve as a 'way in' to these services, creating a new funding model for the agencies that deliver services, and building a legal framework for these agencies (although significant progress has been made in these directions)
Work-related injuries and diseases	• Workplace Safety and Insurance Board (WSIB) has taken an active role in commissioning care to achieve better health and return-to-work outcomes • A network of providers and organizations has evolved to meet the demand induced by WSIB's enhanced role		✓	✓	• Change of approach to treating work-related injuries and diseases such that these are now treated differently than other injuries and diseases
Cancer	• Fourteen regional cancer programs established in 2005 that align with each of the LHINs	✓			• None identified

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Sector, treatment or population	Where did reform happen?	Nature of changes to health-system building blocks			Where did reform not happen?
		Governance	Financial	Delivery	
Care for select conditions (Chapter 7) – continued					
End of life	• Commitment to establish the Ontario Palliative Care Network • Federal 'medical assistance in dying' legislation approved			✓	• Medical assistance in dying not available to those who do not have a 'reasonably foreseeable death' (e.g., persons with long-term conditions that cause them to live in substantial pain or discomfort)
Care using select treatments (Chapter 8)					
Prescription and over-the-counter drugs	• Strengthened consumer/patient engagement, transparency, and use of evidence in decision-making • Increased scope of practice for pharmacists • Established a monitoring system for narcotics prescribing and dispensing	✓		✓	• Increased public coverage for prescription drugs • Further expanded scope of practice for pharmacists (as promised in the 2014 Liberal Party platform)
Complementary and alternative therapies	• Enhanced regulation of health professions (e.g., naturopathy, traditional Chinese medicine)	✓			• None identified
Dental services	• *Long-Term Care Homes Act, 2007* established requirements for oral care for residents			✓	• Integration of care with the health system (beyond limited intersection with hospitals and long-term care homes) or expansion of public coverage
Care for Indigenous peoples (Chapter 9)					
	• Renewal of existing commitment (Aboriginal Healing and Wellness Strategy)	✓	✓	✓	• Extension of coverage to non-status First Nations and to Métis

recessions, one that began in 2001 and the other being the global economic crisis that began in 2008.

When considered in light of these electoral and financial factors, as well as Ontario's slow-and-steady approach to health-system reform, Tables 10.1 and 10.2 reveal that the previous finding that major electoral changes are supportive of significant reform appears to be borne out again in Ontario during this time. A four-year span following the 2003 election of a Liberal majority government after two terms of a majority Progressive Conservative government resulted in 13 of the 31 reforms (close to half of the reforms that took place over 16 years). Of these, six could be seen as constituting 'large' reforms, which included (in chronological order) the:

- *Commitment to the Future of Medicare Act*, *2004* that established an organization that became what is now known as Health Quality Ontario (HQO) to publicly report on health-system performance and support continuous quality improvement;
- *Personal Health Information Protection Act, 2004* that enshrined patient confidentiality as an individual right;
- introduction of interprofessional team-based primary care in the form of Family Health Teams (2005) and a new approach to physician remuneration (blended capitation and fee-for-service payment) after decades of recommendations to move in this direction;
- expansion of the nurse role and team-based primary care through the introduction of Nurse Practitioner-led Clinics in 2006;
- creation of 14 geographically defined Local Health Integration Networks (LHINs) that were given responsibility for the planning and funding of healthcare in their regions, and for ensuring that the different parts of the health system in their regions work together (see Figure 1.1); and
- *Health Systems Improvement Act, 2007* that produced (through omnibus legislation) several notable changes including:
  - a restructured 'public health' sector, including the creation of a new agency (Ontario Agency for Health Protection and Promotion, which was later renamed Public Health Ontario) that supports emergency management and operates public health laboratories in Ontario;
  - four new regulated health professions (naturopathy, homeopathy, kinesiology and psychotherapy); and
  - new requirements for regulatory colleges (e.g., to establish their

own websites with mandated information such as summaries of disciplinary decisions).

