



## 6. Care by sector

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The appropriate citation for this book chapter is: Lavis JN, Hammill AC. Care by sector. In Lavis JN (editor), Ontario's health system: Key insights for engaged citizens, professionals and policymakers. Hamilton: McMaster Health Forum; 2016, p. 209-69.

ISBN 978-1-927565-12-4 (Online)  
ISBN 978-1-927565-11-7 (Print)

## Key messages for citizens

- Community Care Access Centres are the gateway to government-funded home care and long-term care homes, and a source of information about care that is not publicly funded.
- In primary care, teams are increasingly common, typically with a family physician as the ‘most responsible’ provider.
- Private not-for profit hospitals remain the cornerstone of acute specialty care.
- Rehabilitation care is less a sector in its own right than an element of many other sectors.
- Long-term care homes (or nursing homes) are where adults can live and both receive help with daily activities and have access to 24-hour nursing and personal support services.
- The province’s 36 local public health agencies aim to improve the health of Ontarians using strategies that are both population-based (e.g., smoking by-laws) and individually targeted.

## Key messages for professionals

- Home care includes professional (e.g., nursing) services, personal support services (e.g., bathing), and homemaking services (e.g., meals).
- Key pillars of a ‘primary-care home’ include team-based and patient-centred care, same-day appointments, comprehensive and coordinated care, and continuity of care.
- While acute specialty care is still provided in hospitals, Independent Health Facilities and Out of Hospital Premises increasingly provide lower risk diagnostic and therapeutic procedures.
- Payment for rehabilitation care depends on whether citizens are eligible for government-funded care, were injured in an automobile accident or have a work-related injury or disease.
- Long-term care homes provide long-term nursing and personal care, and short-term convalescent and respite care.
- Local public health agencies operate programs in five areas: family health, infectious diseases prevention and control, chronic disease and injuries, environmental health, and emergency preparedness.

## Key messages for policymakers

- Community Care Access Centres are funded by Local Health Integration Networks, and will soon become part of them, and support access to home and community care.
- Primary care has been evolving from a sector dominated by family physicians operating as small business owners and paid on a fee-for-service basis by the Ontario Health Insurance Plan to interprofessional primary-care teams paid through an array of funding models.
- A transition is underway from hospitals to community-based specialty clinics as the primary site for lower risk diagnostic and therapeutic procedures.
- Depending on the circumstances of the patient and care, rehabilitation care is governed by several parts of government and paid for directly by patients, or indirectly by government and those paying automobile, health insurance or workers' compensation premiums.
- Most healthcare in a long-term care home is paid for by government, but clients pay standardized charges for accommodation.
- Local public health agencies are governed at the municipal level by a local board of health and funded by provincial and municipal governments to promote health and prevent disease.

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In the first of four chapters focused on using the building blocks to provide care, we examine care by sector. The six sectors include home and community care, primary care, specialty care, rehabilitation care, long-term care, and public health. Syntheses of the available research evidence about each of these sectors can be identified by searching Health Systems Evidence ([www.healthsystemsevidence.org](http://www.healthsystemsevidence.org)) and using the 'Sectors' filter in the 'advanced search.' These sectors can be described in two ways: 1) by the policies that govern them, the programs and services offered within them, the places where programs and services are provided, and the people who provide the programs and services (i.e., by the 4Ps); and 2) by the governance, financial and delivery arrangements within which they operate (i.e., the building blocks). We focus primarily on the former, and provide sector4P figures (a term we introduced in Chapter 1) to summarize the key features of the sectors, and secondarily on governance, financial and

delivery arrangements.

Before describing these sectors, however, some orientation is warranted. On the one hand, each of these sectors appears quite distinct and conjures up classic images about what happens within them. Home and community care includes the nurse who comes to a client's home to change the dressings on a wound after the client has had surgery, and the agency that a client visits when in need of a range of support services to cope with an addiction. Primary care includes the family physician who is a patient's first point of contact with the health system when ill, diagnoses and treats most conditions, refers complex cases to specialists when needed, and ensures continuity of care. Specialty care can mean both a patient's nearest acute-care hospital (which can be called acute care or hospital care) and the specialists (like surgeons) who see patients in their clinics or in the hospital. Specialty care can be called secondary, tertiary or even quaternary care depending on the level of specialization in the care being provided. Rehabilitation care can mean the rehabilitation clinic that clients visit or the rehabilitation hospital where patients stay when recovering from a major accident, as well as the physiotherapist a client visits for help in dealing with back or shoulder pain. Long-term care includes the long-term care homes where adults can live and have access to 24-hour nursing care, personal support services for help with daily activities, and on-call medical (i.e., physician-provided) care. Public health includes the people and laboratories working, often behind the scenes, to protect and promote the health of Ontarians, often using approaches (like water fluoridation) directed at populations, not individuals.

On the other hand, the boundaries between these sectors can (and perhaps should) be quite porous (patients need to move easily between them after all) and the classic images can be out of date or not fully accurate. For example, home and community care are often lumped together despite each having some unique features. Family physicians are increasingly working as part of an interprofessional healthcare team that may be led by a nurse practitioner, involve registered nurses, social workers, dietitians, pharmacists and other registered health professionals, and be more focused on providing patient-centred, comprehensive and coordinated care than ever before. Much specialty care is now provided outside hospitals, in organizations called Independent Health Facilities or Out of Hospital Premises. Rehabilitation care includes many types of health professionals, including

the occupational therapist who can help an adult with a disability participate in paid or unpaid work, and the speech-language pathologist who can help a child with a speech delay or disorder. Long-term care is sometimes considered part of home and community care because the residents of long-term care homes are living in their home and community just like everyone else. And public health practitioners are often involved in direct service provision (e.g., sexually transmitted disease clinics) and increasingly are being drawn into closer partnerships with primary-care organizations.

While in the past specialty care (particularly hospitals) and to a lesser extent public health (particularly after the SARS outbreak) have been the focus of a great deal of attention, for the past few years the home and community care sector and the primary-care sector have been the ones garnering the most attention.(1; 2) These two sectors, as well as the public health sector, will be affected in significant ways by the passage of the *Patients First Act, 2016*,(3) which is a sufficiently new development that we have not incorporated it in the sector<sup>4P</sup> figures in this chapter or the rest of this book. We address the home and community care sector before turning to the others.

## Home and community care

The key player in home and community care is the Community Care Access Centre (CCAC) in each of Ontario's 14 regions (described in Chapter 1), although these will be absorbed into Local Health Integration Networks (LHINs) by 2017 as a result of the *Patients First Act, 2016*.(3) Each CCAC receives funds from the Government of Ontario (through the LHIN) and uses these funds to pay their own staff and to pay (some or all of the costs of) the many for-profit, not-for-profit and public organizations that provide home and community care. CCAC staff can: 1) provide information about home and community care (and long-term care) options in the area, regardless of whether they are funded (in whole or in part) by the government; 2) determine eligibility for government-funded services and settings (to an upper limit of visits per week, hours per week or both); 3) arrange for and coordinate the delivery of government-funded professional, personal support and homemaking services for people living in their own homes and for school children with special needs (i.e., home care); and 4) make arrangements for admission to (or for getting on the waiting list for) many day programs and supportive housing programs (i.e., community care),

as well as to some chronic-care and rehabilitation beds, and all long-term care homes (which we turn to later in this chapter). Any Ontarian can directly approach a CCAC for these types of support and there is no charge for the support provided by CCAC staff to Ontarians with a valid health card. Ontarians can also directly approach agencies that provide home and community care services to obtain care beyond what the government funds, and then pay for this care themselves.

## Policies that govern home and community care

The key policies that govern home and community care (Figure 6.1) are the:

- 1) *Home Care and Community Services Act, 1994*, which established clients' rights, 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 (and also established what we now know as CCACs, although when they began operation in 1996, there were 43 across the province);
- 2) *Community Care Access Corporations Act, 2001*, which established the mandate, governance and accountabilities of CCACs; and
- 3) *Local Health Systems Integration Act, 2006*, which, in 2007, reduced the number of CCACs from 43 to 14, aligned their boundaries with those of the LHINs, and established the LHINs as their funder.

The regulated health professionals working in the sector are governed by the *Regulated Health Professionals Act, 1991*, and we return to these professionals below. The accountabilities of the community support service agencies, mental health and addiction organizations, and diabetes education centres that are funded by government to provide home and community care are established through contracts called multi-sector service agreements (of which there are currently 260 between CCACs and these agencies).<sup>(4)</sup>

## Programs offered through home and community care

From a program perspective, home care – for people living in their own homes and for school children with special needs – includes four types of services:

- 1) professional services, which include assessing a client's needs, providing care or helping the client to care for herself (and the client's family to

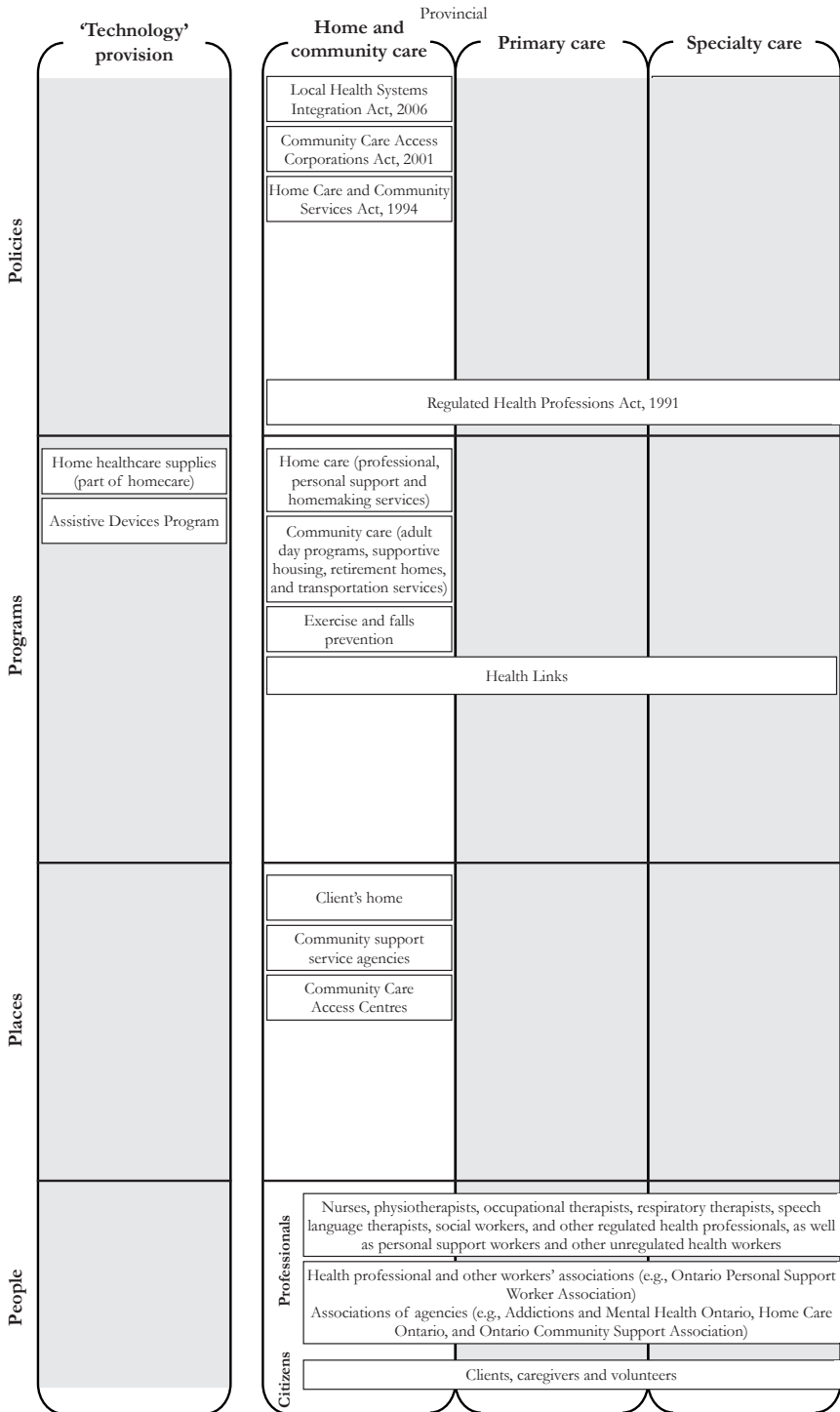
- cope), and can range from nursing care, physiotherapy, occupational therapy, respiratory therapy, speech-language therapy and social work to help with healthy eating and home healthcare supplies (e.g., walking aids and wound dressings);
- 2) personal support services, which include helping clients with daily care or helping clients to safely manage these activities on their own, and can range from help with getting in and out of bed or a chair to bathing, dressing (and undressing), eating, personal hygiene (e.g., mouth and hair care), and toilet hygiene;
  - 3) homemaking services, which include housework (e.g., cleaning, doing laundry), planning and preparing meals, shopping for food or clothing, managing money, and caring for children; and
  - 4) end-of-life care at home, which includes the above as well as in-home visits and respite care by trained volunteers (which we will return to in Chapter 7, where we address end-of-life care).

