2. Governance arrangements

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Key messages for citizens

- The voice of citizens in their own care is protected through a requirement that they give their informed consent to treatment, and increasingly mechanisms are also in place for their voice to be heard in how programs and services are delivered, in how the system's performance is monitored, and in how policy and organizational decisions are made.
- The provincial government has the authority to make a number of decisions about how the system works, but they've also delegated some of this authority to other organizations, such as the ones that regulate what different types of professionals (e.g., nurses or physicians) can do, and the Local Health Integration Networks that plan, integrate and fund care in the province's 14 regions.
- Many of the organizations that provide care are private organizations – some not-for-profit (like most hospitals) and others for-profit (like community pharmacies and the facilities that perform blood tests and X-rays) – and they have a lot of discretion in how they operate.

Key messages for health professionals

- Nursing and medicine are self-regulating professions, which means that the government has established regulatory colleges (led by both members of the profession and the general public) to regulate practice in each profession (e.g., who can call themselves a physician, what a registered nurse is allowed to do).
- The provincial government makes many decisions about the health system (e.g., who is eligible for what prescription drugs as part of the Ontario Drug Benefit Program), but has also delegated some authority to Local Health Integration Networks and to provincial agencies like Cancer Care Ontario.
- The government also acts in a stewardship role for the many private organizations involved in providing care by, for example, setting performance targets and requiring public reporting against these targets, and it is supported in this role by these organizations' voluntary participation in processes like accreditation (organized by Accreditation Canada).

Key messages for policymakers

- The provincial government makes decisions in some areas and delegates decisions in other areas (e.g., to Local Health Integration Networks about planning, integrating and – with much less discretion – funding many types of care, to regulatory colleges about professional practice, and to government agencies about performance monitoring and in some cases performance management).
- The government's stewardship role is particularly important for the many private (for-profit and not-for-profit) organizations that provide care in the health system.
- The federal government plays an important role in setting limits about which prescription drugs a pharmaceutical company can sell in Canada, the maximum 'factory gate' price it can charge (not the wholesale price or the retail price charged by pharmacies), and whether it can advertise to patients, but the details about which drugs are paid for by government are set provincially.

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In this first of four chapters focused on the building blocks of the health system, we focus on governance arrangements, which can be thought of simply as who can make what types of decisions. Governance arrangements include issues like policy authority (e.g., is policymaking decentralized or not?), organizational authority (e.g., are primary-care organizations governed by a community-based board of directors?), commercial authority (e.g., can pharmacies set any price for prescription drugs?), professional authority (e.g., can anyone call themselves a nurse?), and consumer and stakeholder involvement (e.g., are citizens given a voice in policymaking about the health system?). We address each of these types of authority in turn below.

Before doing so, however, it is important to note that governance arrangements can be considered to be the 'regulation' option available to the Government of Ontario as it responds to the differences between healthcare and other goods and services; the other options being public financing (which is addressed in Chapter 3) and information provision (which is relied on to a much lesser degree and addressed in Chapter 4).(1) Public provision of services is used in countries like the U.K. – with

its National Health Service in each of England, Northern Ireland, Scotland, and Wales – but not really in Ontario (with the now historical exception of the provincial government-owned 'mental hospitals' and the current exception of some municipal government-owned long-term care homes). Income transfer is used in countries like Singapore – with its government-financed medical savings accounts – but not in Ontario.

Governance arrangements can also be considered to be the 'legal instruments' available as one of four broad types of policy instrument that the Government of Ontario can use to ensure the health system advances the public interest.(2) Legal instruments include acts and regulations, self-regulation regimes (as have been set up for the province's health professions) and performance-based regulations, the first two of which are widely used in Ontario and the focus of much of this chapter. Other policy instruments include economic instruments (e.g., taxes and fees, public expenditure and loans, public ownership, insurance schemes, and contracts, some of which are the focus of Chapter 3), as well as voluntary instruments (e.g., standards and guidelines and both formalized partnerships and less formalized networks) and information and education instruments (which are addressed in Chapter 4).

Policy authority

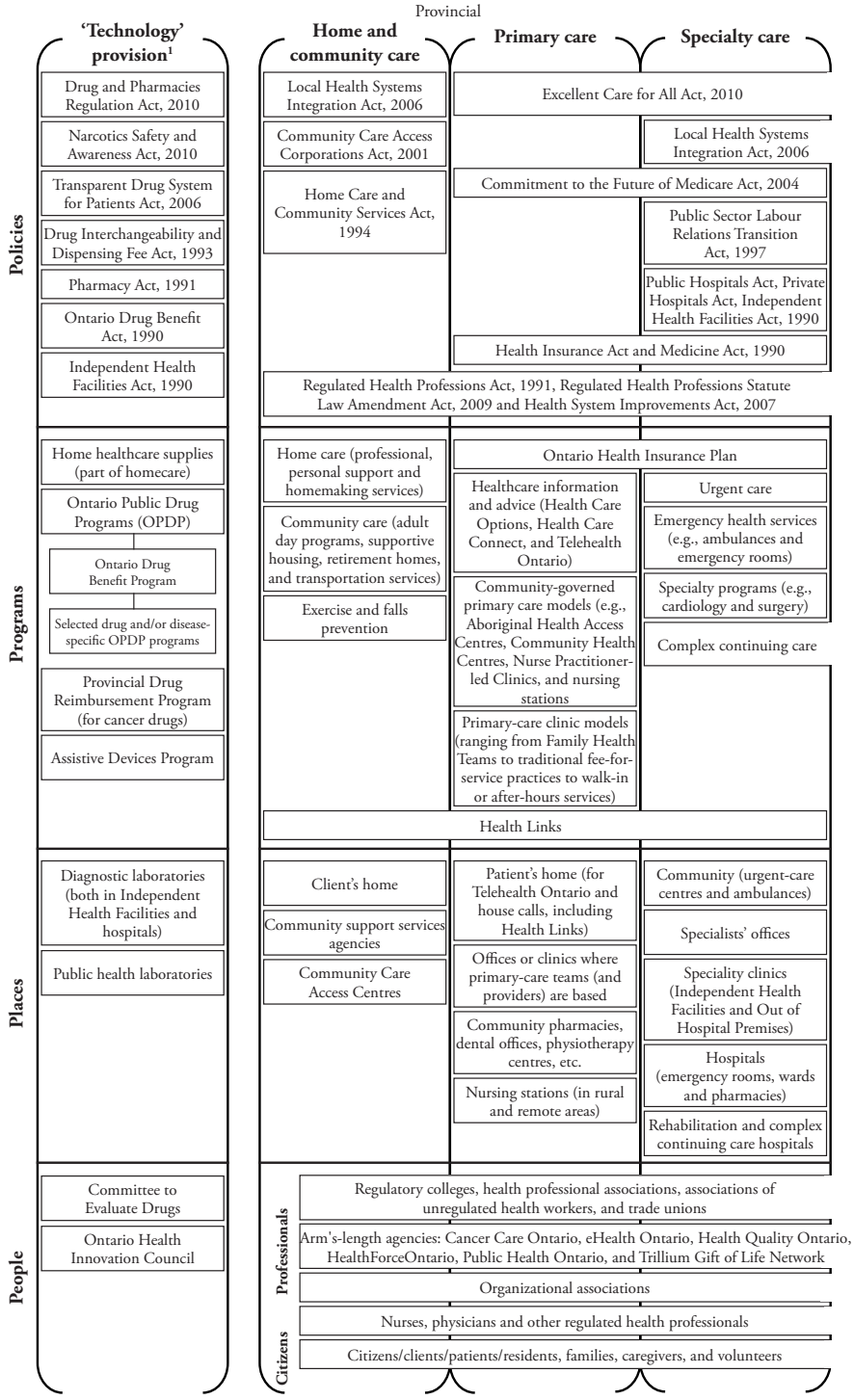
The Government of Ontario has the policy authority to establish, through acts and regulations, who can make what types of decisions, both within government (e.g., Ministry of Health and Long-Term Care) and among the organizations and professionals in the health system, and the citizens the system serves. These acts and regulations can apply across all sectors (e.g., *Regulated Health Professions Act, 1991* and the regulatory colleges created by the Act, which establish things like who can call themselves a nurse and what a physician can do) or to one or more sectors (e.g., *Local Health Systems Integration Act, 2006* which created the Local Health Integration Networks, or LHINs, that plan, integrate and fund care in the province's 14 regions) (see the 'policies' row of Figure 2.1, which provides a broad overview of the health system, particularly its five sectors and prescription drugs). Looking at it from a different perspective, the acts and regulations can apply across the entire system or to particular programs, places or people (professionals or citizens), and some federal government

