1. Introduction and overview

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Key messages for citizens

- The health system is largely the responsibility of the provincial government, albeit within certain broad rules set by the federal government.
- Care is increasingly being organized by region, with each region overseen by a Local Health Integration Network.
- The care provided in hospitals or by physicians is free to patients at the point of use, and more money is now spent on prescription drugs (which are far from free for most patients) than is spent on physicians.
- The money spent on the health system each year ($5,877 on average per Ontarian in 2013) comes from government (two thirds) and private sources like employers or out-of-pocket charges (one third).
- Ontarians (especially women) tend to live long lives, with cancer and heart disease the most common causes of lives being cut short, but many factors beyond the health system contribute to long life expectancy.

Key messages for health professionals

- The provincial government has a big say in how the health system functions, whereas the federal government's role is either less visible (e.g., financial contributions to the provincial government) or more focused (e.g., care for First Nations populations living on reserve).
- The province is divided into 14 regions and most types of care (besides physician-provided care and prescription drugs) are planned and funded by regional bodies (Local Health Integration Networks) that can be sensitive to unique regional needs.
- Patients cannot be charged for medically necessary care provided in hospital or by a physician, but they can be (and are) charged for many other types of care, most notably prescription drugs.
- Long life expectancies mean that health professionals deal with lots of elderly patients, many of whom will die from cancer or heart disease.

Key messages for policymakers

- The provincial government has constitutional responsibility for healthcare, but it intersects with the federal government in areas where the latter has responsibility (e.g., First Nations) or sets broad terms under which financial transfers are provided.
- While two thirds of the system's total costs are paid for by government, the government's share is particularly high for hospital-based and physician-provided care, even if the province's private not-for-profit hospitals and physicians working in private practice operate quite autonomously from government.
- Given that 43 cents of every dollar the government spends goes to healthcare, relatively little money is available for the many other areas where the government needs to act.
- Ontario's generally good health status indicators overall mask significant differences in these indicators across socio-economic and other groups.

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Like all health systems, Ontario's health system operates within a historical, geographic and socio-demographic context, a current political and economic context, and a particular context in terms of the health status of Ontarians. This chapter describes that context and concludes with a brief overview of the book.

Historical context

Decisions made in the past about the health system shape it in profound ways today. Some of the key features of this historical context, particularly those relating to governance and financial arrangements that involve federal/provincial relations (and the hospital-based or physician-provided care that have been the main focus of these relations), include:

1) an early effort (in 1945) failed to introduce a national health-insurance plan that would have covered many types of care for Ontarians (not just hospital-based and physician-provided care);
2) hospital-based care started being paid for by the Government of Ontario in 1957 and physician-provided care followed suit in 1969 (both

of which were preceded by Saskatchewan, in 1947 and 1962, respectively, and supported financially by the federal government), however, hospitals remained independent and private not-for-profit entities and physicians remained working in independent private practice;
3) hospital-care insurance and medical-care insurance were combined programmatically under the Ontario Health Insurance Plan (OHIP) in 1972, and OHIP is administered under the terms of the *Canada Health Act, 1984*, which combined separate pieces of federal legislation in 1984, formally banned any form of user fee for medically necessary hospital-based and physician-provided care, and led to an unsuccessful strike by Ontario's physicians;
4) the federal government began in 1995 to reduce its financial support for the health system in Ontario (and in other provinces and territories), but dramatically increased its support through health accords in 2003 and 2004 in return for action in particular areas (e.g., wait times) and public reporting about progress;
5) the provincial government created Local Health Integration Networks in 2006 to plan, integrate and fund care (including hospital-based care) in their respective regions; and
6) the *Excellent Care for All Act, 2010* created an agency (Health Quality Ontario) and a set of mechanisms (e.g., mandatory Quality Improvement Plans) to support quality improvement in the health system.

For a detailed list of major milestones in the evolution of Ontario's health system, see Table 1.1.

Table 1.1: Major milestones in the health system's evolution

Year	Jurisdiction	Milestone
1945	Canada	Government of Canada fails in its attempt to introduce a national health-insurance plan for family physician-provided care, visiting nurse-provided care, and hospital-based care, and (in late stages) medical specialist-provided care, other nurse-provided care, prescription drugs, laboratory services, and dental services (15)
1948	Canada	National Health Grants Program begins providing grants to provinces and territories to support health initiatives, including hospital construction, public health, professional training, provincial surveys, and public health research (15)
1955	Ontario	Government of Ontario announces its willingness to introduce public payment for hospital and diagnostic services if the federal government shares the cost (and the Government of Canada agrees in principle in 1956) (15)
1957	Canada	Government of Canada passes the *Hospital Insurance and Diagnostic Services Act*, which sets out the conditions for provinces and territories to receive shared-cost financing for hospital-based care (16)
	Ontario	Ontario Hospital Services Commission is created to administer the hospital-insurance plan (15)

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Year	Jurisdiction	Milestone
1959	Ontario	Ontario Hospital Insurance Plan becomes the new name of the Ontario Hospital Services Commission (15)
1964	Canada	Royal Commission on Health Services (Hall Commission) recommends the expansion of provincial health-insurance plans to include physician-provided care (15)
1966	Canada	Canada Assistance Plan begins cost-sharing (between federal and provincial governments) for social services (16)
		Government of Canada passes the *Medical Care Act*, which sets out the conditions for provinces and territories to receive shared-cost financing for physician-provided care (16)
	Ontario	Ontario Medical Services Insurance Plan is created to pay for physician-provided care for those who cannot afford private medical insurance because of age, health status, employment status or ability to pay (15)
1969	Ontario	Government of Ontario creates a health-insurance plan that covers physician-provided care for all Ontarians (16)
1971	Ontario	Department of Health becomes the Ministry of Health
1972	Ontario	Ontario Health Insurance Plan (OHIP) is created to administer a health-insurance plan covering both hospital-based and physician-provided care (15)
1977	Canada	Government of Canada passes the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, which shifts its contributions from a cost-sharing model to a block-funding model (17)
1980	Canada	Health Services Review recommends ending user fees and extra-billing and setting national standards for provincial health-insurance plans in the areas of public administration, comprehensiveness, universality, portability and accessibility (18)
1981	Canada	A provincial/territorial reciprocal billing agreement is reached for inpatient hospital care that is provided to a person travelling outside their home province or territory (16)
1984	Canada	Government of Canada passes the *Canada Health Act*,(19) which combines previous acts related to hospital and medical insurance, bans user fees and extra-billing, and sets the conditions and criteria (related to public administration, comprehensiveness, universality, portability and accessibility) for receiving money from the federal government for provincial health-insurance plans
		The provincial/territorial reciprocal billing agreement is expanded to include outpatient hospital care (16)
1987	Ontario	Ontario Health Review Panel recommends strengthening the role of the individual in personal healthcare and adopting new funding approaches and organizational arrangements to encourage the use of outpatient and community-based health programs (as alternatives to hospital-based care) (20)
1988	Canada	A provincial/territorial reciprocal billing agreement is reached by all provinces (except Quebec) for care provided by a physician to a person travelling outside their home province or territory (16)
1990	Ontario	Ministry of Health becomes the Ministry of Health and Long-Term Care (21)
		Government of Ontario passes the *Independent Health Facilities Act*,(22) which introduces a licensing and funding mechanism for community-based specialty clinics providing care that had been historically provided in hospitals (23)
1995	Canada	Government of Canada effectively merges the Canada Assistance Plan and the Established Programs Financing plan in creating the Canada Health and Social Transfer to support healthcare, social services and post-secondary education, and simultaneously reduces transfer payments to provincial governments (24)
1999	Canada	Federal, provincial and territorial governments (except Quebec) agree to a Social Union Framework Agreement, which provides a collective approach to social (including health) policy and program development (25)