Personal support workers are involved in the delivery of many personal support services, however, they work under the direction of a registered nurse or registered practical nurse and are not a regulated health profession. There is no charge for the home care approved by a CCAC for Ontarians with a valid health card.

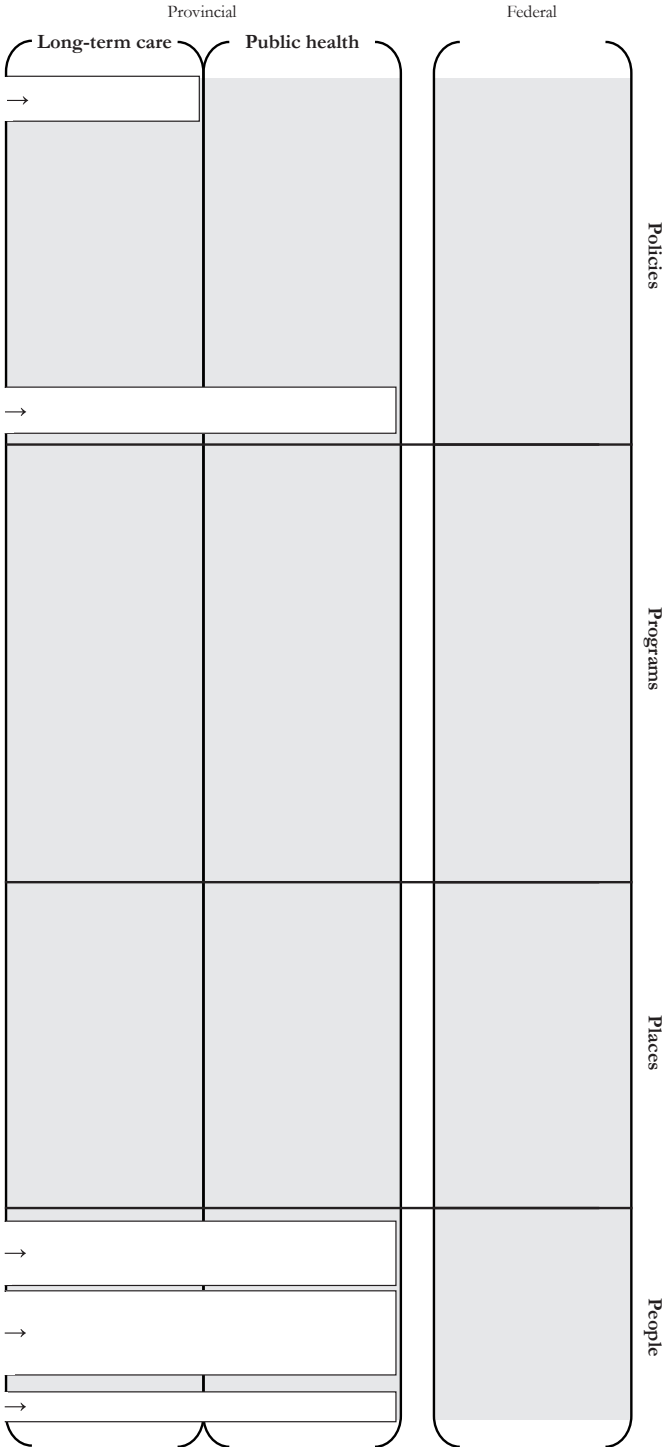
Programs can seem less well defined in community care and can vary from community to community and from population group to population group. Depending on the program area, the reasons may be that: the provincial government may play a less visible role as a funder and steward; many parts of the provincial government may be involved depending on the needs of different population groups (e.g., Ministry of Children and Youth Services, Ministry of Community and Social Services, Ministry of Community Safety and Correctional Services, Ministry of Education, and Ministry of Municipal Affairs and Housing); and municipal governments along with a broad range of for-profit, not-for-profit and public organizations may be involved in complementing provincial government efforts to address the needs of local community residents. Some traditional examples of community care programs include:

- 1) adult day programs that support social, fitness and other healthy activities among those living at home or who are homeless;
- 2) supportive housing, which means housing, typically paid for by the client, and access to many personal support, homemaking and other services (either provided by the landlord or by a separate organization),

Figure 6.1: Home and community care







typically at no additional cost (and such ‘assisted living services in supportive housing’ are often used by the frail elderly and by people with acquired brain injury, HIV/AIDS, mental health issues or physical disabilities);

- 3) retirement homes, which means housing that includes some personal support (e.g., housework) and homemaking services (e.g., meals), as well as social and recreational opportunities and a 24-hour emergency-response system, all of which is typically paid for fully by the client (and which is often used by elderly Ontarians who no longer can or wish to live at home, but who do not need the more intensive care provided in a long-term care home); and
- 4) transportation services for those who do not have access to public transportation or need help in using it.

Other examples of community care programs are specific to a population group. For example, those with a terminal illness can access community hospice services (which include counselling and support groups, among other services) and residential hospices (which provide a broad range of palliative care in a home-like setting). We discuss end-of-life care in greater detail in Chapter 7.

Community care programs are also typically considered to include exercise and falls-prevention programs. Through these programs, individuals can participate in classes that help them improve their strength and balance and that are led by fitness instructors, trained peer facilitators or support workers (not physiotherapists). While not formally considered part of the health system, ‘elderly persons centres’ offer a range of cultural, learning, recreational and social programs for seniors.

Home and community care clients with long-term physical disabilities can also benefit from the Assistive Devices Program, which provides access to a range of personalized assistive devices when prescribed by a physician, including: 1) enteral feeding supplies; 2) insulin pumps and supplies for diabetic children; 3) monitors and test strips for insulin-dependent diabetics (through an agreement with the Canadian Diabetes Association); 4) oxygen and oxygen delivery equipment; 5) respiratory equipment; 6) hearing aids; 7) visual and communication aids; 8) orthoses (braces, garments and pumps); 9) prostheses; and 10) wheelchairs/mobility aids and specialized seating systems.

Health Links is a program designed to meet the needs of clients with complex needs (often multiple, complex conditions that require frequent interactions with professionals in many sectors). CCACs can be the lead organization for Health Links, while community support service agencies and mental health and addiction organizations are its key service providers. Each of the (currently 82) Health Links in the province strives to ensure that those involved in a client's care (nurses, personal support workers, family physician and others) work as a team to develop an individualized coordinated care plan and ensure the plan is followed. They also ensure that clients are taking the right medications and have someone to call who knows them and their situation.

### Places and people involved in home and community care

The places where home and community care are provided range from the client's home (for home care and for assisted living services in supportive housing or in retirement homes), to community support service agencies and mental health and addictions organizations (for classes, day programs, etc.) and residential hospices, to the CCACs themselves (for information, eligibility determinations and some services).

The people involved in home and community care include the clients themselves, caregivers and volunteers, as well as a broad range of health professionals (including those mentioned above as well as the physicians involved in the clients' medical care, and the personal support workers and other unregulated providers of home and community care services). The health professionals are represented by their respective professional associations (and personal support workers by the Ontario Personal Support Worker Association), however, the agencies for which they work are represented by member associations such as Addictions and Mental Health Ontario (for mental health and addiction organizations), Home Care Ontario (for for-profit community support service agencies), and the Ontario Community Support Association (for not-for-profit community support service agencies). Also, CCACs are represented by the Ontario Association of Community Care Access Centres.

## Governance, financial and delivery arrangements in home and community care

Governance, financial and delivery arrangements (i.e., the building blocks) are another lens through which home and community care can be described. Most of the governance arrangements that are salient to home and community care have been addressed under ‘policies’ above. Three key financial arrangements for this sector include: 1) the greater reliance on out-of-pocket payments as a source of financing compared to hospital-based and physician-provided care; 2) the funding to providers flowing primarily through the LHINs and then to CCACs (although the latter will be absorbed into the LHINs under the terms of the *Patients First Act, 2016*); and 3) the use of a ‘commissioning’ model according to which CCACs pay for care that meets the performance standards outlined in service agreements (as is done by the Workplace Safety and Insurance Board and Cancer Care Ontario, or CCO, which we return to in Chapter 7). Also, unlike hospital-based and physician-provided care, home care is not covered under an inter-provincial agreement for Ontarians visiting another province. In terms of delivery arrangements, as of 2014, there were over 800 community support service agencies, over 300 mental health and addiction organizations, 245 diabetes education centres, and 14 CCACs (see Table 4.1). Also, in 2015, 16,877 nurses (17% of all nurses in Ontario) worked in home and community care (see Table 5.4).

## Primary care

The key player in primary care is increasingly the primary-care team and less the individual family physician or nurse practitioner, even though they are likely to be deemed the ‘most responsible’ provider on a given team. That said, about three quarters of Ontarians still receive primary care from a family physician working independently and, as we discuss in Chapter 11, access to family physicians remains a significant concern for some Ontarians. The concept of a ‘patient’s primary-care home’ is gaining traction in Ontario, and includes a number of pillars beyond delivering care using teams and providing access to a most responsible care provider.<sup>(5)</sup> Examples of other pillars include providing patient-centred care (e.g., setting care goals appropriate to a patient’s condition and context), ensuring timely access to care (e.g., using advanced access scheduling to provide same-day appointments for those who need them and providing

24/7 coverage for more urgent issues), providing comprehensive and coordinated care (e.g., proactively providing preventive services to those who may benefit), and ensuring continuity of care (e.g., communicating with home and community care providers, specialists, long-term care homes, and public health practitioners, as well as with pharmacies and dental offices, which we discuss in Chapter 8).(5)