Three other reforms that happened later could be considered as 'large.' These include the:

- *Excellent Care for All Act, 2010* that created the requirement for many types of health organizations (e.g., Family Health Teams and hospitals) to submit annual Quality Improvement Plans to HQO;
- health-system funding reform in 2012 that implemented a Health-Based Allocation Model that provides organization-level funding for hospitals and Community Care Access Centres (CCACs), as well as a payment system called Quality-Based Procedures that reimburse providers based on the type and quantity of patients they treat; and
- formalization of the process for shifting the site of service delivery from hospitals to community-based specialty clinics for low-risk diagnostic and therapeutic procedures that do not require an overnight stay (although this is 'large' in the sense of a change in direction, not in the volume of procedures now being provided in these clinics).

Interestingly these three reforms also appear to align with important factors related to electoral processes, with the *Excellent Care for All Act* being implemented in the lead up to an election, and the implementation of health-system funding reform and introduction of community-based specialty clinics being key pieces of the province's Action Plan For Health Care that was released after the election (in 2012). As noted in the next section about future reforms, the *Patients First Act, 2016,* which will make significant changes to the health system (particularly for planning and funding home and community care and primary care), also appears to fit this pattern.(4)

The foundation for each of three of these reforms (the move to interprofessional team-based primary care with an alternative remuneration model, regionalized planning and funding of healthcare, and community-based specialty clinics) was laid much earlier in the province, further supporting the characterization of the approach to Ontario's health reforms as slow and steady. For the move to interprofessional team-based care, the foundation was laid through the pilot Primary Care Networks that started in 1998 through a collaboration between the Government of Ontario and the Ontario Medical Association. For regionalized planning and funding, the foundation was not in the form of a pilot, but rather a

'wait-and-see' approach, given that all provinces other than Ontario had moved forward with some form of regionalized healthcare in the early 1990s. Lastly, a series of decisions beginning in 1990 supported the development of the infrastructure needed to implement community-based specialty clinics. These past decisions included amending the *Independent Health Facilities Act, 1990*, as well as allowing for the development of private for-profit delivery of medically necessary 'high-tech' diagnostic services in 1996. While these changes were eventually identified as potentially leading to parallel (i.e., public and private) tiers of access to services, this never occurred given subsequent changes in governments with different priorities, but it facilitated the creation of infrastructure for community-based specialty clinics.

We now turn to the nature of the 31 reforms to Ontario's health system. We group them according to the level of the system that each reform affected, namely system, profession, sector, and cross-sectoral (Table 10.1), before turning to where reforms did not happen (Table 10.2). By sector we mean the six sectors described in Chapter 6, namely home and community care, primary care, specialty care, rehabilitation care, long-term care, and public health. For the purpose of this exercise we have considered 'sub-systems' of care (e.g., care for mental health and addictions and cancer care, which we address in Chapter 7) and prescription and over-the-counter drugs (which we address in Chapter 8) to be cross-sectoral.

System-level reforms

Six system-level reforms have been implemented in Ontario since 2000, which provided for far-reaching changes to the health system in the areas of protecting patient confidentiality, strengthening governance and accountability, and providing strategic areas of focus for future reforms. These reforms include:

- enshrining patient confidentiality as an individual right through the *Personal Health Information Protection Act, 2004*, which was recently amended through the *Health Information Protection Act, 2016* to provide a framework for electronic health records and to provide increased accountability, transparency and privacy protection for personal health information (two reforms listed in Table 10.1);
- moving to a regionalized system in 2007 as a result of passing the *Local Health Integration Network Act, 2006*, whereby 14 LHINs are

responsible for planning and integrating the delivery of services at the local level, and for funding the organizations (each typically overseen by its own board of directors) that deliver these services (as opposed to funding these services directly, as other provinces have done, in part to avoid the challenges that can come from high-profile boards focusing only on 'pieces of the puzzle');
- strengthening governance, quality improvement (e.g., with some organizations such as hospitals and Family Health Teams required to submit Quality Improvement Plans to HQO) and evidence-based decision-making first through the *Commitment to the Future of Medicare Act, 2004* and more comprehensively later through the *Excellent Care for All Act, 2010* (two reforms listed in Table 10.1); and
- creating an action plan for healthcare in 2015 (updated from a previous plan in 2012), which articulated four overarching goals:
  - improving access (i.e., providing faster access to the right care),
  - connecting services (i.e., delivering better coordinated and integrated care in the community and closer to home),
  - informing people and patients (i.e., providing the education, information and transparency they need to make the right decisions about their health), and
  - protecting our universal public health system (i.e., making evidence-based decisions on value and quality, to sustain the system for generations to come).