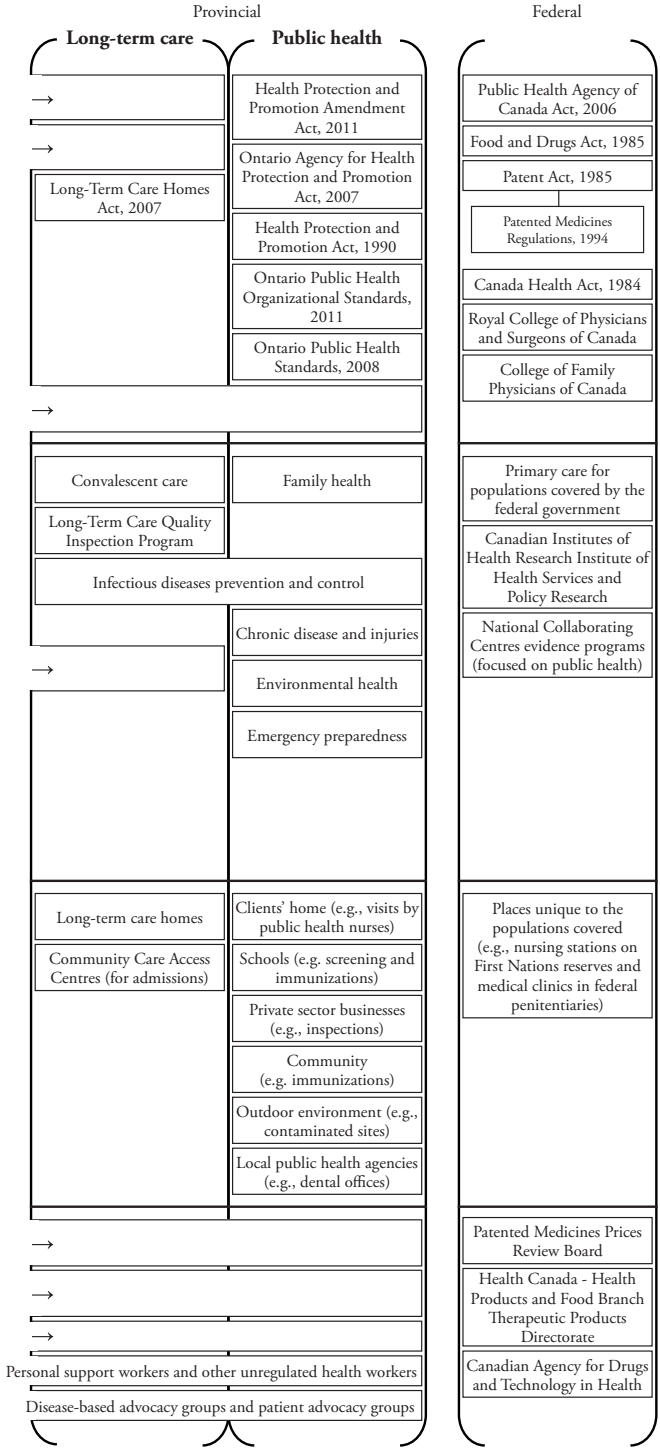
acts and regulations also apply to Ontario's health system. For a detailed list of the key acts that determine who can make what types of decision in the health system, see Table 2.1. Many of the acts use the acronym RSO, 1990, which stands for Revised States of Ontario, 1990, and reflects the fact that the last consolidation of all public statutes and all regulations occurred in 1990 and hence this is the starting point for e-Laws, which provide online access to official copies of Ontario's acts and regulations. The *Patients First Act, 2016* amended 20 existing acts, with key changes including an expansion of the role of the LHINs for planning and integrating primary care and home and community care.(3)

The government has retained policy authority to make decisions in some areas and decentralized that authority in other areas (if one considers such authority to include allocating budgets, developing strategies, and monitoring and reporting on performance or other related activities). It has retained policy authority in a number of key programmatic areas, including, for example, the Ontario Drug Benefit Program, which pays most of the cost of prescription drugs for select groups (see the 'programs' row of Figure 2.1). The government makes decisions about who is covered (e.g., those 65 and over and those receiving social assistance) and what they're covered for (e.g., drugs listed on an approved formulary), with the support of an advisory committee. On the other hand, the government has effectively decentralized some of its policy authority to LHINs (and has indicated that it will decentralize some of this authority further to as-yet-unnamed LHIN sub-regions)(4) and to regulatory colleges (e.g., College of Physicians and Surgeons of Ontario, which regulates the practice of medicine).