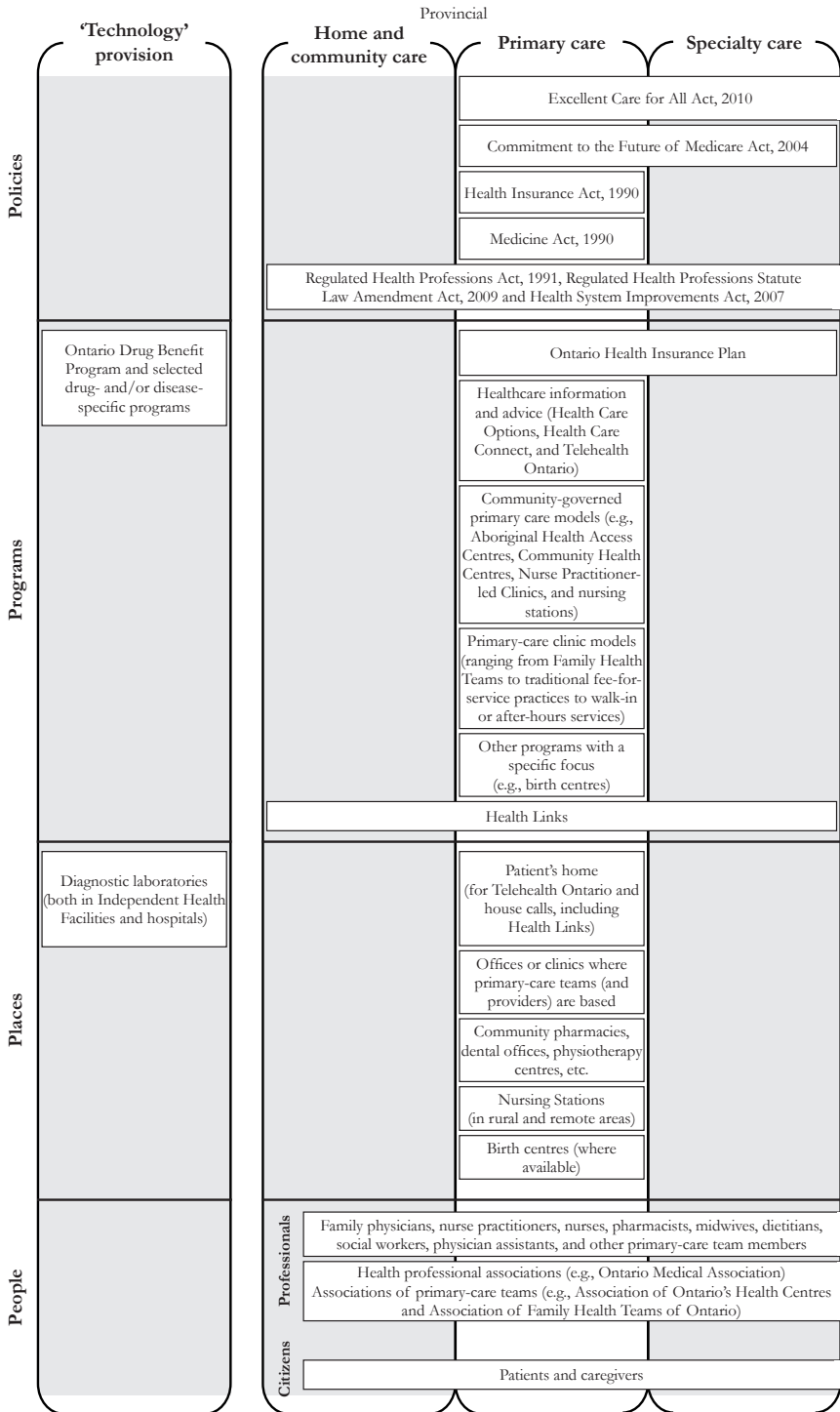
A topic newer to the sector is accountability for a geographically defined population, as opposed to accountability for the patients who have chosen to join the roster of a family physician who (or more rarely a primary-care clinic that) receives at least some form of capitation payment, meaning a fixed payment per patient per year (and as opposed to the lack of explicit accountability for the patients who visit a family physician paid on a fee-for-service basis for each visit). Rural and remote communities, particularly in northern Ontario, have been experimenting with local health hubs over the past few years.(6) These health hubs are connected to a designated local hospital (a ‘district health campus’) and to other health-care providers in the area (e.g., CCACs and community service agencies) as part of an integrated district network, although the primary-care providers involved in these health hubs typically still approach accountability in terms of their patient roster. The Government of Ontario has signalled through the *Patients First Act, 2016* a commitment to establishing geographically defined populations at a ‘LHIN sub-region’ level, which may range from 40,000 citizens to 350,000 in densely populated urban areas.(1).

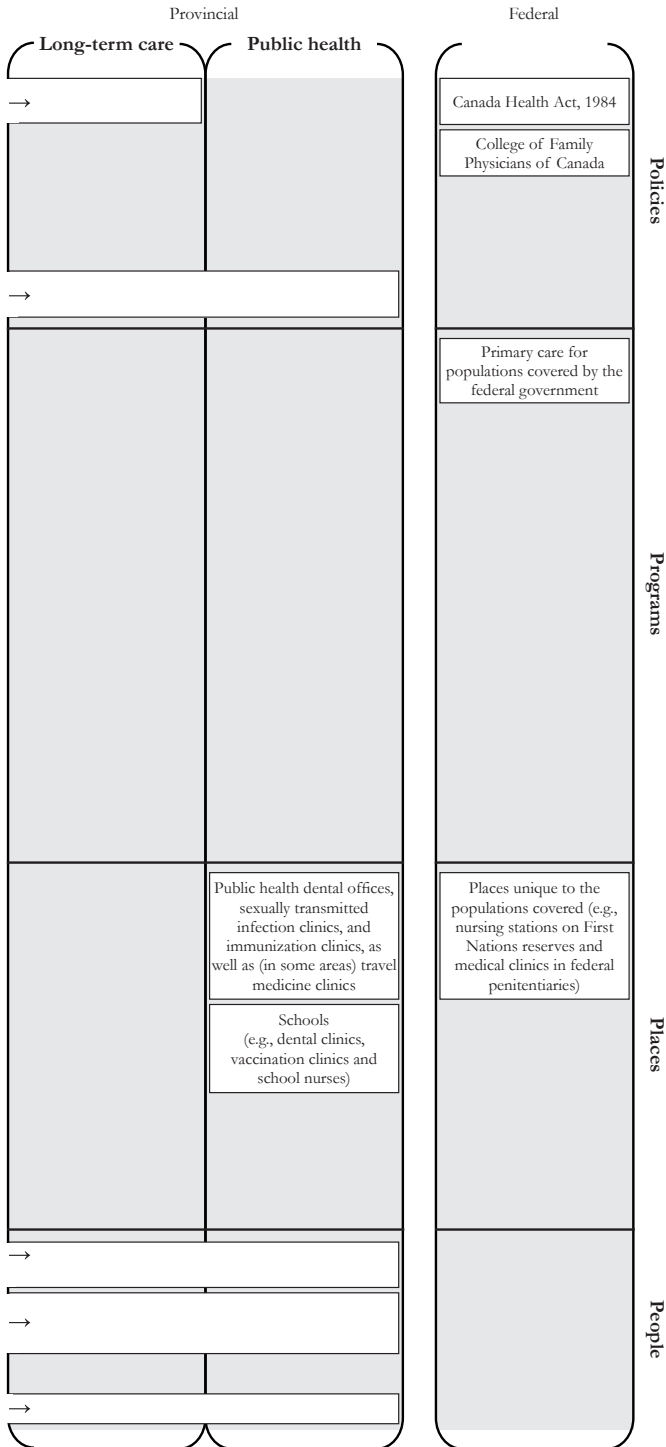
## Policies that govern primary care

Unlike other sectors, primary care is notable for the lack of policies (or at least acts and regulations) that govern care in the sector (Figure 6.2). Existing policies include:

- 1) self-regulation regimes established under the *Medicine Act, 1990* and *Regulated Health Professions Act, 1991* for the physicians and later the nurse practitioners, nurses, social workers, dietitians, pharmacists and other health professionals involved in primary care (as well as under the *Health System Improvements Act, 2007*, which regulated kinesiology, naturopathy and homeopathy, and psychotherapy, and the *Regulated Professions Statute Law Amendment Act, 2009*, which increased the scopes of practice of many regulated health professionals);
- 2) the *Health Insurance Act, 1990* that governs the Ontario Health

Figure 6.2: Primary care





Insurance Plan (OHIP), through which all physicians (not just primary-care physicians) are paid;

- 3) the *Commitment to the Future of Medicare Act, 2004* that reaffirmed the province's commitment to no user fees for medically necessary physician-provided care (as is also required by the federal government's *Canada Health Act, 2004*) and established an organization (that became what is now known as Health Quality Ontario, or HQO) to publicly report on health-system performance and support continuous quality improvement; and
- 4) the *Excellent Care for All Act, 2010* that extended HQO's role in supporting evidence-based practice, albeit in ways that are likely not very visible in primary care (except for the interprofessional teams – Family Health Teams, Nurse Practitioner-led Clinics, Community Health Centres, and Aboriginal Health Access Centres – that must now submit an annual Quality Improvement Plan to HQO as an *Excellent Care for All Act*-inspired addition to their contracts with government).

The College of Family Physicians of Canada plays a role in setting the educational and continuing professional development requirements for family physicians, which are then given force of law by the College of Physicians and Surgeons of Ontario (one of the self-regulation regimes).

If one broadens the notion of policies to include contracts (an economic instrument, as we described in Chapter 2), however, then much of primary care is now subject to performance standards. About three quarters of family physicians (those who have chosen to enter into an alternative funding model) and all interprofessional teams now work under a contract with government and can face penalties when these standards are not met (see Table 3.7 in Chapter 3). Contracts offer greater flexibility than acts and regulations, which can be seen as either a pro or a con depending on one's perspective.

The only accountabilities for any of the pillars of a patient's primary-care home are established through contracts. The Government of Ontario and an advisory group reporting to it have floated the idea of making commitments to certain aspects of the patient's primary-care home applicable across all of primary care, supporting access to other aspects of the patient's primary-care home that are now available only to those working in some models (e.g., other health professionals who can participate as part of a team), and (as noted above) establishing accountability for a defined population.(1; 7)



The policies governing primary care, even when contracts are included in their definition, leave most family physicians operating as small business owners who must live within the norms of their profession (like all physicians) and the terms of an insurance plan that, either some or most of the time, pays them a fee for each service they provide (and prohibits them from charging patients for medically necessary primary care). An evolution in the first category of policies governing primary care – self-regulation regimes – has led to a broadening of the health professionals who can prescribe drugs. Initially only physicians and dentists (and veterinarians) could prescribe, but now nurse practitioners can prescribe, pharmacists can play a very limited role in prescribing, and the government has indicated that it plans to introduce nurse prescribing.

Perhaps the murkiest area in the policies governing primary care involves organizations like Medcan and the Cleveland Clinic that target private companies' senior executives and wrap a concierge-type service around a mix of: 1) medically necessary care for which they can bill OHIP; 2) non-necessary care (and the concierge service) itself that they can bill executives or their companies for directly; and 3) referrals to for-profit facilities in the U.S. that can bill executives directly (even though regular follow-up and addressing complications back in Ontario are likely to be considered medically necessary care for which they can again bill OHIP).