Profession-level reforms

Five profession-level reforms have been implemented in the province since 2000. They focused on:

- expanding scopes of practice for regulated health professions, and introducing new regulated health professions, through legislative changes and direction to regulatory colleges, based on advice from the Health Professions Regulatory Advisory Council – an arm's-length council that provides independent policy advice on the regulation of health professions (two reforms listed in Table 10.1, the first of which is listed in the first row and the second appears in the row describing the *Health System Improvements Act, 2007*);
- developing a nursing strategy in 2001, which created 12,000 new permanent nursing positions, reformed nursing education, and implemented a nursing recruitment and retention strategy;

- enhancing coordination between the education and health systems in the training of health professionals through a joint initiative between the Ministry of Health and Long-Term Care and the then Ministry of Training, Colleges and Universities; and
- developing a provincial strategy (HealthForceOntario) to address the supply and mix of health professionals, which was followed by the creation of the HealthForceOntario Marketing and Recruitment Agency, which focuses on the recruitment, distribution and retention of health professionals.

Sector-based reforms

Ten sector-based reforms have been implemented in the province since 2000. These reforms focused on five of the six sectors covered in Chapter 6, namely home and community care, primary care, specialty care, long-term care, and public health, with one of the reforms (health sector funding reform) affecting two of the sectors. Starting with the home and community care sector, the mandate, governance and accountabilities of CCACs were established in 2001, and the funding model for CCACs (and as noted below, for hospitals as well) began to be shifted as part of health-system funding reform in 2012. Turning to the primary-care sector, an interprofessional team-based primary-care model (Family Health Teams) was launched in 2005, Nurse Practitioner-led Clinics were launched in 2006, and two midwifery-led birth centres were launched in 2014. In specialty care, health-system funding reform was introduced for hospitals (as noted above) and in 2013 (a year later) the process was formalized for the shifting of the site of service delivery from hospitals to community-based specialty clinics. In the long-term care sector, the reform in 2007 expanded the Residents' Bill of Rights, updated regulations, and strengthened the inspection process. In the public health sector, the reforms included creating (as part of the omnibus *Health System Improvement Act, 2007*) what is now known as Public Health Ontario, establishing in 2011 the authority of the provincial chief medical officer of health (through the *Health Protection and Promotion Amendment Act, 2011*), and developing a strategic plan for the public health sector in 2013 (Make No Little Plans).

Cross-sectoral reforms

Since 2000, 10 cross-sector reforms have been implemented, with five of them involving conditions described in Chapter 7 (mental health and addictions, cancer, and end of life), two of them involving treatments described in Chapter 8 (prescription and over-the-counter drugs), and one of them involving Health Links, which we discuss in many chapters. Four of the five reforms involving mental health and addictions were what we labelled 'strategy/recommendations/framework:' 1) the 'Mental Health Accountability' framework (2003); 2) the 'Program Framework for Mental Health and Court Support Services' (2006); 3) the 'Open Minds, Healthy Minds' strategy to address mental health and addictions across the life-span (2011); and 4) the 'Moving on Mental Health' action plan for mental health services for children and youth (2012). The one other reform in this domain was *Bill 168, Brian's Law (Mental Health Legislative Reform), 2000*. The one reform in cancer care was the significant restructuring of cancer care in 2004-05.(5; 6) The reform related to end-of-life care involved the creation of the Ontario Palliative Care Network in 2016. The two reforms related to prescription drugs were the *Transparent Drug System for Patients Act, 2006*, and the *Narcotics Safety and Awareness Act, 2010*. The final cross-sectoral reform involved the creation of Health Links in 2012 to support the delivery of coordinated care in the community for those with complex needs.

Where reform did not happen

As outlined in the last column in Table 10.2, there are many areas where reform could have happened, but did not. Several of these relate to the continued provision of first-dollar coverage (i.e., full coverage, without deductibles or cost-sharing) for care provided in hospitals or by physicians, but not for any other parts of the health system. This includes what many would identify as either sectors that provide essential care such as home and community care (although increased investments have been made in this sector) and rehabilitation care, and forms of treatment that many patients require access to as part of their care plans (most notably prescription drugs), or as part of primary care (dental services). Another area where reform has not happened is the implementation of a comprehensive approach to address the overuse of health services, where most action has taken the form of focused profession-led initiatives, such as Choosing

Wisely Canada.