It has also decentralized some authority to government agencies, such as Cancer Care Ontario (CCO), eHealth Ontario, Health Quality Ontario (HQO), HealthForceOntario, Public Health Ontario, and Trillium Gift of Life Network, which play key roles in cancer care, electronic health records, evidence standards and quality improvement, supply and distribution of health professionals, public health, and organ and tissue donation, respectively (see the top two lines in the 'people' row of Figure 2.1). In a way, the government has shared some authority as well with the medical profession through the Physician Services Committee, which is comprised of representatives from the Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA), and which addresses broad system issues that affect the profession (and under the terms of the Representation

Figure 2.1: Health-system overview





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

Table 2.1: Key acts that determine who can make what types of decision in the health system

Legislation	Consequences
Federal	
British North America (BNA) Act, 1867 (Constitution Act, 1982)	Established healthcare as the constitutional responsibility of provincial governments, effectively leading to the creation of 14 different health systems in Canada – 10 provincial, three territorial, and one set of 'federal' (for Indigenous peoples, armed services personnel, etc.)
Canada Health Act, 1984	Established five criteria that provincial governments must adhere to in the design, delivery and funding of provincial health-insurance programs: public administration, comprehensiveness, universality, portability and accessibility Banned 'extra-billing' and thereby re-affirmed the 'core bargain' with hospitals and physicians: • 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 (fee-for-service) payment
Patent Act, 1985	Established the independent quasi-judicial Patented Medicines Prices Review Board to approve the entry of prescription drugs into the Canadian market, to ensure their prices are not excessive, and to report on research and development spending by patentees
Public Health Agency of Canada Act, 2006	Established the Public Health Agency of Canada and a Chief Medical Officer of Health to advise the Minister of Health and to coordinate federal efforts to identify and reduce public health risk factors (including measures relating to health protection and promotion, population health assessment, health surveillance, and disease and injury prevention), and to support public health emergency preparedness and response at the national level
Ontario - System	
Ministry of Health and Long-Term Care Act, 1990	The *Ministry of Health and Long-Term Care Act* set up the overall administrative structure of the Ontario health system with the minister presiding over and having charge of the ministry and all of its functions
Health Protection and Promotion Act, 1990	Established boards of health for all local public health agencies and the authorities of medical officers of health serving each board Required municipalities to cost-share the funding for all board activities
Mental Health Act, 1990	Established mental health as a subset of healthcare in Ontario, assigned the Minister of Health and Long-Term Care responsibility for designating psychiatric facilities, and governs how people may be involuntarily admitted to psychiatric facilities, how their mental health records are kept and accessed, how their financial affairs are handled, and how they can be released into the community
French Language Services Act, 1990	Guaranteed individuals the right to receive services in French from all provincial ministries and from government agencies in 26 designated areas across the province, as well as allowed hospitals to seek status as designated official French-language service providers (but does not require the 'active offer' of services in French, which means that if individuals do not request services in French there is no obligation to offer them even if French-language services might be highly valued

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Legislation	Consequences
Ontario - System – continued	
Public Sector Labour Relations Transition Act, 1997	Established a framework to resolve labour relations issues arising from the amalgamation of municipalities and other decisions that affect collective agreements and collective-bargaining processes (e.g., requires specialty clinics to assume the terms of existing collective agreements and collective-bargaining processes when commitments to provide diagnostic and therapeutic procedures are transferred from hospitals to specialty clinics, whether or not they had any unionized staff at the time that they began providing the services)
Commitment to the Future of Medicare Act, 2004	Re-affirmed the government's commitment to the principles of public administration, comprehensiveness, universality, portability and accessibility as provided in the *Canada Health Act, 2004*, which includes the province's commitment to no user fees for medically necessary hospital-based and physician-provided care 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
Local Health System Integration Act, 2006	Created 14 regional Local Health Integration Networks (LHINs) to plan, integrate and fund local health services, including home and community care, hospital care and much long-term care Reduced the number of Community Care Access Centres (CCACs) from 43 to 14, aligned their boundaries with those of the LHINs, and established the LHINs as their funder
Health System Improvements Act, 2007	Amended and repealed a number of statutes administered by the Ministry of Health and Long-Term Care and added new legislation including the creation of the Ontario Agency for Health Protection and Promotion (renamed Public Health Ontario in 2011), the requirement for greater transparency for health regulatory colleges, and the establishment of new health profession colleges for naturopathy, homeopathy, kinesiology and psychotherapy
Excellent Care for All Act, 2010	Underpins the Excellent Care for All Strategy, linking quality and evidence-based care Established a new payment mechanism (under the term 'health system funding reform') for hospitals Consolidated several research and advisory bodies under one umbrella, namely HQO
Health Protection and Promotion Amendment Act, 2011	Established the authority for the provincial chief medical officer of health to direct boards of health and local medical officers of health to adopt policies or measures in cases of a pandemic, public health event and/or emergency with health impacts
Ontario - Programs	
Health Insurance Act, 1990	Governs the administration and operation of the Ontario Health Insurance Plan, which provides insurance against the costs of insured (medically necessary) hospital-based and physician-provided services Has been modified by two acts: the *Health Care Accessibility Act, 1990* (now repealed) and the *Commitment to the Future of Medicare Act, 2004*
Ontario Drug Benefit Act, 1990	Governs the Ontario Drug Benefit (ODB) Program (introduced in 1985), whereby the province reimburses pharmacies when they dispense prescription drugs at no charge to eligible persons – primarily seniors and persons on social assistance For those with high prescription drug costs relative to household income, the Trillium Drug Program was added in 1995 to cover all ODB Program-approved drugs

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Legislation	Consequences
Ontario - Programs – continued	
Drug Interchangeability and Dispensing Fee, 1990	Introduced with the *Ontario Drug Benefit Act, 1990* to address rising drug prices and empowered the Executive Officer of the Ministry of Health and Long-Term Care to designate a generic drug as 'interchangeable' with a brand-name drug, and also limited the dispensing fees that pharmacies can charge private customers
Transparent Drug System for Patients Act, 2006	Amended the *Ontario Drug Benefit Act, 1990* and the *Drug Interchangeability and Dispensing Fee Act, 1990* to reform the ODB to improve patient access to drugs, ensure better value for money, reward innovation, and strengthen transparency
Narcotics Safety Awareness Act, 2010	Underlies Ontario's Narcotics Strategy, promoting proper use and prescribing of prescription narcotics and other controlled substance medications through the introduction of a monitoring system
Drug and Pharmacies Regulation Act, 2011	Extended through a regulation in 2011, this act controls the sale of drugs in the province by requiring that they be sold only through registered pharmacists and licensed pharmacies
Ontario - Places	
Public Hospitals Act, 1990	Regulated the establishment of, and provided the operational framework for, private not-for-profit hospitals in Ontario (notwithstanding the name, which suggests incorrectly that these are public hospitals)
Private Hospitals Act, 1990	Prohibits the operation of a for-profit hospital unless licensed as one prior to 29 October 1973
Independent Health Facilities Act, 1990	Provided a funding and licensing mechanism for two types of community-based specialty clinics: • diagnostic Independent Health Facilities (IHFs) to provide imaging (e.g., nuclear medicine and diagnostic radiology and ultrasound), sleep studies and pulmonary function tests • ambulatory care IHFs to provide surgical and therapeutic procedures on an outpatient basis (e.g., cataract surgery) Ontario Regulation 353/13 (effective January 2014) made every IHF within the meaning of the *Independent Health Facilities Act* a prescribed 'health service provider' for the purposes of the *Local Health System Integration Act, 2006*, which gave LHINs the same funding responsibility for IHFs as they have for hospitals
Healing Arts Radiation Protection Act, 1990	Governs the use of radiation in hospitals and Independent Health Facilities
Health Facilities Special Orders Act, 1990	Enables the minister of health to suspend services and facilities if deeming a facility as not operating according to regulation (applies only to laboratories, ambulance services, private hospitals and long-term care homes)
Homes for Special Care Act, 1990	Established requirements for the housing and support services provided to people with serious mental illness as a 'non-institutional' (i.e., community living) alternative to care in psychiatric facilities