### Programs constituting primary care

A wide variety of programs – beyond OHIP that pays for most primary-care services – operate in the primary-care sector (Table 6.1):

- 1) healthcare information and advice, including to assist with finding local healthcare services (Health Care Options), finding a primary-care provider (Health Care Connect) and getting free telephone health advice (Telehealth Ontario);
- 2) community-governed primary-care models that serve socially disadvantaged and hard-to-serve populations (Community Health Centres), Indigenous peoples (Aboriginal Health Access Centres, which we discuss in Chapter 9), and small rural and First Nations communities (nursing stations, which we also discuss in Chapter 9), and the broader population (Nurse Practitioner-led Clinics);
- 3) primary-care clinic models that range from organizations that tick many of the boxes for a patient's primary-care home (Family Health

Table 6.1: Primary-care programs and services

Program	Services	Who delivers/funds	Who is covered
Health care information and advice			
Health Care Options	Online healthcare services locator (database searchable by postal code)	<ul style="list-style-type: none"> <li>Information updated by Community Care Access Centres (CCACs) and community partners</li> <li>Website hosted and funded by the Ministry of Health and Long-Term Care (MOHLTC)</li> </ul>	Ontarians with a valid health card (formerly called an Ontario Health Insurance Plan card)
Health Care Connect	Links ‘unattached’ patients to primary-care providers	<ul style="list-style-type: none"> <li>Website hosted and funded by the MOHLTC</li> </ul>	Ontarians with a valid health card
Telehealth Ontario	Free telephone health advice and healthcare options	<ul style="list-style-type: none"> <li>Registered nurses provide triage services</li> <li>Funded by the MOHLTC</li> </ul>	Anyone
Community-governed primary-care models			
Community Health Centres (CHCs)	Primary-care services, health-promotion and illness-prevention services, and outreach for socially disadvantaged and hard-to-serve populations	<ul style="list-style-type: none"> <li>105 CHCs comprising almost 400 physicians, 300 nurse practitioners, 1,700 other clinical, health promotion and community development professionals, and 800 administrative personnel<sup>1</sup></li> <li>Funded by Local Health Integration Networks (LHINs) (with funds from the MOHLTC)<sup>2</sup></li> </ul>	Ontarians with a valid health card and newcomers with a temporary card
Aboriginal Health Access Centres (AHACs)	Combination of traditional healing, primary care, cultural programs, health promotion, community development, and social-support services provided to First Nations, Inuit and Métis peoples and communities	<ul style="list-style-type: none"> <li>10 AHACs across Ontario provide access to physicians, nurse practitioners, traditional healers, dietitians, social workers, and mental health and addiction support services</li> <li>Funded by LHINs (with funds from the MOHLTC)<sup>3</sup></li> <li>Revenue for additional programs obtained from other government branches, community partners, donations, etc.</li> </ul>	Indigenous Ontarians
Nurse Practitioner-led Clinics (NPLCs)	Basic primary care, including annual physicals, immunizations, episodic illness care, chronic disease management, health promotion, etc.	<ul style="list-style-type: none"> <li>26 NPLCs in 27 communities across Ontario</li> <li>Salaries and operational costs funded through transfer payment agreements between LHINs (with funds from the MOHLTC) and the boards of directors<sup>4</sup></li> </ul>	Ontarians with a valid health card who are enrolled with the NPLC

Continued on next page

Program	Services	Who delivers/funds	Who is covered
Community-governed primary-care models – continued			
Nursing stations	Provide front-line primary healthcare and assess for urgent or non-urgent care in small, rural communities, and First Nations communities	<ul style="list-style-type: none"> <li>• 43 stations in small and rural communities funded by LHINs (with funds from the MOHLTC)</li> <li>• 29 federally funded stations in First Nations communities (four community-operated, 25 Health Canada nurse-run)</li> </ul>	Anyone (those without a health card are asked to make a \$100 donation)
Primary-care clinic models			
Family Health Teams (FHTs)	Primary care, health promotion and disease prevention, patient system navigation support, facilitation of community-based chronic disease management and self-care, and linking to other healthcare organizations	<ul style="list-style-type: none"> <li>• 184 FHTs, comprised of at least 2,400 physicians and a range of non-physician providers (nurses, nurse practitioners, social workers, dietitians, pharmacists, and other providers)</li> <li>• Mostly physician-led but with some governed by mixed provider/community boards</li> <li>• Funded by the MOHLTC</li> </ul>	Ontarians with a valid health card who are enrolled with the FHT
Family Health Groups (FHGs)	Physician delivered primary care (with patient rostering voluntary)	<ul style="list-style-type: none"> <li>• 237 FHGs, with a minimum practice size of three physicians</li> <li>• Funded by the MOHLTC</li> </ul>	Ontarians with a valid health card
Family Health Networks (FHNs)	Comprehensive primary-care services facilitated through provider networks; includes extended hours and nurse after-hours telephone health advice	<ul style="list-style-type: none"> <li>• 21 FHNs, with a minimum practice size of three physicians</li> <li>• FHNs require participating physicians to sign governance and FHN agreements to join with the MOHLTC; may also apply to become FHTs</li> </ul>	Ontarians with a valid health card who are enrolled with the FHN
Family Health Organizations (FHOs) <sup>5</sup>	Primarily physician-delivered primary care; includes extended hours, and nurse after-hours telephone health advice	<ul style="list-style-type: none"> <li>• 475 FHOs with a minimum physician group size of three</li> <li>• Funded by the MOHLTC</li> </ul>	Ontarians with a valid health card who are enrolled with the FHO
Traditional fee-for-service practices	Family medicine; includes diagnosis and treatment of diseases, physical disorders and injuries, as well as referral	<ul style="list-style-type: none"> <li>• Solo-physician practices (no defined practice criteria)</li> <li>• Fee-for-service remuneration for OHIP-insured services</li> </ul>	Ontarians with a valid health card

*Continued on next page*

Program	Services	Who delivers/funds	Who is covered
Primary-care clinic models – continued			
Walk-in or after-hours services	Non-emergency care for people who do not have a primary-care provider or are unable to reach their own	<ul style="list-style-type: none"> <li>• Non-hospital based walk-in clinics</li> <li>• Funded by the MOHLTC</li> </ul>	Ontarians with a valid health card
Midwifery clinics	24-hour primary midwife care and support throughout pregnancy, labour, birth and thereafter for six weeks	<ul style="list-style-type: none"> <li>• Over 400 registered midwives provide care in 103 midwifery clinics</li> <li>• Funded by the MOHLTC</li> </ul>	Ontarians with a valid health card
Birth centres	A home-like setting for birth and delivery, and other support and services such as prenatal classes, birth and postpartum care	<ul style="list-style-type: none"> <li>• Currently there are three midwife-led birth centres</li> <li>• Birth centres are not-for-profit Independent Health Facilities and funded by the MOHLTC through service agreements</li> </ul>	Ontarians with a valid health card
Other programs and services			
Diabetes Education Programs (DEPs)	Guidance on healthy eating, weight management, exercise, blood glucose monitoring and other self-management skills	<ul style="list-style-type: none"> <li>• DEPs usually include nurses and dietitians, and may also include other allied health providers as needed, with some programs requiring referral from a primary-care provider</li> <li>• Funded by LHINs (with funds from the MOHLTC)</li> </ul>	Ontarians with a valid health card
Centres for Complex Diabetes Care (CCDCs)	Short-term multidisciplinary, coordinated care to stabilize patients with complex diabetes and one or more other associated health needs	<ul style="list-style-type: none"> <li>• CCDCs have been established in six LHIN regions, chosen based on the prevalence of diabetes and the complexity and availability of services in the communities</li> <li>• Funded by LHINs (with funds from the MOHLTC)</li> </ul>	18 years of age or older, with Type 1 or Type 2 diabetes
Northern Health Travel Program	Partial reimbursement of medical travel-related costs to those who must travel at least 100 km one way to the closest medical specialists or designated healthcare facility	<ul style="list-style-type: none"> <li>• Approved travel grants are paid at 41 cents per kilometre based on return road distance travel between the area of residence and nearest medical specialist, or approved healthcare facility, with a deductible of 100 kilometres</li> <li>• Funded by the MOHLTC</li> </ul>	Eligible northern Ontario residents, with a valid health card

*Continued on next page*

Program	Services	Who delivers/funds	Who is covered
Other programs and services – continued			
Underserved Area Program (UAP)	A series of incentive programs aimed at recruiting healthcare providers to and retaining them in designated underserved communities <sup>6</sup>	<ul style="list-style-type: none"> <li>• Northern Health Programs of the UAP are administered by the Primary Health Care Branch</li> <li>• Funded by the MOHLTC</li> </ul>	Physicians, nurses and rehabilitation professionals

Sources: 37-53

Notes

<sup>1</sup> New capital projects announced by the MOHLTC in April 2014 included an additional 12 CHCs and 4 AHACs (54).

<sup>2</sup> In the 2013-14 fiscal year, government funding was \$369.9 million. Supplemental revenue for additional programming is obtained through other sources, such as other government branches, charitable donations, etc.(44)

<sup>3</sup> In the 2013-14 fiscal year, government funding was \$23.7 million for AHACs.(37)

<sup>4</sup> Salaries for up to four full-time nurse practitioners, four interprofessional staff, an administrative lead and clerical staff, and operational costs (which include medical supplies, facilities, professional development, program supplies, information technology, etc.).(38)

<sup>5</sup> FHOs were created through the harmonization of Health Service Organizations, which were introduced in 1978, and Primary Care Networks, which were introduced in 1999.(40)

<sup>6</sup> Northern Health Programs include the Northern and Rural Recruitment and Retention Initiative, the Northern Physician Retention Initiative, the Rehabilitation Professionals Incentive Grant, Tuition Support Program for Nurses, Community Assessment Visit Program, Nursing Community Assessment Visit Program, and the Physician Outreach Program for General/Family Practitioners Guidelines. Programs offer a range of taxable incentives, incentive grants, tuition support, and travel reimbursement programs to primary-care providers in underserved communities.(43)

Teams) to traditional fee-for-service practices (and hybrids between the two, including Family Health Groups, Family Health Networks and Family Health Organizations), to walk-in or after-hours services; and 4) a mix of ‘other’ programs that have a specific focus, including pregnancy and childbirth (midwifery clinics and birth centres), diabetes (diabetes education programs and centres for complex diabetes care), and care in the north (Northern Health Travel Program that supports patients’ travel to receive care) or in underserved areas (Underserved Area Program that supports the recruitment of primary-care professionals).

The primary-care clinic models (category 3 above) are where ‘wide variety’ turns into ‘bewildering array’ and where (as noted above) action is being considered. Also, while not specific to primary care (just as it was not specific to the home and community care organizations discussed in the previous section), interprofessional primary-care teams can be the lead organization for, and be key service providers for, Health Links, a program designed to meet the needs of patients with complex needs.

Primary-care patients can also benefit from the Ontario Drug Benefit (ODB) Program and selected drug- and/or disease-specific programs, which we discuss in Chapter 8, as well as from federal government-supported

programs for populations covered by that level of government (i.e., First Nations and Inuit, whom we discuss in Chapter 9, Canadian Forces, eligible veterans, Royal Canadian Mounted Police, inmates of federal penitentiaries, and some refugee claimants).

## Places and people involved in primary care

The places where primary care is provided range from the client's home (for the telephone advice provided through Telehealth Ontario, the house calls provided by a small number of family physicians, sometimes as part of Health Links, and the visits by primary-care providers to long-term care homes), to the offices or clinics where primary-care teams (and providers) are based (and where most Ontarians receive primary care), to the far less numerous nursing stations and birth centres. Most of these offices and clinics are rented on the private market, although some may be owned by physicians themselves or be part of a First Nations reserve (e.g., a nursing station or birth centre). Primary care is also provided in community pharmacies (e.g., advice about prescription and over-the-counter drugs, prescriptions of bupropion or varenicline for smoking cessation, and flu shots), dental offices (e.g., regular preventive check-ups and fillings for dental cavities, which we address in Chapter 8), and physiotherapy clinics, among other settings.

The people involved in primary care include the patients themselves and the physicians, nurse practitioners and increasingly other health professionals involved in their care (nurses, dietitians, and social workers on primary-care teams, as well as chiropractors among others typically practising separately). The health professionals are represented by their respective professional associations, with the Ontario Medical Association (OMA) playing a particularly prominent role given its privileged access to authority through the Physician Services Committee (although as noted in Chapter 1, the OMA has been playing a much less visible role while it is in a contract dispute with the provincial government). Physician assistants, who work under the supervision of a physician and are not a regulated health profession, are represented by a national group – Canadian Association of Physician Assistants – not a provincial group. Primary-care teams are represented by member associations such as the Association of Ontario's Health Centres (for Aboriginal Health Access Centres, community-governed Family Health Teams, Community Health Centres, and Nurse

Practitioner-led Clinics) and the Association of Family Health Teams of Ontario (for Family Health Teams, Nurse Practitioner-led Clinics, and other interprofessional primary-care organizations).