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Year	Jurisdiction	Milestone
2000	Canada	First Ministers' Meeting Communiqué on Health confirms First Ministers' commitment to strengthening and renewing Canada's publicly funded healthcare services through partnership and collaboration, and outlines the vision, principles and action plan for health-system renewal (26)
		The action plan includes collaboration on specific priorities such as access to care; health promotion and wellness; supply of physicians, nurses and other health personnel; home and community care; pharmaceuticals management; health information and communication technology; and health equipment and infrastructure (26)
2002	Canada	Standing Senate Committee on Social Affairs, Science and Technology (Kirby committee) publishes its recommendations for reforming health systems in Canada (27)
		Commission on the Future of Health Care in Canada (Romanow commission) publishes its recommendations (28)
2003	Canada	First Ministers announce the First Ministers Accord on Healthcare Renewal (29)
		Health Council of Canada is established to monitor and report on progress of accord-related reforms (16)
2004	Canada	Government of Canada splits the Canada Health and Social Transfer into the Canada Health Transfer and the Canada Social Transfer.(16) First Ministers announce a 10-year plan to strengthen healthcare (16)
	Ontario	Government of Ontario passes the *Commitment to the Future of Medicare Act,*(30) which reaffirms its commitment to the principles of the *Canada Health Act, 1984*
2005	Ontario	Government of Ontario, as part of its commitments related to the accord, publishes its Wait Time Strategy, which provides increased funding for hip and knee joint replacements, cataract, cardiac and cancer surgeries, and extended MRI hours of operation; and provides for the development of a 'wait times' website and a surgical registry for the five key areas (31)
		Government of Ontario announces the creation of the Ministry of Health Promotion to focus on programs dedicated to healthy lifestyles (and to operate alongside the Ministry of Health and Long-Term Care), although this ministry was later re-absorbed into the Ministry of Health and Long-Term Care
2007	Canada	Federal, provincial and territorial governments, as part of their commitments to the accord, introduce the Patient Wait Times Guarantees initiative (31)
2007	Ontario	Government of Ontario passes the *Local Health Integration Act*,(32) which creates 14 Local Health Integration Networks (LHINs) to plan, integrate and fund local health services, including hospital services (but leaving hospital boards of directors intact)
2010	Ontario	Government of Ontario passes the *Excellent Care for All Act* (33) to support system-wide quality improvement (with an initial focus on hospitals) and through which Health Quality Ontario is established (34; 35)
		Government of Ontario passes the *Broader Public Sector Accountability Act*,(36) which establishes new rules and higher accountability standards for LHINs, hospitals, and broader public-sector organizations (and the LHINs then apply similar standards to the organizations they fund)
2012	Ontario	Commission on the Reform of Ontario's Public Services publishes its recommendations for extensive spending reductions in Ontario, including capping annual increases in healthcare spending at 2.5%, providing more home-based care, and using less expensive health workers (e.g., nurse practitioners) (37)
		Health system funding reform changes funding for hospitals and Community Care Access Centres (38)
2014	Canada	Health Council of Canada ceases to function
2016	Canada	Supreme Court of Canada extends the federal government's fiduciary relationship from status First Nations peoples to include Métis and non-status Indigenous peoples (39)

Sources: 15-42

Four of the most consequential impacts of these decisions for how the health system is experienced by citizens and professionals are:

1) Ontarians have their own health system, not a 'Canadian health system' (although provisions allow for them to be covered under another health-insurance plan if they move to another province or territory);
2) the health system provides medically necessary care for free at the point of use (i.e., with no out-of-pocket charges) to patients if the care is provided in a hospital or by a physician, but not (necessarily) for care provided in other settings or by other regulated health professionals;
3) many physicians see themselves as small-business owners who happen to have customers whose bills are paid by the government; and
4) care is increasingly organized on a regional basis, albeit with a strong stewardship role for government and for government agencies like Health Quality Ontario.

These past decisions also shape decisions about the health system's future in many notable ways, perhaps most noticeably in how efforts to achieve the 'triple aim' – improve the patient experience and population health, and keep per capita costs manageable (which we return to in Chapter 11) – shy away from changes to the independence of the province's physicians and (to a lesser extent) hospitals. Past decisions have channelled resources and created incentives in ways that supported the emergence of large, well-resourced hospital and medical associations that can act as a countervailing power to the government that pays their bills. Past decisions have also changed how professionals and citizens think about the system. For example, many physicians receive payment as individual 'medicine professional corporations,' not as members of interdisciplinary teams or as staff of a primary-care or other organization, and many citizens accept dramatic differences in the way the health system deals with hospital-based and physician-provided care, which is free for patients, and prescription drugs, which are largely paid for by patients or their private insurance plans.

Geographic and socio-demographic context

Ontario has a very large land mass, which complicates access to care in large parts of the province. Since 2007, the province has been divided into 14 regions (Figure 1.1), each overseen by an administrative body called a Local Health Integration Network (LHIN), to enable the planning,

Figure 1.1: Province[1] and its 14 regions, each of which is overseen by a Local Health Integration Network

Sources: 43; 44

Note:
[1] The part of the province shown within the oval has been magnified to show an appropriate level of detail.

integration and funding of care to be adapted to regional needs (ethnocultural or linguistic diversity, transportation, etc.). Some of the regions have a population centre anchoring it (e.g., South West is anchored by London), whereas some population centres straddle multiple regions (e.g., Toronto contains one entire LHIN and parts of three other LHINs). Increasingly care is organized along regional lines, particularly for care like home care, some of which is funded by Community Care Access Centres (one per region, although this function will be taken on by LHINs in 2017),(1) and for care like cancer care, much of which is provided in and supported by regional cancer centres.

A list of the province's main population centres (defined as having more than 200,000 residents) is dominated by Toronto, surrounding centres (Mississauga, Brampton, Markham and Vaughan) and other nearby centres (Hamilton and Kitchener), leaving only a few main population centres (Ottawa, London and Windsor) more than a short drive away from Toronto (Table 1.2). The biggest growth in population over the 2001-11 period

Table 1.2: Main population centres, their corresponding Local Health Integration Network, and their population, 2001 and 2011

Jurisdiction	Local Health Integration Network	Population		
		2001	2011	10-year percentage change
Toronto	Toronto Central (7) and parts of Central West (5), Central (8) and Central East (9)	2,481,494	2,615,060	5%
Ottawa	Champlain (11)	774,072	883,391	14%
Mississauga	Mississauga Halton (6)	612,925	713,443	16%
Brampton	Central West (5)	325,428	523,911	61%
Hamilton	Hamilton Niagra Haldimand Brant (4)	490,268	519,949	6%
London	South West (2)	336,539	366,151	9%
Markham	Central (8)	208,615	301,709	45%
Vaughan	Central (8)	182,022	288,301	58%
Kitchener	Waterloo Wellington (3)	190,399	219,153	15%
Windsor	Erie St.Clair (1)	209,218	210,891	1%
Ontario		11,410,046	12,851,821	13%
Canada		30,007,094	33,476,688	12%

Sources: 45-47

has been in Toronto's surrounding centres, particularly Brampton (61%), Vaughan (58%), and Markham (45%), which have required significant investments in infrastructure and a large inflow of health professionals. These main population centres frequently provide care to those living in rural communities, which are defined as those with a population of less than 30,000 that are more than 30 minutes away from a community with a population of more than 30,000.(2)

Smaller population centres, such as Greater Sudbury, Thunder Bay, Sault Ste. Marie, North Bay and Timmins, serve as key hubs for healthcare in northern Ontario, which is comprised of 145 municipalities in an area covering over 800,000 square kilometres (starting near Parry Sound in the south and ending with Hudson Bay in the north) and representing nearly 90% of Ontario's land mass. This area includes many remote communities, which are mostly Indigenous communities and defined as those lacking year-round road access, relying on a third party (e.g., ferry, train or airplane) for transportation to a larger centre, or both.(2)

Ontario is an ethnoculturally diverse province. In 2011, foreign-born persons living in the province accounted for 30% of the population.(3) The two main population centres with the largest percentage of people born outside the country are Toronto (46%) and Ottawa-Gatineau (19%).(3) Just over a quarter of the province's population (26%) belongs to a visible minority.(3) This percentage is projected to double by 2031.(4) The largest visible minority groups are south Asian (8% of Ontario population) followed by Chinese (5%), southeast Asian (5%), and black (4%).(5) Ontario's visible-minority populations are largely concentrated in the Toronto metropolitan census area, including the municipalities of Markham (where visible minorities account for 72% of its population), Brampton (66%), Mississauga (54%), and the city of Toronto (49%).(3) Indigenous peoples, mostly of First Nations and Métis descent, account for 2% of the population (which we return to in Chapter 9).(3)

Ontario has two official languages (English and French) and no official religion. Just under 5% of Ontarians speak French at home.(6) Almost a third of the population (31%) speak one of many other non-official languages, the most widely spoken being Italian, Spanish, Punjabi and Cantonese.(5) Nearly two thirds of Ontarians (64%) report an affiliation with a Christian religion – of whom nearly two fifths (39%) specifically

report an affiliation with the Roman Catholic church, the sponsor of many private not-for-profit hospitals in Ontario – and 23% report having no religious affiliation.(3) Non-Christian religious affiliations include Muslim (5% of the population), Hindu (3%), Jewish (2%), Sikh (1%) and Buddhist (1%), with the greatest concentrations of these religious affiliations in the metropolitan Toronto area.(3)