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Legislation	Consequences
Ontario - Places – continued	
Home Care and Community Services Act, 1994	Focused on the provision of an alternative to institutional care by ensuring a range of culturally appropriate services be available on a continuum of care to people in the home and in the community, including providing support and relief for caregivers Established clients' rights with regard to home and community care, the basket of covered services, the complaints and appeals process, and (through a regulation) the eligibility criteria for services and the maximum levels of nursing, personal support and homemaking services that can be provided to an individual Established what we now know as CCACs, although when they began operation in 1996 there were 43 across the province
Community Care Access Corporations Act, 2001	Established 43 CCACs as corporate entities (later reduced in number to 14 to match LHIN boundaries) and provides for the CCACs' mandate, governance and accountabilities
Long-Term Care Homes Act, 2007	Defined requirements for licensing and regulation, financing, staff training, services to be provided, and quality monitoring and reporting in long-term care homes, as well as established residents' right to a safe and secure environment and involvement in care planning
Broader Public Sector Accountability Act, 2010	Established a number of new requirements designed to improve accountability and transparency across the broader public sector In the hospital sector, the *Broader Public Sector Accountability Act* banned the practice of hiring lobbyists using public funds, legislated transparent processes for procurement, established new expense and perquisite rules for hospital employees, provided for the creation of reporting directives related to accountability provisions in the Act (e.g., annual reports to LHINs on consultant use, semi-annual public posting of executive and board member expenses), and brought hospitals under the *Freedom of Information and Protection of Privacy Act, 1990* (excepting quality-of-care information)
Ontario - Professionals	
Medicine Act, 1991	Confirmed physicians as self-regulating professionals, outlined the responsibilities of the College of Physicians and Surgeons of Ontario for governing the medical profession, and described the duties, scope of practice and authorized acts of physicians
Ontario Medical Association Dues Act, 1991	Financially strengthened the Ontario Medical Association (OMA) by requiring that every physician in Ontario (whether a member of the OMA or not), pay the association's dues and assessments (or an equivalent amount)
Regulated Health Professions Act, 1991	Provided the legislative framework for the self-governance of the now 28 regulated health professions[1] in Ontario by the now 26 health regulatory colleges[2]
Midwifery Act, 1991	Brought midwives under the *Regulated Health Professions Act, 1991* with the profession overseen and regulated by the College of Midwives of Ontario
Health System Improvements Act, 2007	Included the requirement for greater transparency for health regulatory colleges, and the establishment of new transitional health profession colleges – naturopathy, homeopathy, kinesiology, and psychotherapy

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Legislation	Consequences
Ontario - Professionals – continued	
Regulated Health Professions Statute Law Amendment Act, 2009	Expanded the scope of practice of many regulated health professionals (e.g., nurse practitioners, pharmacists, physiotherapists, dietitians, midwives and medical radiation technologists) and changed the rules related to various aspects of drug administration by select health professionals (nurse practitioners, pharmacists, midwives, chiropodists, podiatrists, dentists, and dental hygienists) Mandated that all regulated health professionals have professional liability insurance, health colleges make team-based care a key component of their quality-assurance programs, and health colleges with professions providing the same or similar services develop common standards for those services
Naturopathy Act, 2015	Brought naturopathy under the *Regulated Health Professions Act, 1991* with the profession overseen and regulated by the College of Naturopaths of Ontario
Ontario - Citizens	
Municipal Freedom of Information and Protection of Privacy Act, 1990	Increased protection of individual information and the right to access municipal government records, including general information and personal records
Substitute Decisions Act, 1992	Established provisions for the naming of powers of attorney and statutory guardians, for both personal care and property, for those found to be mentally incapable of personal care or managing property
Health Care Consent Act, 1996	Established rules with respect to consent to treatment (and situations of emergency treatment), admission to a care facility (including crisis admissions) and receipt of 'personal assistance' services, rules for when a person lacks the capacity to make decisions about such matters, and rules for such a person to contest a decision made for them to an independent provincial tribunal (Consent and Capacity Board)
Bill 68, Brian's Law (Mental Health Legislative Reform), 2000	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
Personal Health Information Protection Act, 2004	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
Bill 119, Health Information Protection Act, 2016	Amended the *Personal Health Information Protection Act, 2004* and other acts to establish a framework for electronic health records, and to provide increased accountability, transparency and privacy protection for personal health information Repealed and replaced the 2004 *Quality of Care Information Protection Act, 2004*, and set out rules for the disclosure and use of quality-of-care information