### Governance, financial and delivery arrangements in primary care

Looking at primary care through the lens of governance, financial and delivery arrangements (i.e., the building blocks) provides a complementary perspective. Most of the governance arrangements that are particularly salient to primary care have been addressed under ‘policies’ above, although it is worth noting here two additional points. First, at the level of primary-care organizations (and as noted in Chapter 2), community-governed interprofessional teams (a subset of Family Health Teams and all Community Health Centres) are governed by boards of directors comprising community members in addition to or instead of owners (unlike physician practices, which may operate as a single medicine professional corporation or under group agreements, but not with community members on a board of directors). Second, at the level of health professions involved in primary care, the provincial government has taken preliminary steps toward pharmacist prescribing and committed to introducing nurse prescribing, both of which are examples of potential changes to professional authority.

Key financial arrangements for this sector include full public payment for medically necessary primary care delivered by family physicians, but using a complex array of funding and remuneration mechanisms (see Table 3.6) that do not flow through LHINs (with the exception of funding for Community Health Centres and other community-governed primary-care models) as they do for most other providers. That said, the *Patients First Act, 2016* designated interprofessional teams, but not physician practices, as ‘health service providers’ that are funded by and accountable to LHINs. Public health expenditures tend to be reported for midwifery services but not for other primary-care providers (see Table 3.4).

Turning to delivery arrangements, as of 2014 there were 4,012 pharmacies (most of which are in community settings), 1,206 primary-care practices designated as one of Family Health Organizations/Groups/Teams/Networks or Comprehensive Care Models, 105 Community Health Centres, 103 midwifery clinics, 26 Nurse Practitioner-led Clinics, 10

Aboriginal Health Access Centres, and three birthing centres (see Table 4.1). As of 2013, there were 13,973 family physicians (who are more often male than female, Canada-trained than foreign-trained, and working in urban than rural settings), and as of 2013, there were 608 midwives (see Table 5.2 and 5.5), but most other counts of health professionals do not distinguish those working in the primary-care sector from those working in other sectors. The density of family physicians (in 2013) was one per 1,000 population (or 103 per 100,000 population) (see Table 5.3).

## Specialty care

The key player in acute specialty care remains the acute-care hospital, which is where patients go for emergency care, where they are admitted because of the severity of their illness or the nature or complexity of the care they require, and where they may go to see their specialist if the specialist runs a clinic or keeps an office in the hospital. As hospitals have responded to financial incentives for greater volumes of procedures and shorter lengths of stay, and faced a limited supply of long-term care homes and other settings to which they can discharge patients who no longer need care in an acute-care hospital, they increasingly provide care to a large pool of very sick patients and a small pool of healthier patients awaiting discharge to other settings (administratively called ‘alternative-level-of-care’ patients and sometimes pejoratively called ‘bed blockers’ because they are taking up a bed that could go to a patient currently waiting on a hospital gurney in the emergency room).

As we point out in previous chapters and return to below, notwithstanding the name of the act that governs them (the *Public Hospitals Act, 1990*), the vast majority of hospitals are private not-for profit hospitals (not public hospitals, which suggests that they are government-owned and -operated). Some larger communities have one ‘general’ hospital and one ‘Catholic’ hospital meeting the criteria, with ‘Catholic’ hospitals typically not providing abortions and in future possibly not permitting medical assistance in dying. Four Ontario cities (Hamilton, London, Ottawa and Toronto) have a dedicated children’s hospital. The only public (i.e., government-owned and -operated) hospitals in Ontario – the large psychiatric hospitals – have now become private not-for-profit hospitals as well (e.g., Centre for Addictions and Mental Health in Toronto and Waypoint Centre for



Mental Health Care in Penetanguishene). A small number of hospitals were ‘grandfathered’ when hospital-care insurance was introduced and continue to operate as private for-profit corporations (e.g., Shouldice Hospital in Toronto, which specializes in hernia repair). Hospitals are funded by the provincial government through the LHIN in their region, and neither not-for-profit nor for-profit hospitals can charge patients for medically necessary hospital care. They can and do charge patients for ‘extras’ like a private room and parking (although in response to growing frustration with parking fees, hospitals now face limits on these fees). Many hospitals, in particular teaching hospitals, house large hospital research institutes, although these more commonly pursue investigator-driven research than address the evidence needs of the hospital (with some exceptions, including the Centre for Practice-Changing Research at the Ottawa Hospital Research Institute).

While hospitals have been the key player in specialty care – both for acute care and for many other forms of specialty care – for many decades, this is changing, both organically and as a result of the provincial government’s commitment to “moving procedures into the community.” (8, p.12) Community-based specialty clinics increasingly provide – or could provide – lower risk diagnostic procedures (e.g., echocardiograms and colonoscopies) and therapeutic procedures (e.g., cataract procedures, hysterectomies, knee arthroscopies, and prostate surgery), at least in larger population centres. These clinics include hospitals that only provide such procedures (e.g., Hotel Dieu Hospital in Kingston), free-standing clinics operated by hospitals (e.g., Stoney Creek Campus, St. Joseph’s Healthcare Hamilton), organizations called Independent Health Facilities (e.g., Kensington Eye Institute in Toronto), and organizations called Out of Hospital Premises. Independent Health Facilities currently provide many diagnostic procedures (e.g., computed tomography, magnetic resonance imaging, and positron emission tomography, also known as CT, MRI and PET scans) and therapeutic procedures (e.g., abortion, dialysis, and many types of surgery). These facilities are typically privately owned and, in the case of many Independent Health Facilities providing diagnostic tests, such as diagnostic imaging, nuclear medicine tests, pulmonary function tests, and sleep-study tests, they are often owned by large for-profit companies. The facilities receive from OHIP both a facility fee for the use of the facility and a professional fee for the specialist (with the exception of the 10 providing diagnostic procedures, which are globally funded). Out of Hospital Premises, which

are also privately owned, currently provide cosmetic surgery, endoscopy and interventional pain management under the administration of a variety of types of anesthesia, but the organization does not receive a facility fee from OHIP (just the physician fee). Neither Independent Health Facilities nor Out of Hospital Premises allow overnight stays. Just as with care in hospitals, medically necessary care in Independent Health Facilities and Out of Hospital Premises is free to patients at the point of use.

There is an interdependence between specialists and hospitals, and perhaps there should be one between community-based specialty clinics and hospitals. Many specialists rely on hospitals for access to operating suites, equipment and staff, among other things. Hospitals, in turn, rely on these specialists to provide inpatient coverage and/or consultation, emergency-room coverage and/or consultation, and education (when the hospital is an academic teaching centre), parts of which are sometimes referred to as ‘clinical governance.’ Specialty clinics, on the other hand, may rely on hospitals for access to diagnostic services and do rely on them to accommodate referrals of high-risk patients and emergency transfers (whether or not they do so under the terms of a formal arrangement). Hospitals may see such specialty clinics as ‘poaching’ healthier patients – effectively a source of revenue from their LHIN – who need a procedure, test or assessment that the hospital could have provided.

## Policies that govern specialty care

Unlike primary-care clinics, specialty-care settings are directly regulated, but as a patchwork, with many of the policies that govern specialty care depending on what (e.g., anesthesia) or where (hospitals or Independent Health Facilities) care is provided (Figure 6.3):

- private not-for-profit hospitals (including those operating their own free-standing specialty clinics and those effectively operating as specialty clinics) are governed under the terms of the (inaccurately named) *Public Hospitals Act, 1990*;
- private for-profit hospitals are governed by the *Private Hospitals Act, 1990*;
- Independent Health Facilities are governed by the *Independent Health Facilities Act, 1990* and policies from the College of Physicians and Surgeons of Ontario;
- Out of Hospital Premises are governed under the terms of regulation

114/94 of the *Medicine Act, 1991* and related policies from the College of Physicians and Surgeons of Ontario; and

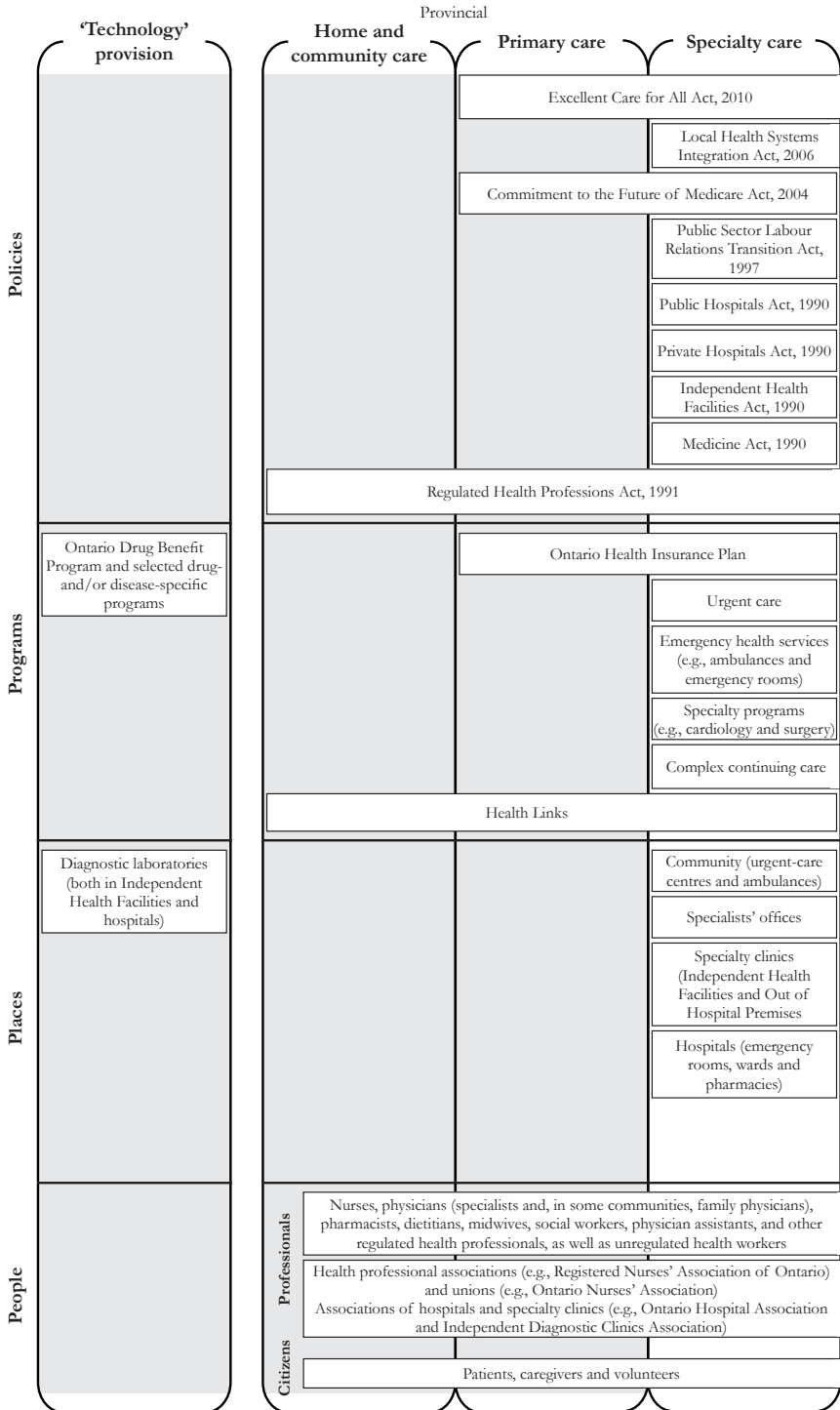
- hospitals and specialty clinics that use radiation are governed by the *Healing Arts Radiation Protection Act, 1990*.