Ontarians have relatively high socio-economic status on average but face significant inequality. As we return to later in the chapter, the average gross domestic product (GDP) per capita in 2013 was $51,340 (compared to $53,868 in Canada as a whole) in 2013 dollars (as opposed to the 2002 dollars used as the reference in a later table). However, more than a tenth (12%) of the Ontario population is living in poverty, with these individuals and families concentrated in larger census metropolitan areas such as Windsor and Toronto (18% and 15% of the population living in poverty, respectively).(5; 7; 8) Also, the employment rate in Ontario is 61%.(9) Ontario has the highest percentage (29%) of university-degree holders of all Canadian provinces and a higher proportion than the national average (26%).(10) Nearly one quarter (24%) of the adult population has a high-school diploma as their highest educational attainment, and more than one in 10 (11%) have no certificate, diploma or degree qualifications.(5)

Political context

Ontario shares many features of the current political context for its health system with other provinces, including:

1) healthcare is the provincial government's constitutional responsibility;
2) the provincial government is bound by the public administration, comprehensiveness, universality, portability and accessibility principles of the federal government's *Canada Health Act, 1984*, namely: a) the provincial health insurance plan (OHIP) must be publicly administered, b) all medically necessary hospital-based and physician-provided care must be covered through the plan, c) all eligible Ontario residents must be covered by the plan, d) Ontarians moving to other provinces must be covered by the plan (currently for two months) after they become a resident in a new province, and e) Ontarians must not be charged fees for medically necessary hospital-based and physician-provided care (in contrast, there are no provisions as to whether or how the provincial

government must treat care provided outside hospitals or by health professionals other than physicians, which includes prescription drugs (provided outside hospital), home care, rehabilitation care, and long-term care); and

3) the 'core bargain' that the government effectively struck with hospitals in the 1950s and with physicians in the 1960s maintained a private delivery model when the payment mechanism was changed from private to public.

This core bargain has left the province with a legacy of private-practice physicians and private not-for-profit hospitals (the latter being the case despite the legislation governing these hospitals being called the *Public Hospitals Act, 1990*).

On the other hand, some features of the political context for the health system take a particular form in or are unique to Ontario. Examples of this include:

1) the current (Liberal) majority government effectively faces no veto points and can make changes to the system as it wishes, provided that the *Canada Health Act, 1984* provisions are adhered to, although in practice Ontario governments have been particularly hesitant to introduce reforms that would impinge on physicians' private practices (and to a lesser extent on the autonomy of the boards of directors governing hospitals), but quicker to introduce or permit reforms in other areas (e.g., the privatization of the rehabilitation sector);(11)
2) the Ontario Medical Association is in a particularly powerful role compared to other professions because the Physicians Services Committee gives them a more direct 'policy participation' role than other professionals enjoy (although this has been sorely tested by the government's recent fee cuts and by the government's and association's inability to agree on a new Physician Services Agreement, which has led the association to curtail its involvement in government-organized or co-organized activities);
3) additional vocal interests include other professional associations (e.g., Registered Nurses' Association of Ontario) and organizational associations (e.g., Ontario Hospital Association), and to a lesser extent citizen groups (e.g., Ontario Health Coalition, which is dominated by trade unions); and
4) media attention over the contracting practices of the government agency (eHealth Ontario) charged with supporting the introduction

and use of information and communication technology (e.g., ICT such as electronic health records) in the province (in 2009), and over challenges in addressing severe acute respiratory syndrome or SARS, (in 2003) have led to a climate of fear around contracting and concerns around ICT and public-health emergency preparedness.

These features of the political context for Ontario's health system can be understood in relation to four groups of factors – institutions, interests, ideas and factors external to the system – that help to explain why policy-making processes unfold in the way that they do (Table 1.3). We provide more details about how and why such factors matter in an online course, offered through Health Systems Learning, entitled 'Setting Agendas and Developing and Implementing Policies.' A one-page summary of the course is available on the McMaster Health Forum website (see 'About us' then 'Our resources').

Table 1.3: Political context

Notable examples and their implications
Institutions (policy legacies)
British North America Act, 1867 • Healthcare is the constitutional responsibility of provincial governments, while other domains (e.g., defence, relations with Indigenous peoples) are the responsibility of the federal government • As a result, Canada has 14 health systems (or 13 systems plus a set of programs): ◦ 10 provincial health systems (with Ontario's being one of them) ◦ three territorial health systems ◦ a set of federal government-supported health programs that cover First Nations peoples and Inuit, Canadian Armed Forces, eligible veterans, Royal Canadian Mounted Police, inmates of federal penitentiaries, and some refugee claimants (48)
Canada Health Act, 1984 • The Government of Ontario must adhere to the five principles of public administration, comprehensiveness, universality, portability and accessibility to receive federal government support for healthcare ◦ In 2015-16 the Government of Ontario received $21.3 billion in transfers from the federal government (Canada Health Transfer $13.9 billion, Canada Social Transfer $5.1 billion, and equalization $2.3 billion) (49) • The initial 'core bargain' that brought hospitals and then physicians into a public payment model left the delivery of care 'private': ◦ private not-for-profit hospitals deliver care with first-dollar, one-tier public payment ◦ private-practice physicians deliver care with first-dollar, one-tier public (often fee-for-service) payment

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Notable examples and their implications
Institutions (government structures)

Government of Ontario:(50)
• Liberal majority government
• Unicameral legislature
  • Seat distribution in the Legislative Assembly of Ontario: 58 Liberal, 29 Progressive Conservative, and 20 New Democrat
• Effectively no veto points
Federal government:(51)
• Liberal majority government
• Bicameral legislature
  • Seat distribution in the House of Commons: 182 Liberal, 97 Conservative, 44 New Democrat, 10 Bloc Québécois, one Green, one independent, and three vacant seats
  • Seat distribution in the Senate: 42 non-affiliated, 41 Conservative, 21 independent Liberal, and one vacant seat
• Weak veto point with the Senate
Court system:(52)
• Ontario Court of Justice (General Division and Provincial Division)
• Court of Appeal
• Supreme Court of Canada

Institutions (policy networks)
Policy networks in the health system are pluralist, with fragmented state authority coupled with poorly developed organized interests (compared to some other countries) • Most policy networks are considered pressure pluralist, whereby the government or government agency is autonomous and organized interests assume policy advocacy roles • The Ontario Medical Association is arguably in a clientele pluralist network and it typically assumes a policy participation role on issues pertaining to physicians (through the Physician Services Committee)
Interests
Main healthcare interest groups (see Figure 2.3 for a more extensive list): • professional associations (e.g., Ontario Medical Association, Ontario Nurses' Association and Registered Nurses' Association of Ontario) • institution-based interest groups (e.g., Ontario Hospital Association) • citizen-based interest groups (e.g., Ontario Health Coalition)
Ideas
Values (53) • With regard to traditional domains of hospital-based and physician-provided services, Canadians have historically valued a 'one-tier, no user fee' system • Canadians are more open to two-tier care and for-profit delivery in areas such as home care and high-tech care Knowledge • Applied research centres conducting health policy research
External factors
"Have not province" • Ontario was a "have province" (i.e., a province that does not receive 'equalization' payments from the federal government to equalize its ability to generate tax revenues) until the 2009-10 fiscal year when it received its first equalization payment and since which it has continued to receive yearly payments ($347 million in 2009-10 and $2 billion in 2014-15) (49) Commission on the Reform of Ontario's Public Services (i.e., Drummond report) • A 2012 report advising the Government of Ontario on deficit reduction in the public service (37) eHealth Ontario • Established in 2008 to create and maintain electronic health records • Ontario Auditor General's 2009 report identified the mismanagemnet of funds (54)

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Notable examples and their implications
External factors – continued
Severe acute respiratory syndrome (SARS) outbreak • Ontario was the hardest-hit Canadian province in the 2003 outbreak, with the majority of the country's SARS cases concentrated in Toronto (55)
Strong investigative journalism and experienced journalists • e.g., The Toronto Star, André Picard from The Globe and Mail