Sources: 6; 8-45

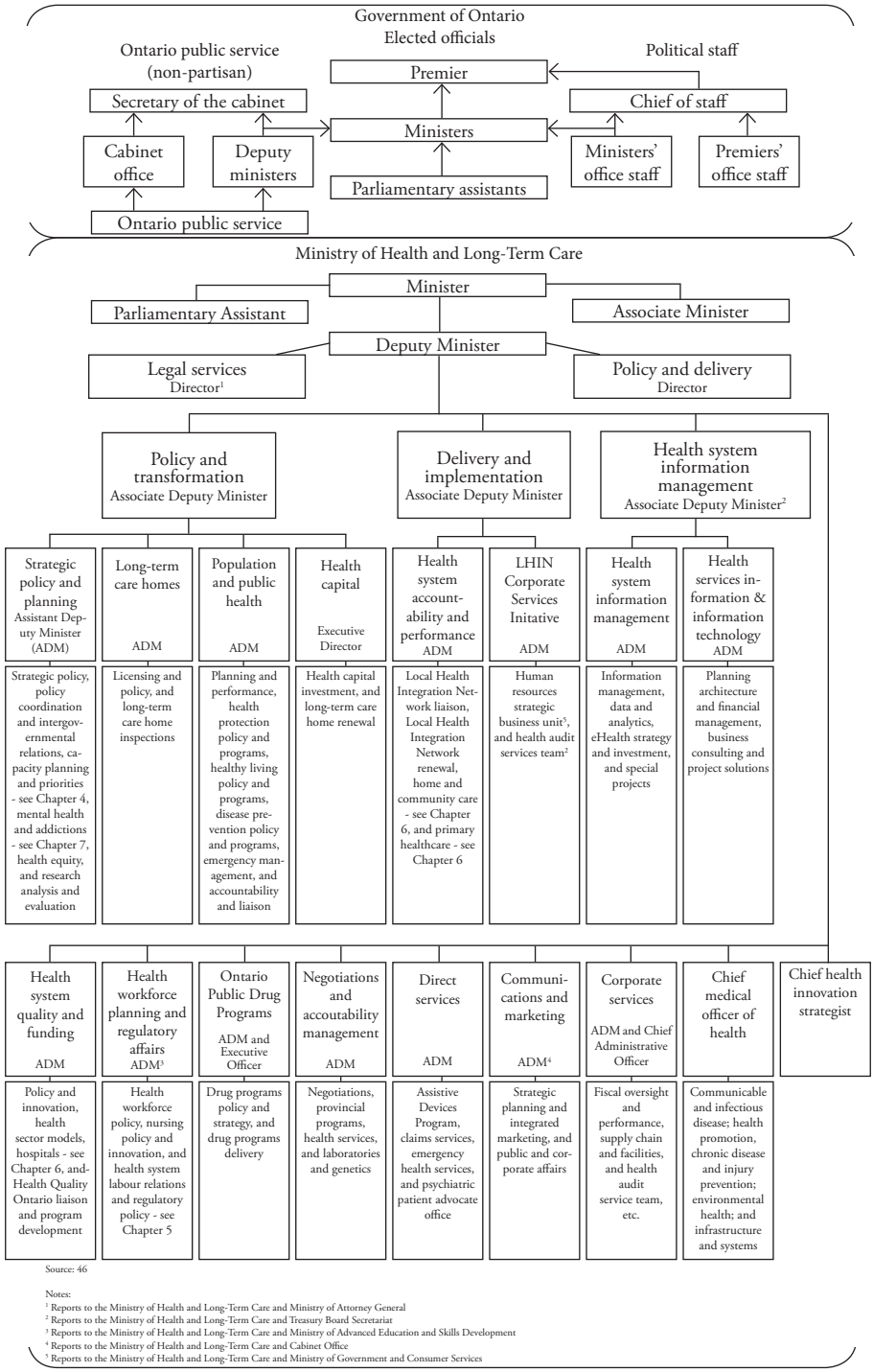
Notes:
[1] Audiology, chiropody, chiropractic, dental hygiene, dental technology, dentistry, denturism, dietetics, homeopathy, kinesiology, massage therapy, medical laboratory technology, medical radiation technology, medicine, midwifery, naturopathy, nursing, occupational therapy, opticianry, optometry, pharmacy, physiotherapy, podiatry, psychology, psychotherapy, respiratory therapy, speech-language pathology, traditional Chinese medicine
[2] Audiologists and speech-language pathologists are regulated by a single professional college as are chiropodists and podiatrists.

Rights Agreement this committee can continue to function despite the lack of a Physician Services Agreement).

The government also acts in a stewardship role for the many private organizations involved in providing care. Beyond its role in establishing who can do what, it may, for example, set performance targets and require public reporting against these targets (see the 'places' row of Figure 2.1). The health system is complex, with lots of moving parts, and most of us only experience select parts of it. But for a health system to perform well in improving the patient experience and population health and in keeping per capita costs manageable, policy authority is needed, even if it takes many forms (from hands-on government control to light-touch stewardship).

Not surprisingly, the government has developed a highly complex structure to determine who can make what types of decisions and to actually make decisions about the highly complex health system (Figure 2.2). While decisions about regulation and funding, among others, go to the democratically elected politicians who are members of cabinet (premier and ministers) or who direct other central agencies (Treasury Board Secretariat and Ministry of Finance), and some decisions (e.g., proposed acts) go to the legislature (where elected members of provincial parliament sit), the minister (also elected but appointed to a ministerial role by the Premier) and Ministry of Health and Long-Term Care have delegated policy authority for many decisions. The ministry itself is overseen by a deputy minister and divided up into many divisions, each headed by an assistant deputy minister and addressing particular aspects of the health system. The staff working in the ministry are (politically neutral) public servants who advise the minister and implement the minister's (or cabinet's or the legislature's) decisions (e.g., plan, budget, fund and administer programs, invest in infrastructure, monitor progress against action plans, convene expert groups, and manage stakeholders). Some ministry staff (e.g., Executive Officer of the Ontario Public Drug Programs and Chief Medical Officer of Health) have a dual accountability, and report both to the deputy minister and to the legislature. The minister also has a small number of political advisors who provide political advice. Increasingly the government convenes inter-ministerial groups to address issues that involve multiple ministries, such as the mental health of children and youth, and participates in inter-governmental groups (e.g., Council of the Federation and Conferences of Federal-Provincial-Territorial Ministers of Health) to

Figure 2.2: Key parts of government that determine who can make decisions and what types of decisions they can make



Source: 46

Notes:
[1] Reports to the Ministry of Health and Long-Term Care and Ministry of Attorney General
[2] Reports to the Ministry of Health and Long-Term Care and Treasury Board Secretariat
[3] Reports to the Ministry of Health and Long-Term Care and Ministry of Advanced Education and Skills Development
[4] Reports to the Ministry of Health and Long-Term Care and Cabinet Office
[5] Reports to the Ministry of Health and Long-Term Care and Ministry of Government and Consumer Services

address issues that are national in scope, such as the health workforce.

Organizational authority

The corporate directors of the many private organizations involved in providing care have broad organizational authority to – either directly or through the management staff they hire – buy or lease space, recruit and employ staff, and organize how care is provided as long as they are operating within the rules set by relevant government acts and regulations or by regulatory college policies (e.g., having the president of the medical staff, chair of the medical advisory committee and chief nursing executive be non-voting members of hospital boards of directors). Some of the organizations are not-for-profit (e.g., most community-based mental health and addictions agencies, Community Health Centres, hospitals and rehabilitation clinics), others are for-profit (e.g., community pharmacies that are often owned by large chains, many Independent Health Facilities that provide diagnostic and therapeutic procedures, and a small number of hospitals that were functioning before hospital-care insurance was introduced), and a very small number are public (e.g., some municipal government-owned long-term care homes, and all local public health agencies). Many primary-care organizations are difficult to categorize because they range from a solo physician with an incorporated practice (who effectively functions as a small business owner) to a community-governed Family Health Team or Community Health Centre (which has community members, in addition to or instead of owners, on its board of directors). The solo physician's 'organization' (or practice) is not regulated per se, but the physician is regulated by the College of Physicians and Surgeons of Ontario.