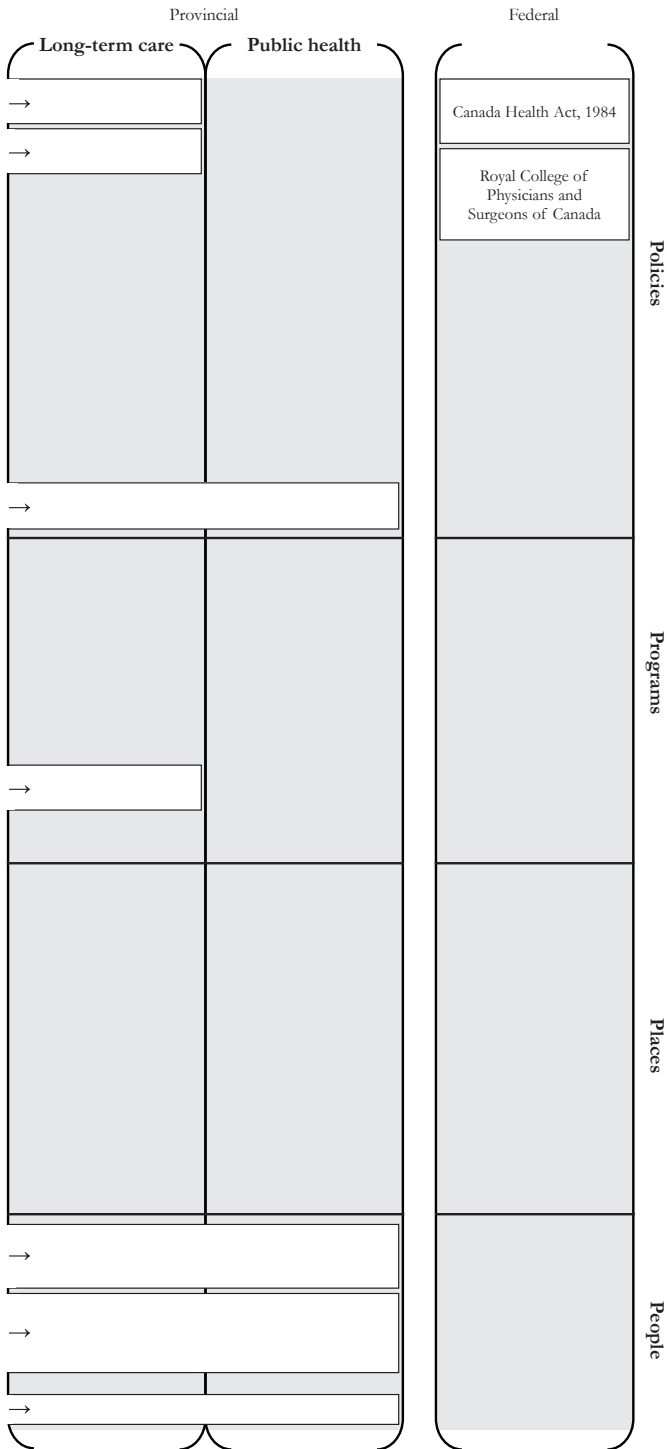
Specialty clinics providing endoscopy, mammography and pathology services are also governed from a quality management and public reporting perspective under the terms of an agreement between CCO and the College of Physicians and Surgeons of Ontario. Hospitals and now specialty clinics can voluntarily subject themselves to accreditation by Accreditation Canada. Specialists, like all physicians, are governed by the *Medicine Act, 1991* and by the *Regulated Health Professions Act, 1991*. Also, the Royal College of Physicians and Surgeons of Canada plays a role in setting the educational and continuing professional development requirements for specialists, which (like family physicians) are then given force of law by the College of Physicians and Surgeons of Ontario. Specialty physician offices (like primary-care clinics) are not regulated directly, even though the specialists working in them may be providing the same procedures as those being provided in regulated settings.

Other relevant policies governing specialty care include the:

- 1) *Public Sector Labour Relations Transition Act, 1997*, as an extension of its precursor, the *Labour Relations Act, 1995*, that requires specialty clinics to assume the terms of existing collective agreements and collective-bargaining processes when commitments to provide 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);
- 2) *Commitment to the Future of Medicare Act, 2004*, that reaffirmed the province's commitment to no user fees for medically necessary hospital care (as noted in the previous section and as is also required by the federal government's *Canada Health Act, 2004*) and established HQO to publicly report on health-system performance and support continuous quality improvement (including the requirement for hospitals to make available to the public an annual Quality Improvement Plan);
- 3) *Local Health System Integration Act, 2006* that established the LHIN as the payer for medically necessary hospital care; and
- 4) *Excellent Care for All Act, 2010* that requires all hospitals to prepare and publicly report against an annual Quality Improvement Plan, as well as to tie a proportion of their chief executive officer's pay to performance.

Figure 6.3: Specialty care





## Programs constituting or involving specialty care

A wide variety of programs are available in the acute-care sector or at the intersection between the sector and other sectors:

- 1) Health Links, a program that is designed to meet the needs of patients with complex needs (ideally without admission to a hospital) and that can be led or contributed to by a hospital;
- 2) urgent-care centres that fill a gap between primary care and a hospital emergency room;
- 3) emergency health services that include dispatch centres, land ambulances, air ambulances, base hospitals, and emergency rooms (Table 6.2);
- 4) specialty programs in over 60 areas (e.g., internal medicine specialties like cardiology and surgical specialties like orthopedics, as well as anesthesia, obstetrics and gynecology, pediatrics, psychiatry, radiology, and laboratory medicine); and
- 5) complex continuing care for people requiring long-term, medically complex care that cannot be provided at home or in a long-term care home.

Table 6.2: Urgent and emergent specialty care

Program	Services	Who delivers/funds	Who is covered
Ambulatory/outpatient care			
Urgent care	Diagnosis/treatment for urgent, but non-life threatening illnesses or injuries	<ul style="list-style-type: none"> <li>• Urgent-care centres (day, evening, weekends)</li> <li>• Funded by Local Health Integration Networks (LHINs) (with funds from the Ministry of Health and Long-Term Care or MOHLTC)</li> </ul>	All Ontarians with a valid health card
Emergency care			
Dispatch centres	Prioritize 911 requests; deploy, coordinate and direct the movement of all ambulances and emergency response vehicles within a geographic catchment area; and facilitate patient transfers	<ul style="list-style-type: none"> <li>• 19 Central Ambulance Communications Centres (11 operated by the MOHLTC, five by hospitals, and three by municipalities) and three locally based Ambulance Communications Services</li> <li>• Funded by the MOHLTC</li> </ul>	Everyone

*Continued on next page*

Program	Services	Who delivers/funds	Who is covered
Emergency care – continued			
Land ambulance	Emergency paramedic and patient transfer services	<ul style="list-style-type: none"> <li>• 42 municipalities and eight other designated delivery agents operate/provide services</li> <li>• Funded by the MOHLTC (50% for municipalities and 100% for First Nations communities and territories without municipal organizations)</li> </ul>	All Ontarians with a valid health card; a portion of the ambulance cost is covered with some exemptions
Air ambulance	Inter-facility patient transfers, on-scene emergency response requiring aero-medical evacuation; transport of organs and surgical recovery teams	<ul style="list-style-type: none"> <li>• Ornge, a not-for-profit organization responsible for all air transport operations/services, is accountable to the MOHLTC through a performance agreement</li> <li>• Funded by the MOHLTC</li> </ul>	All Ontarians with a valid health card; must be requested by a physician
Base hospitals	Provide continuing education, and advice on and monitoring of advanced life support procedures performed by land ambulance paramedics	<ul style="list-style-type: none"> <li>• Seven regional base hospitals (comprising a group of physicians working out of a hospital) have agreements to provide services with the MOHLTC</li> <li>• Funded by the MOHLTC</li> </ul>	Coverage is for emergency health services personnel, not individuals
Emergency rooms (ERs)	Triage, treatment of severe illnesses, and life-threatening injuries	<ul style="list-style-type: none"> <li>• 126 hospitals provide 90% of Ontario's ER care</li> <li>• Funded by LHINs (with funds from the MOHLTC)</li> </ul>	All Ontarians with a valid health card

Sources: 45; 54-60

A key program from the perspective of most specialists is of course OHIP that pays the fees for any medically necessary care they provide. These specialists typically need to have a recent referral from a family physician in order to be eligible for full payment of these fees.

## Places and people involved in specialty care

The places where specialty care is provided range from the patient's home in only indirect ways (for Health Links or when calling 911) and community (with urgent-care centres and ambulances) to the far more common specialists' offices, specialty clinics (Independent Health Facilities and Out of Hospital Premises), and hospitals (emergency rooms and wards). Specialty dental services are provided in dental offices, which we address in Chapter 8. Ontarians based in rural and remote communities may need to travel

long distances to access a specialist or hospital (and as mentioned in the previous section, the Northern Health Travel Program can provide partial reimbursement for medically necessary travel, and as will be discussed in Chapter 9, another mechanism is available to support travel by Indigenous peoples).

The people involved in specialty care include the patients themselves and the nurses, specialists and many other types of professionals involved in their care. The health professionals are represented by their respective unions (e.g., Ontario Nurses' Association), which engage in collective bargaining on their behalf, and professional associations (e.g., Registered Nurses' Association of Ontario, OMA). Hospitals are represented by the Ontario Hospital Association and many Independent Health Facilities are represented by the Independent Diagnostic Clinics Association.

### Governance, financial and delivery arrangements in specialty care

We turn now to the building blocks for specialty care. Most of the complex governance arrangements that are salient to specialty care have been addressed under 'policies' above, and the unevenness of the playing field created by the different acts and regulations governing hospitals, Independent Health Facilities, and Out of Hospital Premises warrants repeating here. Key financial arrangements for this sector include full public payment for medically necessary hospital-based care and specialty physician-provided care, only the former of which flows through LHINs (see Table 3.4). Hospitals remain the single largest recipient of public health expenditures, accounting for 36% of these expenditures in 2013 (see Table 3.3). Funding mechanisms include historically derived 'global' budgets, a funding allocation derived from a (largely) anticipated service-volume model (called the Health-Based Allocation Model), and a set of prospective payments for select episodes of care (called Quality-Based Procedures), as well as philanthropic donations and other private sources (e.g., rent and parking). Turning to delivery arrangements, as of 2014 there were 151 private not-for-profit hospitals (some of which are large, multi-site hospitals), six private for-profit hospitals, and four specialty psychiatric hospitals, as well as 934 Independent Health Facilities and 273 Out of Hospital Premises (see Table 4.1). As of 2013, there were 14,449 specialist physicians (who are even more likely than family physicians to be male rather than female, Canada-trained rather than foreign-trained, and working in urban rather



than rural settings) (Table 5.2). The density of specialist physicians (in 2013) is 1.1 per 1,000 population (or 107 per, 100,000 population) (see Table 5.3).

## Rehabilitation care

Rehabilitation care is quite different from the other five sectors in several ways: 1) it is less a sector than an element of many other sectors; 2) it lacks an easily identifiable key player that occupies the same pivotal role that CCACs, primary-care teams (or family physicians), hospitals, long-term care homes and local public health agencies play in other sectors; 3) a significant proportion of its focus is ‘outside’ what is typically understood to be the health system – on children and youth with physical, communication or developmental challenges, on adults with automobile accident-related injuries, and on adults with work-related injuries or diseases (which we discuss in Chapter 7); and 4) it has been more extensively ‘privatized’ than other sectors, shifting from more public payment to more private payment (i.e., paid for out-of-pocket or with private insurance) and shifting from private not-for-profit delivery to more private for-profit delivery.