Sources: 15; 37; 48-56

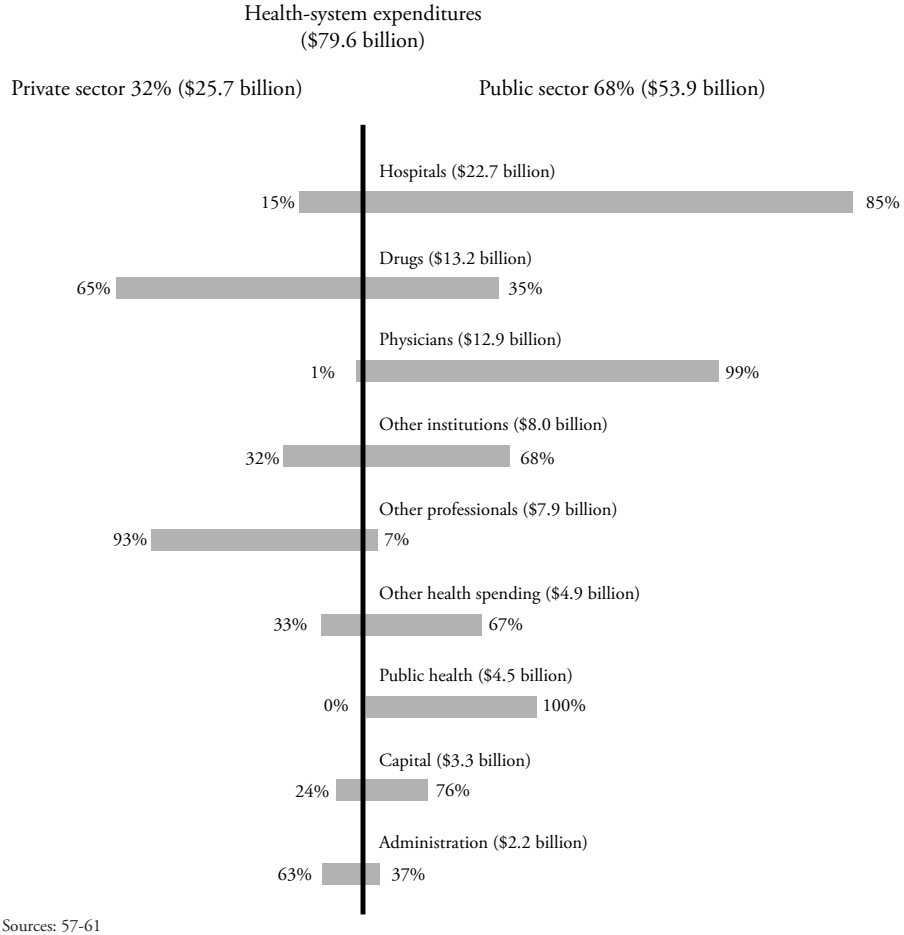
Economic context

A key point of background to the current economic context for Ontario's health system is the public/private mix in spending on the system. Public expenditures (i.e., expenditures by government) account for roughly two thirds of all spending, whereas private expenditures (i.e., by employers or by citizens paying insurance premiums or making out-of-pocket payments, etc.) account for the remaining one third (Figure 1.2). However, this generalization masks differences between care covered by the 'core bargain' (care provided in hospitals and by physicians), which is 85-99% paid for by government, versus care not covered by the core bargain (e.g., prescription drugs and care provided in other settings or by other health professionals), which is more likely to be paid for by private sources (e.g., 65% for prescription drugs and 93% for other health professionals). A second key point of background is that more money (from public and private sources combined) is now spent on prescription drugs than on physicians.

In 2013, $5,877 was spent per person on care, which in 2002 dollars was the equivalent to spending $4,869 per person on care (on GDP per capita of $41,740, so roughly 12%) (Table 1.4). Of this total amount, $3,296 was paid for by government and $1,572 privately, in 2002 dollars. The percentage of total spending from government (68%) was more than in the U.S. (47%), slightly less than the percentage in Canada as a whole (71%), and less than in the U.K. (84%) in the same year.(12)

In the 2014-15 fiscal year, the provincial government spent 43 cents of each dollar of revenue (not counting borrowing) on the health system ($40 billion/$94 billion in 2002 dollars) (Table 1.5). Interest on the government's debt is the equivalent of 20% of the amount spent on the health system ($8 billion/$40 billion in 2002 dollars). The provincial government debt amounted to $15,388 in 2002 dollars for every Ontarian (or 40% of the

Figure 1.2: Public/private mix in spending on the health system, 2013



Sources: 57-61

Table 1.4: Key economic indicators, 2000 to 2013

Economic indicator	Ontario			Canada
	2000	2010	2013	2013
Gross domestic product (GDP)[1] (millions)	472,302	540,343	565,614	1,539,641
GDP per capita[1]	40,426	41,137	41,740	43,795
Total health spending[2] (millions)	41,008	63,113	65,977	173,536
Total health spending[2] ($ per capita)	3,509	4,805	4,869	4,936
Total health spending as percentage of GDP[2]	9%	12%	11%	11%
Public-sector health spending[2] (millions)	27,266	43,060	44,669	122,737
Public-sector health spending[2] ($ per capita)	2,333	3,278	3,296	3,491
Public-sector health spending as a proportion of total health spending[2]	67%	68%	68%	71%

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Economic indicator	Ontario			Canada
	2000	2010	2013	2013
Private-sector health spending[2] (millions)	13,742	20,068	21,308	50,799
Private-sector health spending[2] ($ per capita)	1,176	1,527	1,572	1,445
Private-sector health spending as a proportion of total health spending[2]	34%	32%	32%	29%

Sources: 14; 59; 61-71

Note:
[1] Inflation adjusted to 2002, according to Statistics Canada's Consumer Price Index (all items), CANSIM 326-0020: value x (CPI 2002/CPIi) = value (2002) where i = year
[2] Inflation adjusted to 2002, according to Statistics Canada's Consumer Price Index (healthcare), CANSIM 326-0020: value x (CPI 2002/CPIi) = value (2002) where i = year

Table 1.5: Government financial overview, 2000-01 to 2014-15[1]

	2000-01	2010-11	2014-15
Revenue ($ billions)			
Taxation	52	61	65
Government of Canada	6	20	17
Income from government business enterprises	4	4	4
Other non-tax revenue	6	7	7
Total revenue	68	92	94
Expense ($ billions)			
Health	24	38	40
Education	11	19	20
Post-secondary education/training	—	6	6
Children's and social services	—	11	12
Justice	3	4	3
Other programs	—	17	13
Total program expense	65	95	94
Interest on debt to revenues	—	8	8
Total expense	—	104	102
Reserve	0	0	0
Annual deficit	—	(12)	(8)
Indicators of financial condition			
Interest on debt to revenues	—	9%	8%
Net debt-to-GDP	—	35%	40%
Total spending-to-GDP	—	19.3%	17.9%
Net debt per capita	—	13,938	15,388
Tangible capital assets per capita	—	4,544	5,592

Sources: 14; 72-74

Note:
[1] Data not available for the specific reference period are denoted by —. Inflation adjusted to 2002, according to Statistics Canada's Consumer Price Index (healthcare), CANSIM 326-0020: value x (CPI 2002/CPIi) = value (2002) where i = year

province's GDP). These data suggest that the government has little room to manoeuvre in terms of how much more it can spend on the health system, and that any additional spending likely comes at the cost of spending on education, children and social services, and other areas of government responsibility, unless the government finds other sources of revenue.

Health status of the population

Given that many factors beyond the health system contribute to life expectancy and mortality rates, such data about the health status of the population are typically a better reflection of the context for the health system than indicators of its performance. Ontarians can boast generally good health status on average, however, some Ontarians (e.g., those with lower incomes, Indigenous peoples) have worse health status. We return to the health status of Indigenous peoples in Chapter 9.

On average, Ontarians born between 2009 and 2011 can expect to live to age 82, and if they survive to age 65, they can expect to live until 86, all of which is roughly comparable to the rest of Canada (Table 1.6). Ontario women live roughly four years longer than Ontario men. This gender differential narrows when one considers years of life lived in good health; in 2005-07, health-adjusted life expectancy for women in Ontario was 1.5 years longer than for men (70.5 versus 69).(13) In the province, 4.6 infants (i.e., children under one year of age) die for every 1,000 live births, which is also roughly comparable to the situation in Canada as a whole (Table 1.7). On the other hand, the rate of mortality (death) per 100,000 population, both among those younger than age 75 (premature mortality) and for potentially avoidable mortality (whether prevented among those still without a condition, among those with a condition but at risk of it getting worse or suffering from complications, or both), is typically a bit lower in Ontario than in Canada taken as a whole (Table 1.8). The number of potential years of life lost due to premature or potentially avoidable mortality is small compared to many other countries in the world, but still striking (e.g., 2,831 years of life were lost from potentially avoidable mortality for every 100,000 Ontarians). The top two leading causes of death in Ontario are cancer (malignant neoplasms) and heart disease (Table 1.9).

Table 1.6: Life expectancy at birth and at age 65, 2000-02 and 2009-11[1]

	Ontario		Canada
	2000-02	2009-11	2009-11
Life expectancy at birth, females	82.1	83.9	83.6
Life expectancy at birth, males	77.4	79.8	79.3
Life expectancy at birth, total population	79.8	81.9	81.5
Life expectancy at age 65, females	20.4	21.9	21.7
Life expectancy at age 65, males	17.2	19.0	18.8
Life expectancy at age 65, total population	18.9	20.5	20.3

Sources: 75; 76

Note:
[1] Life expectancy is calculated using three years of data and is the number of years a person would be expected to live (starting at birth or at age 65).