While reforms to the types of services receiving first-dollar coverage may seem particularly difficult to implement given the finite resources available, several areas where reforms have not happened seem to be on the horizon. For example, as noted in the next section, the *Patients First Act, 2016* will address many of the accountability and planning gaps noted for home and community care (other than first-dollar coverage) and primary care, and to a lesser extent public health.(4) Moreover, while mental health and addictions continues to be treated separately from 'physical health,' Ontario's slow-and-steady approach to reform may yet result in progress towards efforts such as defining core services to be available in communities across the province, establishing a lead agency that can serve as a 'way in' to these services, creating a new funding model for the agencies delivering these services, and building a legal framework for them (although significant progress has been made in these directions).

Proposed reforms

Health-system reform priorities in Ontario for a 10-year period (2014-24) have been articulated through both the Liberal government's 10-year plan for the health system and Premier Kathleen Wynne's mandate letter to the Minister of Health and Long-Term Care following the 2014 election in Ontario,(7; 8) which we summarize in Table 10.3. As can be seen from the table, the priorities focus on:

- system-level, profession-level, sector-level and cross-sectoral reforms to strengthen governance, financial and delivery arrangements, and to strengthen seniors care (including for their families and caregivers); and
- sector-level reforms to strengthen services for maternal and child health.

While several priorities have already been addressed (e.g., increasing funding for infertility services and home care, increasing wages for personal support workers, and creating a strategy for end-of-life care), others are in the process of being implemented (e.g., launching the remaining Health Links), or first steps have been taken toward implementing them (e.g., passing the *Health Information Protection Act, 2016* to establish a framework for electronic health records as part of using technology more effectively). No 'large' reforms, however, were formally proposed as part of this agenda

Table 10.3: Overview of health-system reform priorities, 2014-24

Priorities[1]	Type of reform			
	System-level	Profession-level	Sector-level	Cross-sectoral
Strengthen governance arrangements by: • supporting institutional collaboration • providing a patient ombudsman • ensuring Ornge's (i.e., air ambulance and medical transport service) accountability and transparency	✓		✓	
Strengthen financial sustainability (as an aspect of financial arrangements) of the health system by: • maintaining annual health spending growth at 3% • increasing funding for Ontario's Mental Health and Addictions Strategy	✓			✓
Strengthen delivery arrangements by: • using technology more effectively • guaranteeing that every Ontarian has access to a primary-care provider • reducing wait times on referrals to specialists by 50% • coordinating delivery of care between healthcare providers as well as between Local Health Integration Networks, Community Care Access Centres and local public health agencies • providing culturally appropriate care by building community wellness • creating 36 additional Health Links • expanding scopes of practice (e.g., nurses and pharmacists) • advocating for a national drug insurance program • coordinating and expediting drug-approval processes	✓	✓	✓	✓
Strengthen maternal and child health by: • increasing funding for infertility services • providing access to free vaccinations • implementing a newborn screening program			✓	
Strengthen seniors care, including families/caregivers by: • increasing funding for home care • increasing wages for personal support workers • creating a palliative care and end-of-life care strategy • supporting family caregivers • increasing funding for activity and community grant programs • creating 25 new 'memory clinics'	✓	✓	✓	✓

Sources: 7; 8

Note:
[1] Priorities have been drawn from both the Liberal government's 10-year plan for the health system (released in 2014) and Premier Kathleen Wynne's mandate letter to Eric Hoskins, Minister of Health and Long-Term Care.

until recently. Specifically, the Liberal government passed the *Patients First Act, 2016,* (4) which involves amendments to 20 existing pieces of legislation, with key changes including an expansion of the role of the LHINs in planning and integrating primary care and home and community care.(4) The key goals outlined in the legislation include:

- improving access to primary care for patients;
- improving local connections and communication among home and community care, primary care, and hospitals to ensure equitable access and a smoother patient experience;
- ensuring that patients only have to tell their story once, by enabling healthcare providers to share and update their healthcare plans;
- making it easier for physicians, nurses, and other primary-care providers to connect their patients to the healthcare they need;
- providing smoother patient transitions among home and community, primary, specialty, and long-term care, and with mental health and addictions care;
- improving consistency of home and community care across the province so that people know what to expect and receive good care regardless of where they live in the province;
- strengthening health planning and accountability by monitoring performance;
- ensuring public health practitioners have a voice in health-system planning by establishing a formal relationship between LHINs and local boards of health; and
- facilitating local healthcare planning to ensure decisions are made by people who best understand the needs of their communities, and that LHIN boards reflect the communities they serve.