These organizations are also subject to (what can be thought of as) institutions of independent accountability. For example, under the terms of the *Excellent Care for All Act, 2010*, four types of organizations (Community Care Access Centres, interprofessional team-based primary-care organizations, hospitals, and long-term care homes) must submit a Quality Improvement Plan annually to HQO.(5) Under the terms of legislation that assigns an independent accountability role to CCO and to the College of Physicians and Surgeons of Ontario, organizations providing colonoscopy, mammography and pathology services, which may otherwise 'fall through the cracks' between these two organizations'

responsibilities, are subject to a quality-management program (organized by a partnership between CCO and the College of Physicians and Surgeons of Ontario) that provides evidence standards, supports quality improvement, and publicly reports on quality at the provincial, regional, organizational and professional levels (just as is done for, say, the regional cancer centres and Independent Health Facilities that are more directly under the single authority of CCO and the College of Physicians and Surgeons of Ontario, respectively).

Organizations may also be required, or voluntarily agree, to be subject to institutions of independent accountability, as many hospitals and other facilities do (for cardiac care) with the Cardiac Care Network of Ontario, and a broader range of organizations do (for all aspects of their functioning) with Accreditation Canada (a national organization).

Commercial authority

Commercial authority in the health system is particularly salient for technologies such as drugs (both prescription and over-the-counter), devices (both medical and assistive), diagnostics and vaccinations. Only some companies may be licensed to produce a given technology and limits may be placed on the length of their patents, the size of their profits, the prices they can charge, who can buy from them and how, the approaches they can use in marketing, the people they can involve in sales and dispensing, and how their commercial liability works. The most well established regime affecting commercial authority in the health system is likely for prescription drugs. As will be discussed in Chapter 8, the federal government plays a significant role here, by establishing which drugs can enter the market and with what 'factory gate' ceiling price (not the wholesale price or the retail price charged by pharmacies), and by banning direct-to-consumer advertising of prescription drugs (although with the province's U.S. neighbour being one of only two countries in the world that does not ban such advertising, Ontarians are still exposed to a fair amount of it).

Professional authority

Clear rules about professional authority bring order to what would otherwise be a 'wild west' of individuals calling themselves a physician (whether or not they had the necessary training or licence), working outside their scope of practice (such as a registered nurse prescribing drugs, although the government has signalled its intent to move in this direction), providing care in a setting that does not meet established standards (such as providing general anesthesia in a physician's office), not maintaining their competence or reasonable standards of safety and quality (through continuing professional development and appropriate facility protocols), and practising without professional-liability insurance (through the Canadian Medical Protective Association for physicians and comparable bodies for other professionals). Some professionals may be prohibited from engaging in strike/job action that could jeopardize human life.

Interestingly, the list of registered health professionals who can call themselves 'doctor' when providing (or offering to provide) health services to individuals includes physicians (medical doctors) as well as chiropractors, dentists, naturopaths (who must use the phrase 'naturopathic doctor' after their name), optometrists, practitioners of traditional Chinese medicine, and psychologists. Audiologists have initiated a Charter challenge to be able to do the same.(6) A pharmacist or other regulated health professional who also holds a PhD can call themselves doctor, but not when providing (or offering to provide) health services to individuals. Veterinarians can also call themselves doctor.

Most professional authority is established through the regulatory colleges, which were created by the *Regulated Health Professions Act, 1991* and its various amendments.(6) The 26 colleges' websites typically provide a list of the policies that apply to members of their respective professions. An example would be the policies that were developed by the College of Physicians and Surgeons of Ontario for all physicians who are members of the college: www.cpso.on.ca/policies-publications/policy. Some health workers' authority is not formally regulated (e.g., personal support workers).

Citizen and stakeholder involvement

A key aspect of the governance arrangements of the health system is whether, how and under what conditions citizens have a formally recognized voice in their own care (e.g., informed consent to care and shared decision-making in what that care entails), in care provision (e.g., how a particular program or service is delivered), in system monitoring (e.g., which performance indicators are the focus of data collection and public reporting), and in policy and organizational decisions (e.g., what values should drive decision-making about how primary care is organized). Also important is whether, how and under what conditions other stakeholders (e.g., professionals and managers) are given a voice in policy and organizational decisions. And while this chapter is focused on governance arrangements, citizens and other stakeholders can, of course, seek to influence decisions through advocacy, lobbying and other informal channels, and through voting in elections.

Citizens have a formally recognized voice in their own care through a requirement (specified in the *Health Care Consent Act, 1996*) that they give their informed consent to treatment and through a right (articulated in the *Freedom of Information and Protection of Privacy Act, 1990*) to access their own personal health information (and to have the privacy and confidentiality of their personal healthcare information respected) (Table 2.2). They also have to give their informed consent to participate in research, with the key foundation for such consent being the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.(7) What is much less formalized is the voice of citizens in shared decision-making about their care more generally, which is made easier through resources like the Decision Aids Database (maintained by the Ottawa Hospital Research Institute and available both directly and through the McMaster Optimal Aging Portal). Their voice in shared decision-making may not be actively supported by all health professionals.

Citizens also have a formally recognized voice in care provision (e.g., how a particular program or service is delivered) in a number of care settings, but it is typically not systematically or transparently elicited. In some of these care settings, this may only be through provisions for a complaints process. When patients have a concern with a particular health professional, complaints are handled through the relevant regulatory college. For home,

Table 2.2: Governance arrangements underpinning citizen engagement in the health system

Relevant policies
Patient autonomy and choice
Health Care Consent Act, 1996 provides rules that apply consistently in all healthcare settings with respect to consent to treatment (focusing on communication, patient autonomy and decision-making capacity) • Regulatory colleges have formal guidelines for obtaining informed consent relevant to their respective professional members
Patient rights
Freedom of Information and Protection of Privacy Act, 1990 provides individuals with the right to access their own personal health information
Personal Health Information Protection Act, 2004 (PHIPA) and the *Health Information Protection Act, 2016* place limitations on the collection and sharing of healthcare information, including in electronic form
The Information and Privacy Commissioner of Ontario resolves appeals and privacy complaints under PHIPA, publicly reports breaches of PHIPA, and provides healthcare professionals with information on how to protect private information
Patient engagement
Excellent Care for All Act, 2010 (ECFAA) mandates patient engagement as part of the Quality Improvement Plan process in all Ontario hospitals[1]
Local Health Systems Integration Act, 2006 formally mandates the Local Health Integration Networks to engage citizens in the planning, integrating and funding of local health services
Patient complaints
Regulated Health Professionals Act, 1991 mandates that all health professional colleges have patient relations and quality assurance programs, processes to monitor and report on their effectiveness, and disciplinary procedures
Home Care and Community Services Act, 1994 requires that all home and community care service agencies have processes for appeals and complaints in place
Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10 under the act (2010) outlines long-term care home-related complaints procedures, and include a Residents' Bill of Rights articulating the right of residents to quality care
Public Sector and MPP Accountability and Transparency Act, 2014 mandates the appointment of a specialized provincial Patient Ombudsman to respond to patient complaints and conduct investigations against Community Care Access Centres (CCACs), hospitals, and long-term care homes
Public reporting
ECFAA mandates Health Quality Ontario to publicly report on the quality of the Ontario health system and, through related regulations, mandates CCACs, interprofessional team-based primary-care organizations, hospitals, and long-term care homes to measure and report publicly on key quality indicators on an annual basis (and for primary care and hospital settings this includes measures of patient and provider satisfaction)
Although not a current ECFAA requirement, voluntary initiatives to evaluate quality in primary care are ongoing[2]