To illustrate the first point, rehabilitation care is a key element of:

- 1) home and community care, given physiotherapy, occupational therapy and speech-language therapy are among the types of professional services included as part of home and community care, and that CCACs can deem eligible for government funding, arrange for and coordinate;
- 2) primary care, given physiotherapy can be accessed by a referral from a primary-care team member or accessed directly without a referral;
- 3) specialty care, given there are both dedicated rehabilitation and complex continuing care hospitals (e.g., Toronto Rehabilitation Institute and Holland Bloorview Kids Rehabilitation Hospital) as well as dedicated ‘rehabilitation beds’ in acute-care hospitals, and given that physiatrists are a type of specialist that focuses specifically on physical medicine and rehabilitation; and
- 4) long-term care, given physiotherapy is among the types of funded professional services available in a long-term care home, both for long-term care home residents and for individuals receiving temporary convalescent care or respite care in a long-term care home.

As background to the fourth point, before the early 1990s physiotherapy could be accessed only by referral from a physician and typically was available in OHIP-funded physiotherapy clinics and in hospital outpatient clinics. With no increase in the number of, or budget for, OHIP-funded clinics, restrictions on eligibility for government-funded services, and competing pressures on hospitals that caused them to close their outpatient clinics (as well as a number of concurrent changes in the automobile insurance and workers' compensation systems), physiotherapy was largely removed from the basket of covered primary-care services. Payment for physiotherapy now depends on factors such as whether citizens are deemed eligible for government-funded care by the CCAC (for care in their own home) or by the Ontario Disability Support Program; are enrolled with a Family Health Team or obtain care from a Community Health Centre that includes a physiotherapist as a member of the team; have access to a Community Physiotherapy Centre and meet the requirements related to age (under 19 or 65 and older) or recent discharge from hospital; are a hospital inpatient or long-term care home resident; were injured in an automobile accident; or have a work-related injury or disease. Otherwise, citizens (which we mean in the broad sense of the term, including permanent residents and refugees) may pay out-of-pocket or draw on their private-insurance coverage if they have it.

### **Policies, programs and places for, and people in, rehabilitation care**

As an element of other sectors, rehabilitation care has few dedicated policies and few dedicated government-funded programs per se (Figure 6.4 and Table 6.3). The relevant policies and programs in each sector apply to the rehabilitation care provided in that sector. For example, the *Public Hospitals Act, 1990* applies to dedicated adult rehabilitation and complex continuing care hospitals just as it does to other hospitals. And the government pays Community Physiotherapy Centres for eligible rehabilitation care and OHIP pays the physiatrists working in hospitals and specialty clinics for medically necessary rehabilitation care. That said, those elements of rehabilitation care that are 'outside' the aegis of the Ministry of Health and Long-Term Care (e.g., care for children with disabilities or for adults injured in automobile accidents or at work) can be governed by policies in other parts of government, such as the ministries of children and youth services, community and social services, education, finance through the Financial Services Commission of Ontario, and labour through the

Workplace Safety and Insurance Board. Also, rehabilitation care clients with long-term physical disabilities can also benefit from the Assistive Devices Program, which (as described in the home and community care section) provides access to a range of personalized assistive devices when prescribed by a physician.

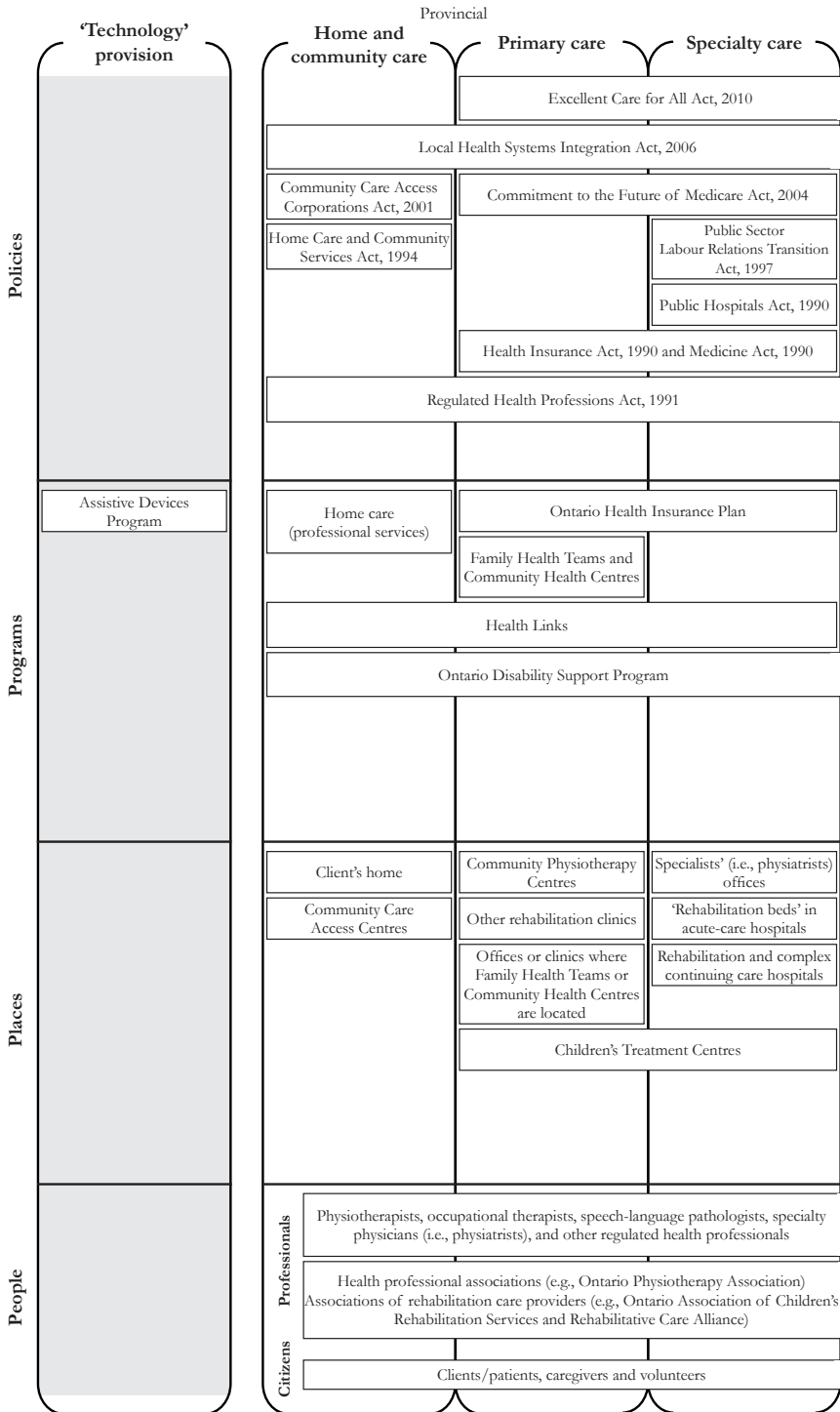
The places where rehabilitation care is provided range from clients' homes (for home care) and the offices or clinics where physiotherapists are based (for primary care), often alongside other regulated health professionals and unregulated health workers, to hospitals (for specialty care) and long-term care homes.

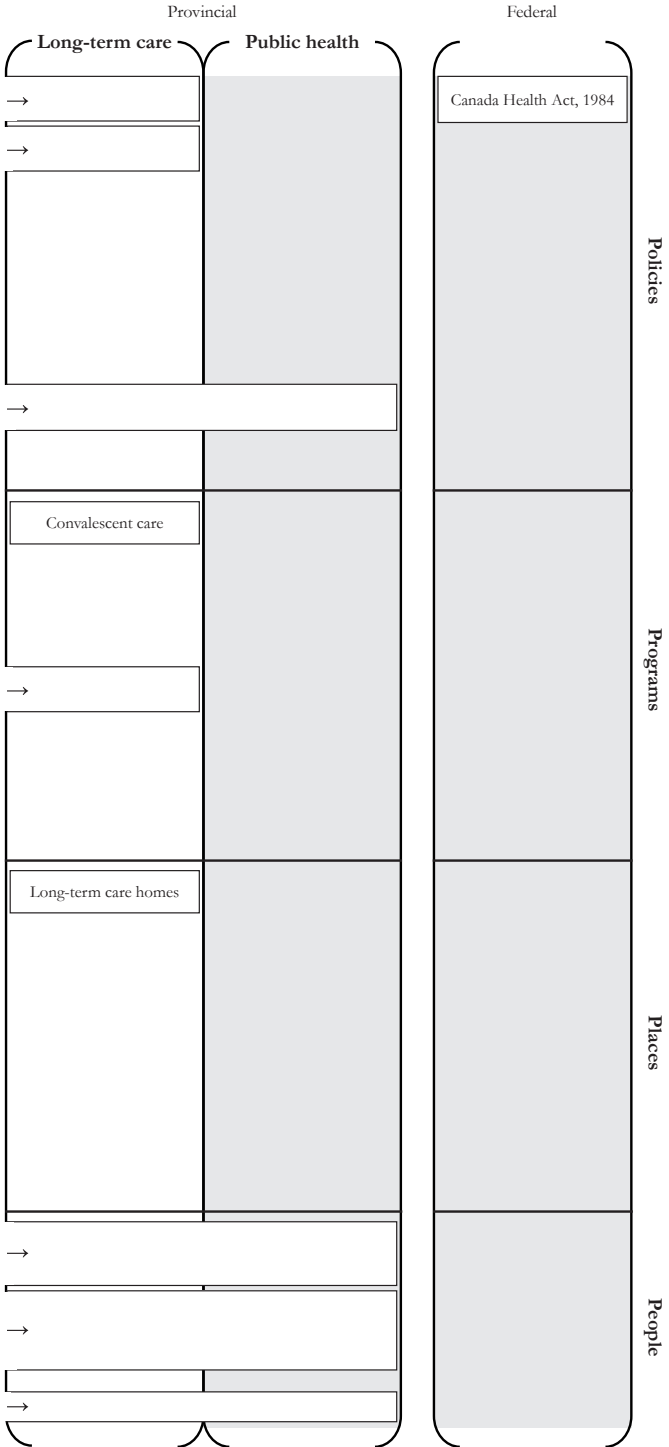
The people involved in rehabilitation care include the patients or clients themselves and the rehabilitation professionals mentioned above. The health professionals are represented by their respective professional associations (e.g., Ontario Physiotherapy Association) and the clinics they own or work for are represented by member associations such as the Ontario Association of Children's Rehabilitation Services (for Children's Treatment Centres) and Ontario Rehab Alliance (for organizations providing rehabilitation care to those injured in automobile accidents). The sector's work is also supported by a collaborative called the Rehabilitative Care Alliance, the secretariat for which is maintained by the GTA Rehab Network, which itself serves the greater Toronto area.