Table 1.7: Infant, perinatal and maternal mortality indicators for 2000, 2010 and 2011

	Ontario			Canada
	2000	2010	2011	2011
Infant mortality rate[1] (deaths per 1,000 total births)	5.3	5.0	4.6	4.8
Perinatal mortality rate[2] (deaths per 1,000 total births)	6.7	5.9	5.9	6.0
Maternal mortality[3] (age-standardized mortality rate per 1,000 population)	0.1	0.1	0.1	0.1

Sources: 77-79

Notes:
[1] Death of a child under one year of age, with stillbirths excluded
[2] Death of a child under one week of age or a stillbirth (>28 weeks of gestation)
[3] Taken from leading causes of death based on 2011 World Health Organization, International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10): pregnancy, childbirth and the puerperium

Table 1.8: Premature and potentially avoidable mortality, by number of deaths and as age-standardized rates per 100,000 population for 2000, 2010 and 2011

	Ontario			Canada
	2000	2010	2011	2011
Mortality (and age-standardized rate per 100,000 population)				
Premature mortality[1]	33,789 (287.9)	33,474 (229.0)	33,231 (221.2)	91,901 (233.3)
Potentially avoidable mortality[2]	24,301 (207.4)	24,373 (167.1)	23,880 (159.1)	66,194 (168.5)
Mortality from preventable causes[3]	14,885 (126.6)	15,532 (105.7)	15,178 (100.5)	43,118 (109.5)
Mortality from treatable causes[4]	9,416 (80.9)	8,842 (61.4)	8,702 (58.6)	23,076 (59.0)
Potential years of life lost[5] (and age-standardized rate per 100,000 population)				
Premature mortality	533,950 (4,724.5)	544,006 (3,970.2)	528,442 (3,777.1)	1,478,962 (4,087.1)

Continued on next page

	Ontario			Canada
	2000	2010	2011	2011
Potential years of life lost[5] (and age-standardized rate per 100,000 population) – continued				
Potentially avoidable mortality	389,684 (3,464.6)	411,178 (3,026.6)	393,339 (2,831.0)	1,109,416 (3,094.4)
Mortality from preventable causes	233,324 (2,027.1)	252,488 (1,793.1)	241,221 (1,676.5)	707,117 (1,930.1)
Mortality from treatable causes	156,360 (1,437.5)	158,689 (1,233.5)	152,119 (1,154.5)	402,299 (1,164.3)

Source: 80

Notes:
[1] Deaths of individuals younger than age 75
[2] Premature deaths that could potentially have been avoided through all levels of prevention (primary, secondary, tertiary)
[3] Premature deaths that could potentially have been prevented through primary prevention efforts
[4] Premature deaths that could potentially have been avoided through secondary or tertiary prevention
[5] Number of years of potential life not lived when a person dies 'prematurely' (i.e., before age 75)

Table 1.9: Leading causes of death, by number of deaths and as age-standardized rates per 100,000 population for 2000, 2010 and 2011[1]

Leading causes of death (ICD-10)	Ontario			Canada
	2000	2010	2011	2011
Malignant neoplasms	23,253 (177.3)	26,628 (152.3)	26,842 (149.0)	72,476 (154.1)
Disease of the heart	20,926 (154.3)	17,983 (93.4)	17,614 (88.3)	47,627 (91.0)
Cerebrovascular disease	6,149 (44.7)	5,315 (27.0)	4,930 (24.0)	13,283 (24.8)
Accidents (unintentional injuries)	2,842 (22.3)	4,283 (25.0)	4,203 (23.8)	11,184 (22.1)
Chronic lower respiratory diseases	3,393 (25.0)	3,684 (19.6)	3,800 (19.6)	10,716 (24.2)
Diabetes mellitus	2,830 (21.2)	2,873 (15.6)	2,867 (15.1)	7,194 (14.5)

Source: 79

Note:
[1] Based on 2011 World Health Organization, International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)

Overview of the book

The bulk of the book is organized into three parts, the first of which is 'the building blocks of the system.' The 'building blocks' include governance arrangements (i.e., who can make what types of decisions); financial arrangements (i.e., how revenue is raised to pay for care and how organizations are funded, professionals remunerated, products and services purchased, and consumers incentivized); and delivery arrangements (i.e., where and with what supports care is provided and by whom care is provided). The latter building block has been divided into two parts: infrastructure and workforce. There are parallels to the World Health Organization's 'building blocks,' but our experience in coding all of the systematic reviews and economic evaluations in the world about strengthening health systems (for inclusion in Health Systems Evidence – www.healthsystemsevidence.org – a free online resource) have led us to use governance, financial and delivery arrangements as building blocks.

The second part of the book – 'using the building blocks to provide care' – has been organized into 'care by sector' (i.e., home and community care, primary care, specialty care, rehabilitation care, long-term care and public health, which we use as an organizing framework throughout the book); care for select conditions (where we focus on four conditions or groupings of conditions that are handled in unique ways in the health system, namely mental health and addictions, work-related injuries and diseases, cancer, and end of life); care using select treatments (where we focus on three types of treatment that are handled in unique ways in the health system, namely prescription and over-the-counter drugs, complementary and alternative therapies, and dental services); and care for a select population (where we focus on Indigenous peoples, whose historical relationship to, and treatment by, government has created a unique patchwork of care and a political imperative to right past wrongs). We explain our rationale for singling out select conditions and treatments and a select population in more detail in the corresponding chapters.

To explain 'care by sector' a little more, home and community care includes both the nursing care provided at home after hospital discharge and the care provided by community-based organizations (e.g., assisted living in supportive housing). Primary care has historically meant a family physician, but increasingly means interprofessional teams of physicians, nurses

and other professionals. Specialty care includes hospitals (and their outpatient clinics), condition-specific facilities (e.g., for cancer or mental health and addictions), and a mix of other types of facilities (such as Independent Health Facilities and Out of Hospital Premises, and private laboratories). Long-term care includes places like long-term care homes and complex continuing care facilities (or units within hospitals). Public health is typically focused on population-based interventions, but in Ontario it sometimes also involves direct service provision to individuals, albeit usually with more of a prevention focus than a treatment focus.

In this (second) part of the book we repeatedly use a figure that shares column and row headers to highlight similarities and differences. The key column headers include five of the six sectors listed above (with rehabilitation care excluded because it is an element of most of the other sectors), and these are bracketed by column headers for 'technology' provision (prescription and over-the-counter drugs, medical and assistive devices, diagnostics, and vaccinations) and for any key federal government or national organization involvement. The row headers include policies (e.g., acts); programs (e.g., Ontario Health Insurance Plan and Ontario Drug Benefit Program); places (e.g., primary-care clinics, laboratories, pharmacies, hospital emergency rooms, and long-term care homes); and people (both professionals like nurses and citizens like people living with diabetes, as well as the organizations that regulate or represent them). We call it the sector4P figure for short (Figure 1.3).

The third part of the book – change and progress – has been divided into health-system reforms (where the focus is an analysis of reforms introduced since 2000) and assessment of the health systems (where the focus is what formal evaluations of the system tell us about whether it is achieving its objectives). The book ends with a brief conclusion.

To facilitate comparisons across health systems, parts of the general structure of the book and the focus and organization of some of the tables and figures follow the approach used by published books on national health systems (e.g., Health Systems in Transition series coordinated by the European Observatory on Health Systems and Policies), or by published or planned books on other provincial/territorial health systems (e.g., Nunavut and Saskatchewan). These books can be identified through Health Systems Evidence, by selecting 'health-system descriptions' as the document type