Sources: 15; 18; 33; 43; 47-60

Notes:

[1] Citizens councils have also been established to engage citizens in healthcare delivery (e.g., the Ontario Citizens' Council was created to act as an advisory body to the Executive Officer of Ontario Public Drug Programs and the Minister of Health and Long-Term Care.(59)

[2] An example is the Primary Care Patient Experience Survey undertaken by Health Quality Ontario, Association of Ontario Health Centres, Ontario College of Family Physicians, Ontario Medical Association and the Association of Family Health Teams of Ontario. Health Quality Ontario has also developed Quality Improvement Plan indicators for CCACs and long-term care.

community, hospital and long-term care organizations, complaints are handled through the organization itself. Now, with any aspect of the health system, citizens may direct concerns to a Patient Ombudsman, who first assumed the role in July 2016 (Table 2.2). On a related point, citizens have a formally recognized voice in system (and hospital) monitoring through a requirement (in the *Excellent Care for All Act, 2010*) for public reporting on patient (and professional) satisfaction on an annual basis.

Whereas there is much activity but also much heterogeneity drawing on the voice of citizens in policy and organizational decisions, select citizens play a formal governance role on:

1) government boards that address citizen consent and capacity issues (Consent and Capacity Board), issues related to lack of criminal responsibility because of mental illness (Ontario Review Board), payment for patient services (Health Services Appeal and Review Board), physician-payment issues (Physician Payment Review Board), and professional practice issues (Health Professions Appeal and Review Board);
2) government committees that address cases of disputed Ontario Health Insurance Plan (OHIP) coverage for patients (Medical Eligibility Committee), financial assistance for those who contracted hepatitis C (Ontario Hepatitis C Assistance Plan Review Committee) and cases of disputed OHIP coverage for select (typically non-physician) health professionals (Review Committees); and
3) governing boards of professional regulatory bodies (e.g., College of Physicians and Surgeons of Ontario), LHINs, hospitals, community-governed primary-care clinic models (e.g., Community Health Centres), and other organizations.

LHINs are formally mandated by their governing legislation to engage citizens in planning, integrating and funding local health services. Also, select citizens play a legislatively mandated advisory role through the Ontario Citizens' Council (which provides advice on the values of Ontario's citizens about government drug policy), (8) and an informal advisory role through standing initiatives at the provincial level (e.g., Ministry of Health and Long-Term Care's Patient and Family Advisory Council, CCO's Patient and Family Advisory Council, and HQO's Patient, Family and Public Advisors Council), programmatic initiatives at the provincial level (e.g., McMaster Health Forum's citizen panels program), one-off initiatives at the provincial level (e.g., Citizens' Reference Panel on Health Services), and a variety of initiatives at the organizational level (e.g., patient councils

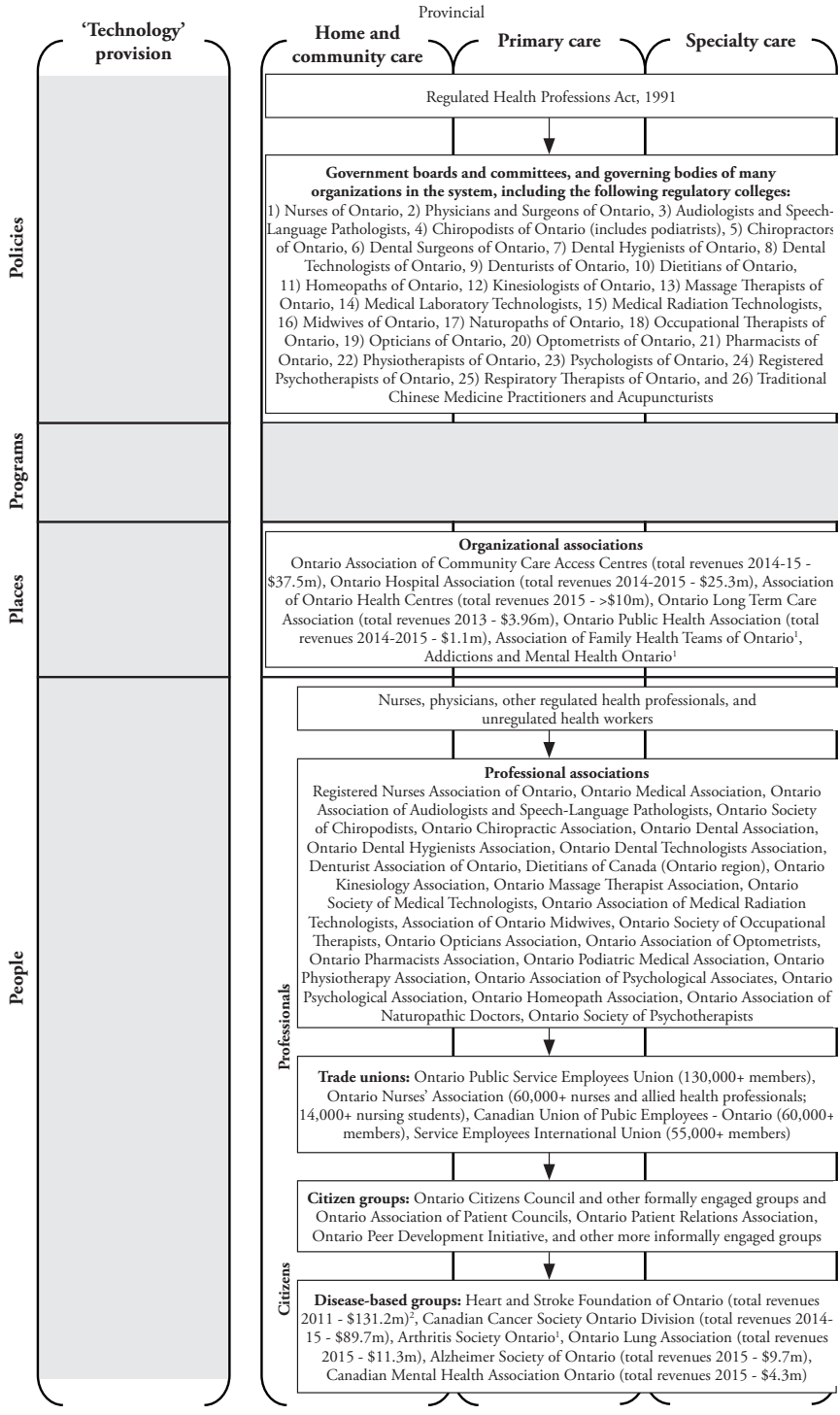
at hospitals).