Similar to the other recent 'large' reforms outlined earlier, this proposed reform seems to have emerged due to several factors related to the electoral process, including:

- a new leader of the governing party (Kathleen Wynne);
- commitments that came from a campaign (the priorities in Table 10.2 that were articulated shortly after the election);
- appointment of champions once in power (Eric Hoskins as the new minister of health and Robert Bell as the new deputy minister of health); and
- an announcement of the legislation in the first half of a political mandate.

Moreover, this reform has been proposed during a time of fiscal crisis, when much attention has been paid to doing things differently to reduce the government's large budget deficit (although this does not appear to include providing LHINs with any influence over spending on prescription drugs or physicians, and it fails to align the boundaries of local public health

agencies to those of the LHINs, both of which have presumably been the focus of significant resistance by key stakeholders).

Also, Ontario's slow-and-steady approach to health-system reform seems to have played a role, as the foundation for many of the proposed changes were put in place much earlier. The most notable earlier reforms that made the *Patients First Act, 2016* possible include the implementation of inter-professional team-based primary care (which is proposed to be expanded on in order to provide population-level coverage for primary care), and the establishment of LHINs (which, under the new legislation, will have their role expanded to include home and community care – although payment for physicians will still come from the Ministry of Health and Long-Term Care). Moreover, the priorities assimilated in the *Patients First Act, 2016* were extensively 'road tested' through the 2012 and 2015 Action Plans for Health, and more recently through a discussion paper that was published in December 2015 by the ministry about strengthening patient-centred healthcare. The latter included much of what is contained in the now passed legislation.(9)

Conclusion

This chapter shows that the last decade and a half has been a time of many health-system changes that have moved the province towards more of a true 'system' (i.e., a system that takes a coordinated approach to planning and funding care across sectors). The most significant changes appear to have emerged due to factors related to electoral processes (most notably a change in governing party in 2003 and a new leader for a majority government in 2014). Moreover, many of the significant reforms that have either taken place more recently or have been proposed have been made possible by a 'slow-and-steady' approach to health-system reform, whereby policies put in place much earlier (or not put in place, in the case of a regionalized approach to planning and funding the system) have laid a foundation for larger reforms later.

Perhaps the most notable areas where significant reforms have not been implemented, and which therefore represent barriers to a true 'system' of integrated care, are strengthening care for mental health and addictions and enhancing prescription-drug funding. The former has seen the development

of legislation, programs and several frameworks and strategies, but none that would be considered significant changes (at least on the scale of implementing the LHINs, Family Health Teams, restructuring public health or the changes articulated in the *Patients First Act, 2016*). Given the pattern of health-system reform, it would seem that Ontario appears poised to build on this steady process of foundation building towards more significant changes (e.g., to defining core mental health and addictions services to be available in communities and establishing a lead agency for these services). Moreover, given that progress towards these larger policy goals seems to have been made in the first half of a political mandate, the prospects for such reform appear high.(10; 11) However, for prescription-drug funding, which constitutes the second largest healthcare expenditure in the province,(12) the picture seems quite different, as there has been little activity. The last substantive funding change was the introduction of the Trillium Drug Program in 1995, which may point to the need for an external impetus to change, such as the increasing emphasis being put on moving towards a national pharmacare plan. This was included as a priority in the Liberal government's 10-year plan for the health system.

For those interested in keeping abreast about new reforms that have been proposed or implemented, many sources can be used, including: media coverage (e.g., by following specific media sources or by systematically searching indexes of media coverage, such as LexisNexis); government media releases; transcripts of parliamentary debates (i.e., Hansard); and statements of intent to introduce reforms (e.g., electoral platforms of the governing party, speeches from the Throne, budget announcements, mandate letters from the premier to the minister of health, and ministry action plans). For analyses of the factors leading to specific reforms, and their consequences, *Health Reform Observer - Observatoire des Réformes de Santé* periodically publishes articles about reforms in Ontario.

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