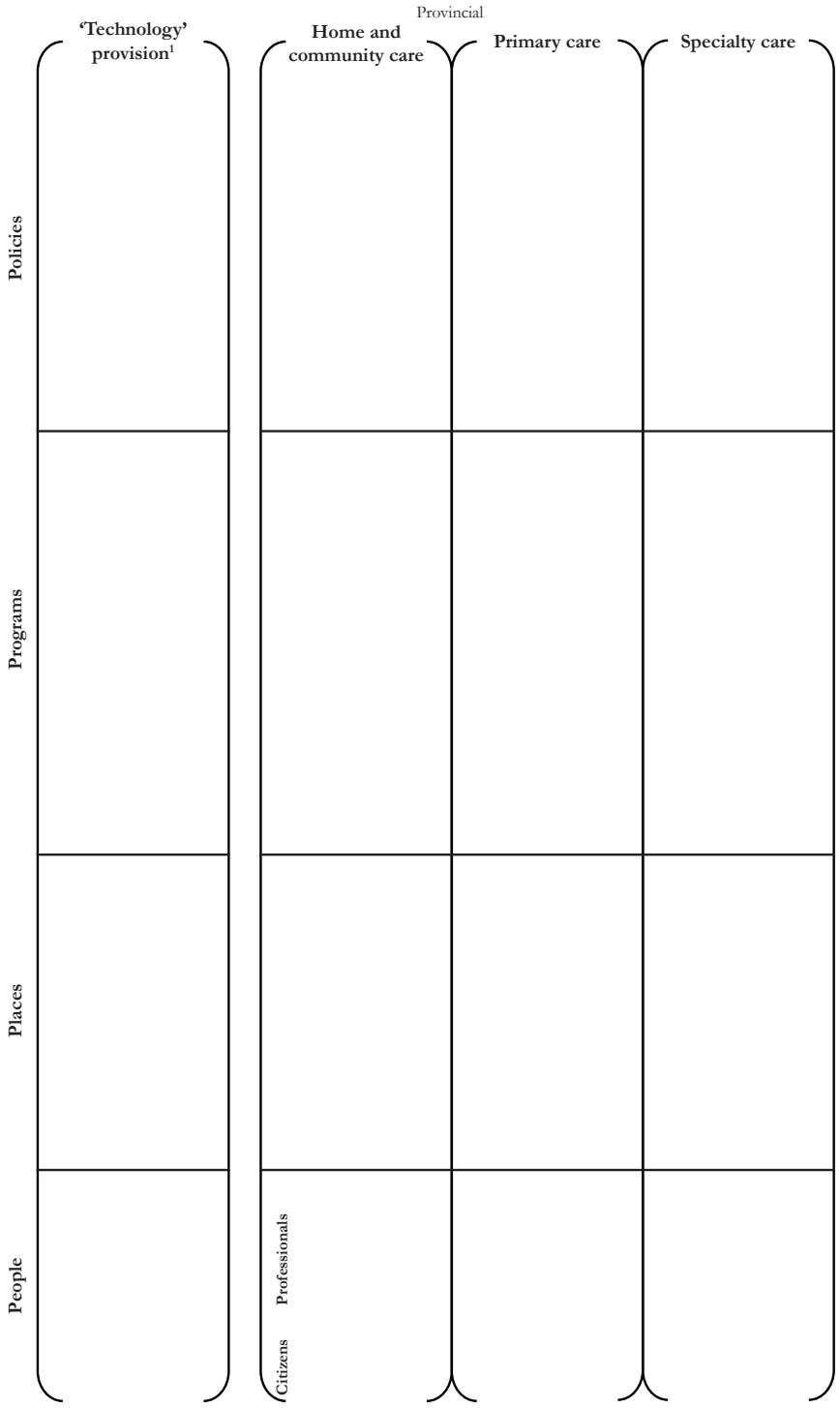
and the name of the country in the 'advanced search.' For example, Chapters 1-5 and 10-12 are broadly comparable to chapters appearing in these published or planned books, and the approach to providing Ontario data for the year 2000, year 2010 and the most recent year for which data are available, as well as data for the country as a whole whenever possible, is comparable to the planned books. That said, we have also departed significantly from these books in a number of ways, including expanding what would have been Chapter 6 into four separate chapters (Chapters 6-9), which we felt was necessary to do justice to the complexity of how care is provided in Ontario, and introducing the sector4P figures, which highlight key features of a sector or other part of the health system 'at-a-glance.'

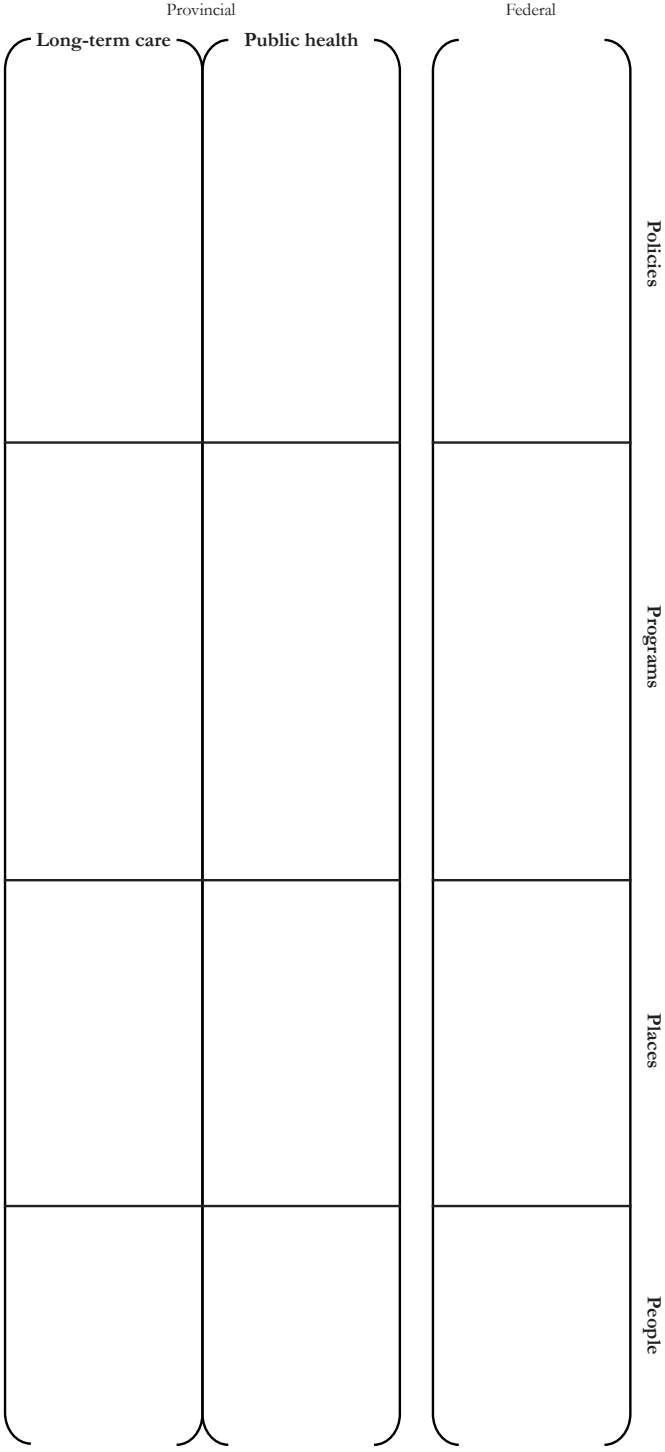
To facilitate comparisons over time, tables or figures that present financial data for multiple years have been adjusted for inflation using Statistics Canada's Consumer Price Index (2002 = 100). Specifically, we applied the Consumer Price Index for Ontario using the 'healthcare' component (e.g., 2002 = 100 and 2015 = 124).(14) Given the sometimes significant difference between forecasts of financial data and the actual financial data that are eventually published, we typically do not present forecasts. While this decision can leave the impression that some of our data are 'old,' they are in fact the most recently published data.

To facilitate more in-depth examination of the issues raised in the book, we have added all of the key documents cited in the book to Health Systems Evidence (provided they meet its eligibility criteria). These documents can be identified and accessed (again through hyperlinks when freely available) by selecting 'Ontario's health system documents' as the type of complementary content and then using additional filters (e.g., 'primary care' as the sector), or by simply copying and pasting the title of the document into the 'open search' box.

Lastly, to make our descriptions readable by a diverse audience and to make comparisons possible across health systems and over time, we have effectively disaggregated a complex health system into its component parts (both its governance, financial and delivery arrangements, and the ways that care is provided in different sectors, for select conditions, using select treatments, and for a select population), while recognizing that these parts interact with one another in dynamic ways and that these parts individually and collectively adapt to events like a system reform.