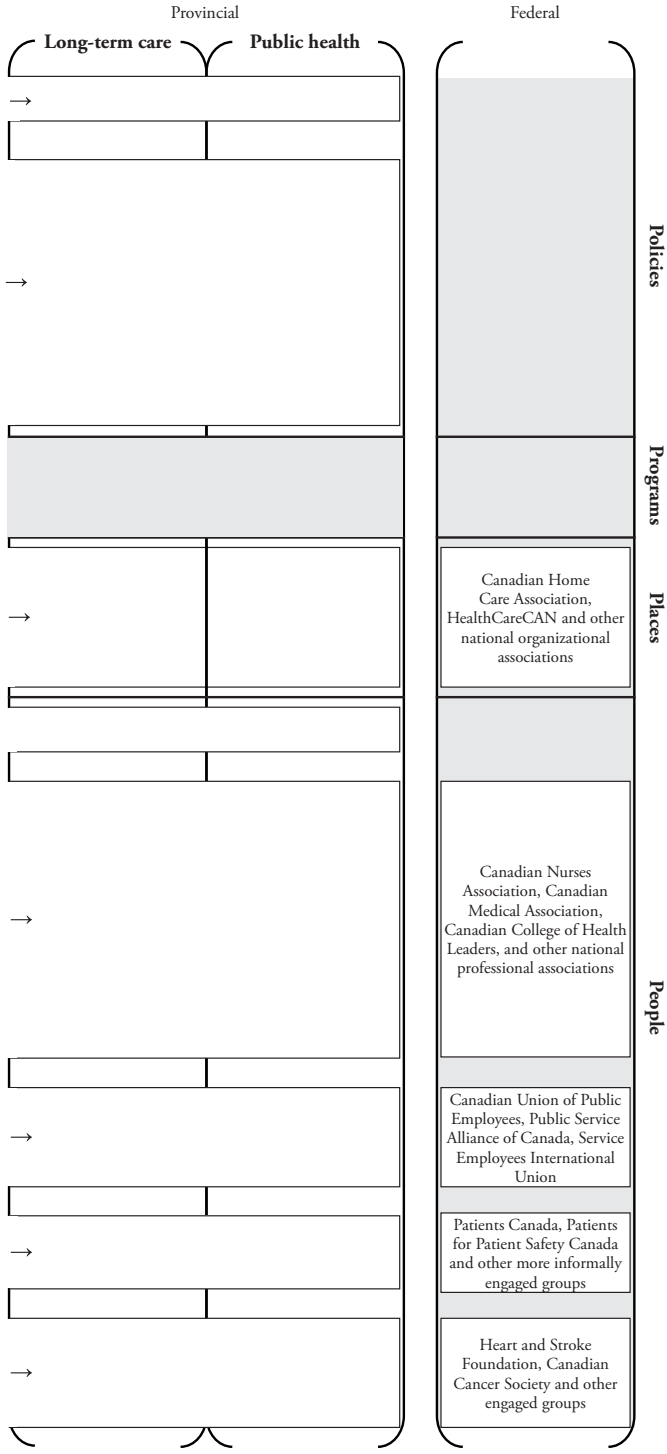
Stakeholders (e.g., organized groups of professionals) often have a voice in policy and organizational decisions but typically not in a systematic or transparent way. However, exceptions exist, such as with the Physicians Services Committee (which gives physicians a voice in policy decisions that affect their profession) and many of the government boards and committees and governing boards noted above, as well as with initiatives like the McMaster Health Forum's stakeholder dialogues (which convene a broad range of policymakers, stakeholders and researchers to address a health-system problem, options for addressing it, and key implementation considerations). It is perhaps not surprising that much stakeholder engagement is handled in an ad hoc and behind-closed-doors manner given the vast array of citizen and other stakeholder groups with personal, professional, financial and other interests in the health system.

Key citizen and stakeholder groups include (Figure 2.3):

1) regulatory colleges, which regulate professional practice, adjudicate patient complaints, and oversee quality in Independent Health Facilities and Out of Hospital Premises, among other roles (as such colleges would not be considered a stakeholder group by many, we have placed them in the 'policies' row);
2) organizational associations that represent everything from large, influential organizations (e.g., hospitals) to smaller, less well-resourced organizations (e.g., Family Health Teams);
3) professional associations that represent professions that can contribute to large programming and advocacy budgets (e.g., the OMA, which runs programs to support the use of electronic health records, among other objectives, and the Registered Nurses' Association of Ontario, which develops and supports the use of best-practice guidelines, among other programs);
4) trade unions that negotiate contracts (addressing wages, benefits and employment conditions), some of which focus on a profession (e.g., Ontario Nurses' Association), while others focus on a broad range of types of staff (e.g., Ontario Public Service Employees Union);
5) citizen/patient groups, which can vary from groups that are formally coordinated by government or government agencies as mentioned above (e.g., Ontario Citizens' Council) to groups that operate independently (e.g., Patients Canada); and

Figure 2.3: Citizen and stakeholder organizations involved in the health system





Sources: 61-74

Notes:
[1] Financial details not available
[2] After 2011 the Heart and Stroke Foundation of Ontario (HSFO) unified their operations and transferred all assignable assets and liabilities to the Heart and Stroke Foundation of Canada (HSFC). The amount listed is the last total revenue available for HSFO. The most recent (2014) total revenues for HSFC are $185.3 million.

6) disease-based groups, ranging from high-profile national health charities (e.g., Heart and Stroke Foundation of Ontario) to more grassroots organizations, the latter of which can sometimes receive significant funding from pharmaceutical/biotechnology companies (in which case they have been called 'astroturf' groups by some).

In Figure 2.3, these are typically listed in order of decreasing revenue or membership. Also, given the 'program' row was not needed, it was deleted in this sector4P figure.

Conclusion

The governance arrangements for the health system are complex and allow for innovation in some areas but constrain it in others. They comprise what some have called institutions of deliberation (e.g., legislature, citizens' councils), stewardship (e.g., Ministry of Health and Long-Term Care), and independent accountability (e.g., HQO). Increasingly governance arrangements are being rigorously studied and syntheses of the available research evidence on many key government arrangements can be identified by searching Health Systems Evidence (www.healthsystemsevidence.org) and using the 'Governance arrangements' filter in the 'advanced search.' In Chapter 3 we will turn to financial arrangements, and what some have called the institutions of finance (e.g., OHIP, LHINs), and in Chapter 4 we will turn to delivery arrangements, including what some have called institutions for information (e.g., Institute for Clinical Evaluative Sciences, Statistics Canada) and normative institutions (e.g., HQO, with its evidence standards).

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