Figure 1.3: Structure of the figure used in select chapters in the book





Note:
[1]Includes drugs, vaccines, devices, diagnostics and surgeries

References

1. Ministry of Health and Long-Term Care. Patients first: Action plan for health care. Toronto: Queen's Printer for Ontario; 2015. http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_patientsfirst.pdf (accessed 25 August 2016).
2. Ministry of Health and Long-Term Care. Rural and northern health care framework. Stage 1 report. Toronto: Queen's Printer for Ontario; 2011.
3. Statistics Canada. Immigration and ethnocultural diversity in Canada, catalogue no. 99-010-X2011001 (National Household Survey, 2011). Ottawa: Statistics Canada; 2013. http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.pdf (accessed 26 August 2016).
4. Statistics Canada. Canada year book 2012. Chapter 13: Ethnic diversity and immigration. Ottawa: Statistics Canada; 2012. http://www.statcan.gc.ca/pub/11-402-x/2012000/pdf/ethnic-ethnique-eng.pdf (accessed 24 August 2016).
5. Statistics Canada. Ontario (Code 35) (table). National Household Survey (NHS) Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004-XWE. Ottawa: Statistics Canada; 2013. https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E (accessed 26 August 2016).
6. Statistics Canada. Census program. Table 4 - Number of people and proportion of the population reporting French by selected language characteristic, New Brunswick and Ontario, 2006 and 2011. Ottawa: Statistics Canada; 2015. https://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-314-x/2011003/tbl/tbl3_1-4-eng.cfm (accessed 2 November 2016).
7. Statistics Canada. Table 202-0802 - Persons in low income families, annual, CANSIM (database). Ottawa: Statistics Canada; 2013. http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=2020802&&pattern=&stByVal=1&p1=1&p2=-1&tabMode=dataTable&csid= (accessed 25 August 2016).
8. Statistics Canada. Windsor, CMA, Ontario (Code 559) (table). National Household Survey (NHS) Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004-XWE. Ottawa: Statistics Canada; 2013. http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E (accessed 26 August 2016).
9. Statistics Canada. Labour force characteristics, seasonally adjusted, by province (monthly) (Quebec, Ontario, Manitoba). Ottawa: Statistics Canada; 2016. http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/lfss01b-eng.htm (accessed 24 August 2016).
10. Statistics Canada. Education in Canada: Attainment, field of study and location of study. National Household Survey, 2011. Catalogue no. 99-012-X2011001. Ottawa: Statistics Canada; 2013. http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-012-x/99-012-x2011001-eng.pdf (accessed 26 August 2016).
11. Gildiner A. What's past is prologue: A historical-institutionalist analysis of public-private change in Ontario's rehabilitation health sector, 1985-1999 [PhD dissertation]. Toronto: University of Toronto; 2001.
12. World Bank. Health expenditure, public (% of total health expenditure). Washington: World Bank Group; 2015. http://data.worldbank.org/indicator/SH.XPD.PUBL (accessed 26 August 2016).
13. Statistics Canada. Table 102-0122 - Health-adjusted life expectancy, at birth and at age 65, by sex and income, Canada and provinces, occasional (years), CANSIM (database). Ottawa: Statistics Canada; 2012. http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1020122 (accessed 25 August 2016).
14. Statistics Canada. Table 326-0020 - Consumer Price Index, monthly (2002=100 unless otherwise noted), CANSIM (database). Ottawa: Statistics Canada; 2016. http://www5.statcan.gc.ca/cansim/a26?id=3260020 (accessed 24 August 2016).
15. Lavis JN, Arcus K, Forest P-G, Abelson J, Mendelsohn M. Commissioning a new political bargain for Canada's health-care system. Hamilton: Program in Policy Decision-Making; 2002.
16. Health Canada. Canada's health care system. Ottawa: Health Canada; 2014. http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php - a3 (accessed 25 August 2016).
17. Canada Parliament House of Commons. Federal-Provincial Fiscal Arrangements Act (R.S.C., 1985, c. F-8). Ottawa: Canada Parliament House of Commons; 1985. http://laws.justice.gc.ca/PDF/F-8.pdf (accessed 26 August 2016).
18. Hall E. Health Services Review '79. Canada's National-Provincial Health Program for the 1980's: A Commitment for Renewal. Ottawa: Health and Welfare; 1980.
19. Canada Parliament House of Commons. Canada Health Act (R.S.C., 1985, c. C-6). Ottawa: Canada Parliament House of Commons; 1985. http://laws-lois.justice.gc.ca/eng/acts/C-6/FullText.html (accessed 26 August 2016).
20. Evans J. Toward a shared direction for health in Ontario: Report of the Ontario Health Review Panel. Toronto: The Ontario Health Review Panel; 1987.
21. Legislative Assembly of Ontario. Ministry of Health and Long-Term Care Act, 1990, R.S.O. 1990, c. M.26. Toronto: Queen's Printer for Ontario; 1990. http://www.e-Laws.gov.on.ca/html/statutes/english/elaws_statutes_90m26_e.htm (accessed 25 August 2016).
22. Legislative Assembly of Ontario. Independent Health Facilities Act, 1990, R.S.O. 1990, c. I.3. Toronto: Queen's Printer for Ontario; 1990. http://www.e-Laws.gov.on.ca/html/statutes/english/elaws_statutes_90i03_e.htm (accessed 25 August 2016).
23. Ministry of Health and Long-Term Care. Independent Health Facilities fact sheet. Toronto: Queen's Printer for Ontario; 2014. http://www.health.gov.on.ca/en/public/programs/ihf/docs/ihf_fact.pdf (accessed 25 August 2016).
24. Madore O. The Canada Health and Social Transfer: Operation and possible repercussions on the health care sector. Current Issues Review. Ottawa: Government of Canada; 2003.

25. Canadian Intergovernmental Conference Secretariat. Social Union Framework Agreement (SUFA). Ottawa: Government of Canada; 1999. http://www.scics.gc.ca/english/conferences.asp?a=viewdocument&id=638 (accessed 24 August 2016).

26. Canadian Intergovernmental Conference Secretariat. News release - First Ministers' meeting communique on health, September 11, 2000. Ottawa: Canadian Intergovernmental Conference Secretariat; 2000. http://www.scics.gc.ca/english/conferences.asp?a=viewdocument&id=1144 (accessed 25 August 2016).

27. Standing Senate Committee on Social Affairs Science and Technology. The health of Canadians – the federal role. Final report. Volume six: Recommendations for reform. Ottawa: Parliament of Canada; 2002. http://www.parl.gc.ca/content/sen/committee/372/soci/rep/repoct02vol6-e.htm (accessed 24 August 2016).

28. Romanow R. Building on values: The future of health care in Canada. Ottawa: Privy Council. Commission on the Future of Health Care in Canada; 2002.

29. Canadian Intergovernmental Conference Secretariat. 2003 First Ministers' accord on healthcare renewal. Ottawa: Canadian Intergovernmental Conference Secretariat; 2003. http://www.scics.gc.ca/CMFiles/800039004_e1GTC-352011-6102.pdf (accessed 24 August 2016).

30. Legislative Assembly of Ontario. Commitment to the Future of Medicare Act, 2004 (S.O. 2004). Toronto: Queen's Printer for Ontario; 2004. http://www.e-Laws.gov.on.ca/html/statutes/english/elaws_statutes_04c05_e.htm (accessed 25 August 2016).

31. Government of Ontario. Ontario's wait time strategy. 2005. https://news.ontario.ca/opo/en/2005/05/ontarios-wait-time-strategy.html (accessed 25 August 2016).

32. Legislative Assembly of Ontario. Local Health System Integration Act, 2006, S.O. 2006, c. 4. Toronto: Queen's Printer for Ontario; 2010. http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06l04_e.htm (accessed 25 August 2016).

33. Legislative Assembly of Ontario. Excellent Care for All Act, 2010, S.O. 2010, c. 14. Toronto: Queen's Printer for Ontario; 2010. https://www.ontario.ca/laws/statute/10e14 - BK0 (accessed 24 August 2016).

34. Ministry of Health and Long-Term Care. About the Excellent Care for All Act. Toronto: Queen's Printer for Ontario; 2013. http://health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aspx (accessed 26 August 2016).

35. Ministry of Health and Long-Term Care. About Excellent Care for All regulations. Toronto: Queen's Printer for Ontario; 2016. http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/act_regs.aspx (accessed 25 August 2016).

36. Legislative Assembly of Ontario. The Broader Public Sector Accountability Act, 2010, S.O. 2010, c. 25. Toronto: Queen's Printer for Ontario; 2010. http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2420&detailPage=bills_detail_the_bill (accessed 24 August 2016).

37. Ontario Financing Authority. Commission on the reform of Ontario's public services. Toronto: Queen's Printer for Ontario; 2012.

38. Ministry of Health and Long-Term Care. Health system funding reform (HSFR). Toronto: Queen's Printer for Ontario; 2014. http://www.health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding.aspx (accessed 25 August 2016).

39. Supreme Court of Canada. Daniels v. Canada (Indian Affairs and Northern Development). Ottawa: Supreme Court of Canada; 2016. http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/15858/index.do (accessed 24 August 2016).

40. Commission on the Reform of Ontario's Public Services. Public services for Ontarians: A path to sustainability and excellence. Toronto: Queen's Printer for Ontario; 2012.

41. Legislative Assembly of Ontario. Health Insurance Act (R.S.O. 1990, c. H.6). Last amendment: 2009, c. 33, Sched. 18, ss. 11, 17 (2). Toronto: Queen's Printer for Ontario; 2009. http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h06_e.htm (accessed 25 August 2016).

42. Parliament of Canada. Canada's federal and provincial health care inquiries: 1940s to 2003. Library of Parliament; 2003. http://www.lop.parl.gc.ca/content/lop/ResearchPublications/tips/tip95-e.htm (accessed 29 September 2016).

43. Local Health Integration Network. Local Health Integration Networks. Toronto: Queen's Printer for Ontario; 2005.

44. Statistics Canada. Health regions: Boundaries and correspondence with census geography, catalogue no. 82-403-X. Geography Division for the Health Statistics Division. Ottawa: Statistics Canada; 2013.

45. Statistics Canada. Population and dwelling counts, for Canada, provinces and territories, and census subdivisions (municipalities), 2011 and 2006 censuses. Ottawa: Statistics Canada; 2011.

46. Statistics Canada. Population and dwelling counts, for Canada, provinces and territories, and census subdivisions (Municipalities), 2001 and 1996 censuses - 100% data. Ottawa: Statistics Canada; 2001.

47. Statistics Canada. Population and dwelling counts, for Canada, provinces and territories, 1991 and 1996 censuses - 100% data. Ottawa: Statistics Canada; 1996.

48. Government of Canada. The federal role in health and healthcare. Ottawa: Government of Canada; 2005. http://www.lop.parl.gc.ca/content/lop/researchpublications/prb0858-e.pdf (accessed 26 August 2016).

49. Department of Finance. Federal support to provinces and territories. Federal support to Ontario. Ottawa: Government of Canada; 2015. http://www.fin.gc.ca/fedprov/mtp-eng.asp - Ontario (accessed 25 August 2016).

50. Legislative Assembly of Ontario. Branches of government. Toronto: Queen's Printer for Ontario; 2014. http://educationportal.ontla.on.ca/en/about-parliament/how-parliament-works/parliamentary-traditions/what-parliament/branches-government (accessed 26 August 2016).

51. Parliament of Canada. Forty-second, party standings in the House of Commons. Ottawa: Parliament of Canada; 2015. http://www.parl.gc.ca/parlinfo/Files/Parliament.aspx?Item=b67c82bf-0106-42e5-9be1-46ecb5feaf60&Language=E&MenuID=Lists.Parliament.aspx&MenuQuery=http%3A%2F%2Fwww.parl.gc.ca%2Fparlinfo%2Flists%2FParliament.aspx (accessed 24 August 2016).

52. Ministry of the Attorney General. Current structure of the Ontario courts. Toronto: Queen's printer for Ontario; 2010. http://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/cjr/firstreport/courts.asp (accessed 28 August 2016).

53. Abelson J, Mendelsohn M, Lavis JN, Morgan SG, Forest P-G, Swinton M. Canadians confront health care reform. Health Affairs 2004;23(3): 186-193.

54. Office of the Auditor General of Ontario. Special report: Ontario's electronic health records initiative. Toronto: Office of the Auditor General of Ontario; 2009.

55. Health Canada. Learning from SARS. Renewal of public health in Canada. A report of the National Advisory Committee on SARS and public health. Ottawa: Health Canada; 2003.

56. Lavis JN. Studying health-care reforms. In: Lazar H, Lavis JN, Forest P-G, Church J, editors. Paradigm freeze: Why it is so hard to reform health care in Canada. Kingston: McGill-Queen's University Press; 2013.

57. CIHI. National health expenditure trends, 1975 to 2015. Series B, table B.1.1, Total health expenditure, by province/territory and Canada, 1975 to 2015—current dollars. Ottawa: Canadian Institute for Health Information; 2015.

58. CIHI. National health expenditure trends, 1975 to 2015. Series B, table B.2.1, Private sector health expenditure, by province/territory and Canada, 1975 to 2015—current dollars. Ottawa: Canadian Institute for Health Information; 2015.

59. CIHI. National health expenditure trends, 1975 to 2015. Series B, table B.2.3, Private sector health expenditure as a proportion of total health expenditure, by province/territory and Canada, 1975 to 2015—current dollars. Ottawa: Canadian Institute for Health Information; 2015.

60. CIHI. National health expenditure trends, 1975 to 2015. Series B, table B.3.1, Public sector health expenditure, by province/territory and Canada, 1975 to 2015—current dollars. Ottawa: Canadian Institute for Health Information; 2015.

61. CIHI. National health expenditure trends, 1975 to 2015. Series B, table B.3.3, Public sector health expenditure as a proportion of total health expenditure, by province/territory and Canada, 1975 to 2015—current dollars. Ottawa: Canadian Institute for Health Information; 2015.

62. CIHI. National Health Expenditure Trends, 1975 to 2015. Series A, table A24, total health expenditure by source of finance, Canada, 1975 to 2015—constant dollars. Ottawa: CIHI; 2015.

63. CIHI. National Health Expenditure Trends, 1975 to 2015. Series A, table A25, total health expenditure by source of finance, Canada, 1975 to 2015—constant dollars. Ottawa: CIHI; 2015.

64. CIHI. National health expenditure trends, 1975 to 2015. Series B, table B.1.4, total health expenditure, by province/territory and Canada, 1975 to 2015—constant dollars. Ottawa: Canadian Institute for Health Information; 2015.

65. CIHI. National health expenditure trends, 1975 to 2015. Series B, table B.3.5, public sector health expenditure, per capita, by province/territory and Canada, 1975 to 2015—constant dollars. Ottawa: Canadian Institute for Health Information; 2015.

66. CIHI. National Health Expenditure Trends, 1975 to 2015. Series B, table B24, private sector health expenditure, by province/territory and Canada, 1975 to 2015—constant dollars. Ottawa: CIHI; 2015.

67. CIHI. National Health Expenditure Trends, 1975 to 2015. Series B, table B25, private sector health expenditure, by province/territory and Canada, 1975 to 2015—constant dollars. Ottawa: CIHI; 2015.

68. CIHI. National health expenditure trends, 1975 to 2015. Series B, table B.3.4, public sector health expenditure, by province/territory and Canada, 1975 to 2015—constant dollars. Ottawa: Canadian Institute for Health Information; 2015.

69. CIHI. National Health Expenditure Trends, 1975 to 2015. Series B, table B35, public sector health expenditure, by province/territory and Canada, 1975 to 2015—constant dollars. Ottawa: CIHI; 2015.

70. Statistics Canada. Table 384-00384 - Gross domestic product, expenditure-based, provincial and territorial, annual, CANSIM (database). Ottawa: Statistics Canada; 2014. http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/econ15-eng.htm (accessed 24 August 2016).

71. Statistics Canada. Table 151-0001 - Estimates of population by age group and sex for July 1, Canada, provinces and territories. Ottawa: Statistics Canada; 2015. http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&pattern=Estimates+of+population+by+age+group+and+sex+for+July+1%2C+Canada%2C+provinces+and+territories&tabMode=dataTable&srchLan=-1&p1=1&p2=-1 (accessed 25 August 2016).

72. Ministry of Finance. Public accounts of Ontario 2000-2001. Annual report and consolidated financial statements. Toronto: Queen's Printer for Ontario; 2001.

73. Ministry of Finance. Public accounts of Ontario 2009-2010. Annual report and consolidated financial statements. Toronto: Queen's Printer for Ontario; 2010.

74. Treasury Board Secretariat. Public accounts of Ontario 2014-2015. Annual report and consolidated financial statements Toronto: Treasury Board Secretariat; 2015.

75. Statistics Canada. Table 102-0512 - Life expectancy, at birth and at age 65, by sex, Canada, provinces and territories, annual (years), CANSIM (database). Ottawa: Statistics Canada; 2012. http://www5.statcan.gc.ca/cansim/a05?searchTypeByValue=1&lang=eng&id=1020512&pattern=1020512 (accessed 26 August 2016).

76. Statistics Canada. Table 84-537-X - Life tables, Canada, provinces and territories 2009 to 2011, CANSIM (database). Ottawa: Statistics Canada; 2013. http://www.statcan.gc.ca/pub/84-537-x/84-537-x2013005-eng.htm (accessed 24 August 2016).

77. Statistics Canada. Table 102-0504 - Deaths and mortality rates, by age group and sex, Canada, provinces and territories, annual, CANSIM (database). Ottawa: Statistics Canada; 2013. http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health21a-eng.htm (accessed 24 August 2016).

78. Statistics Canada. Table 102-0508 - Perinatal mortality (number and rates) and components, Canada, provinces and territories, annual, CANSIM (database). Ottawa: Statistics Canada; 2013. http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1020508&tabMode=dataTable&srchLan=-1&p1=-1&p2=9 (accessed 25 August 2016).

79. Statistics Canada. Table 102-0563 - Leading causes of death, total population, by sex, Canada, provinces and territories, annual, CANSIM (database). Ottawa: Statistics Canada; 2014. http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1020563&tabMode=dataTable&srchLan=-1&p1=-1&p2=9 (accessed 25 August 2016).

80. Statistics Canada. Table 102-4312 - Premature and potentially avoidable mortality, Canada, provinces and territories, annual, CANSIM (database). Ottawa: Statistics Canada; 2014. http://www5.statcan.gc.ca/cansim/pick-choisir?lang=eng&p2=33&id=1024312 (accessed 26 August 2016).