### **Governance, financial and delivery arrangements in rehabilitation care**

Governance, financial and delivery arrangements (i.e., the building blocks) are another lens through which rehabilitation care can be described. While the most salient governance arrangements have been addressed under 'policies' above, the key point to note is that rehabilitation care is not governed as a sector per se (as are the other five sectors), but as a set of people working, and programs being delivered, in places typically thought of as primarily belonging to other sectors. As with home and community care, rehabilitation care is more often financed from out-of-pocket payments than primary care, specialty care and public health, and is more difficult to track in terms of public expenditures from a sectoral perspective. In terms of delivery arrangements, as of 2014, there were more than 300 Community Physiotherapy Centres and 21 Children's Treatment Centres (see Table 4.1), as well as 55 general rehabilitation hospitals (labelled group

Figure 6.4: Rehabilitation care





**Table 6.3: Rehabilitation care**

Program	Services	Who delivers/funds	Who is covered
<b>Community-based rehabilitation</b>			
Community Physiotherapy Centres (CPCs)	Physiotherapy services (assessment, diagnosis, treatment) for select patients with injuries, chronic conditions, and disabilities, as well as after certain surgical procedures	<ul style="list-style-type: none"> <li>• Close to 300 privately owned CPCs (referral from a physician, nurse practitioner or Community Care Access Centre, or CCAC, required)</li> <li>• Funding by Local Health Integration Networks (LHINs) (with funds from the Ministry of Health and Long-Term Care or MOHLTC) with service agreements based on an episode of care model<sup>1</sup></li> </ul>	Under 19 years or 65 years and over; or spent at least one night in hospital prior to care; or require therapy at home or in a long-term care home; or income support recipients; <sup>2</sup> as well as a valid health card
Outpatient rehabilitation programs <sup>3</sup>	Physiotherapy, occupational therapy, speech-language pathology, social work, and nursing; may also provide access to adjunct services and specialty clinics	<ul style="list-style-type: none"> <li>• 113 'health service provider' (HSP) corporations in multiple hospital sites; some programs in Community Health Centres (CHCs)</li> <li>• Funded by LHINs (with funds from the MOHLTC)</li> </ul>	All hospital-registered outpatients with a valid health card
Specialized geriatric services (SGS)	Preventive, continuing and restorative care services, including geriatric emergency management <sup>4</sup> for seniors	<ul style="list-style-type: none"> <li>• SGSs are provided in both community-based and hospital settings (e.g., CHCs, inpatient geriatric rehabilitation units)</li> <li>• Funded by LHINs (with funds from the MOHLTC)</li> </ul>	Frail and at-risk and medically complex seniors with a valid health card
<b>Inpatient rehabilitation</b>			
Convalescent care programs (CCP)	Prepare individuals to return home after a stay in hospital, with a focus on recovery of strength and functioning, and can include needed rehabilitation services	<ul style="list-style-type: none"> <li>• Arranged through CCACs, convalescent care is provided in CCP beds in long-term care homes</li> <li>• Funded by LHINs (with funds from the MOHLTC)</li> </ul>	Applicants (from both home and hospital settings) must be 18 years of age or older and have a valid health card
Inpatient rehabilitation	Regular and restorative rehabilitation support including physiotherapy, occupational therapy, speech-language pathology, social work, and nursing	<ul style="list-style-type: none"> <li>• 154 HSP organizations (includes 55 general rehabilitation and 10 special rehabilitation hospitals, as well as dedicated rehabilitation and complex continuing care beds)<sup>5,6</sup></li> <li>• Funded by the LHINs (through the MOHLTC)</li> </ul>	All hospital rehabilitation inpatients with a valid health card

*Continued on next page*

Program	Services	Who delivers/funds	Who is covered
Other			
Private rehabilitation services	Private for-profit physiotherapy and other rehabilitation services	• Privately owned and operated clinics/practices, funded through private insurance (e.g., automobile or health) or the Workplace Safety and Insurance Board or paid out-of-pocket	Not covered under the Ontario Health Insurance Plan

Sources: 9; 61-70

Notes:

<sup>1</sup> Under individual funding agreements, the clinic is paid a set price per episode of care (w312 in 2013) to provide physiotherapy services for a total target number of episodes per clinic within the time period of the agreement. The program funds only treatment by a physiotherapist and/or support staff. It does not cover any other services/programs such as group exercise, activation, or falls prevention classes, services to maintain an existing level of function, or services provided concurrently with physiotherapy services already provided or funded by other MOHLTC or health-system programs or through automobile insurance or the insurance plan established under the *Workplace Safety and Insurance Act, 1997*. The costs of any equipment or supplies, including equipment or supplies recommended for individual home use, are not eligible for funding.(9; 66)

<sup>2</sup> Income support programs include Ontario Works and the Ontario Disability Support Program.(66)

<sup>3</sup> These programs include outpatient physiotherapy programs, hand and upper limb clinics, orthopedic rehabilitation (including post-op joint programs), cardiac rehabilitation programs, neurological rehabilitation and stroke programs, outpatient speech-language pathology programs, multidisciplinary outpatient rehabilitation programs, outpatient occupational therapy programs, pediatric rehabilitation (including speech therapy programs), prosthetics and amputee rehabilitation programs, pulmonary and respiratory rehabilitation programs, and geriatric rehabilitation.(70)

<sup>4</sup> Geriatric emergency management involves screening and assessing seniors in emergency departments to determine frailty and if at-risk, and linking them to specialized geriatric services in the community. Ninety geriatric nurse clinicians provide geriatric emergency management as part of emergency department care teams.(62; 70)

<sup>5</sup> Group E hospitals are general rehabilitation hospitals and group J hospitals provide special rehabilitation services for disabled persons in a region of Ontario specified by the minister for each hospital.(12; 13)

<sup>6</sup> In 2013, hospitals had just over 2,500 dedicated regular rehabilitation beds; the number of CCC beds for rehab was not available.

E under the *Public Hospitals Act, 1990*), 10 special rehabilitation hospitals (group J), three ‘continuing care centres’ (group R) that provide ‘low intensity, long duration’ rehabilitation, and 108 chronic-care hospitals (groups F and G) that provide rehabilitation care for some of their ‘complex continuing care’ patients.’(9-16) Beyond these government-funded centres and hospitals, the infrastructure for rehabilitation care is difficult to characterize. In 2013, there were 6,950 physiotherapists (for a density of 0.005 per 1,000 – or 51 per 100,000 population), 4,892 occupational therapists (for a density of 0.004 per 1,000 – or 36 per 100,000 population), 3,137 respiratory therapists, and 3,014 speech-language pathologists (see Tables 5.2 and 5.3).

## Long-term care

The key player in the long-term care sector is long-term care homes (historically called ‘nursing homes’), where clients receive 24/7 access to nursing and personal care – generally more than can be safely met through supportive housing or a retirement home, but not so much care that they require admission to a hospital unit. Long-term care homes can also provide

two short-stay programs, namely convalescent care and respite care, with a maximum stay of 90 days. As we return to below, they can be private for-profit, private not-for-profit or publicly owned (by municipal governments), and some have been established and maintained by the councils of First Nations bands.

All nursing and personal support services (provided by registered nurses or registered practical nurses and by personal support workers, respectively), as well as medical services (provided by physicians and nurse practitioners), rehabilitation therapy (provided by physiotherapists, occupational therapists, speech-language pathologists, and recreation therapists), restorative and social services (provided by social workers), clinical pharmacy services (provided by pharmacists) and nutritional services (provided by dietitians), provided (or arranged for) by long-term care homes are funded by the government (directly, through the LHIN or – in the case of medical services – through OHIP).(17; 18)

Clients, on the other hand, pay standardized charges for their accommodation. For example, in March 2016, these charges were roughly \$1,775 per month for the long-stay basic option (which can be subsidized by the government for those who cannot afford it), \$2,150/month for a long-stay semi-private room, and \$2,550/month for a long-stay private room, and with a daily rate of \$37.77 for short stays.(19) The government sets these accommodation fees for all long-term care homes. Clients also pay for any healthcare goods, services and equipment that are not provided as part of the government-funded care listed above. Long-term care home staff provide residents with information about, and assistance in obtaining, these goods, services and equipment.(20)

Two additional players in the sector intersect with other sectors:

- 1) complex continuing care facilities (or units within hospitals), which were described in relation to both specialty care and rehabilitation care, and which provide complex continuing care for people requiring long-term, medically complex care that cannot be provided at home or in a long-term care home; and
- 2) CCACs, which determine eligibility for and make arrangements for admission to (or for getting on the waiting list for) all long-term care homes and some complex continuing care facilities (or units), and which will be absorbed into LHINs under the terms of the *Patients*



*First Act, 2016.*

The CCACs' 'gatekeeper' role does not apply to First Nations' long-term care homes, which make their own decisions about admissions (or what are commonly called 'placements' in the sector).

## Policies that govern long-term care

The key policies that govern long-term care (Figure 6.5) are the:

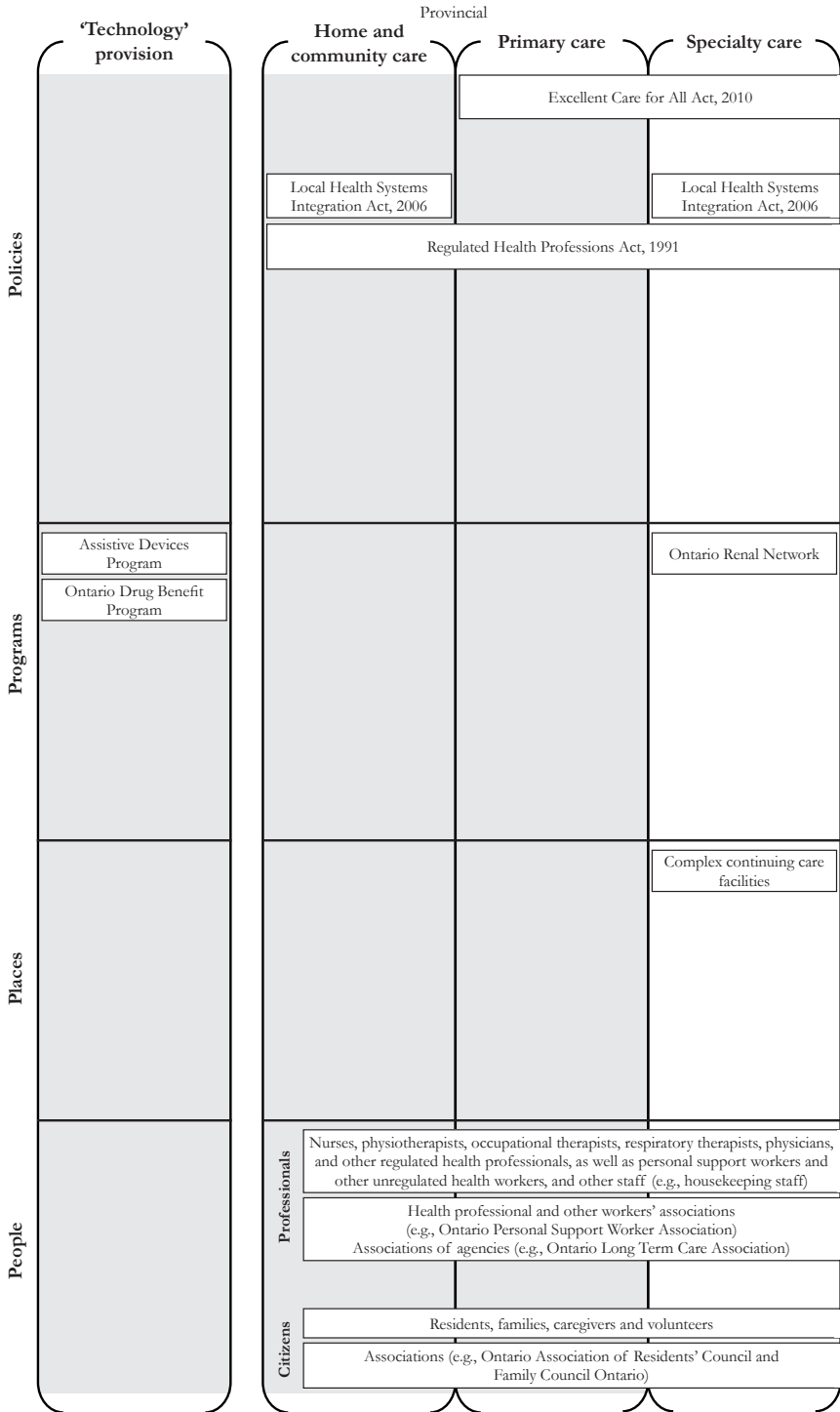
- 1) *Local Health Systems Integration Act, 2006* that established the government and LHINs as the funder of all long-term care homes (although municipal homes also receive a direct operating and capital subsidy from municipal governments, which varies by municipality);
- 2) *Long-Term Care Homes Act, 2007* that defined requirements for licensing and regulation, financing, staff training, services to be provided, and quality monitoring and reporting in long-term care facilities, as well as established residents' right to a safe, secure environment and involvement in care planning; and
- 3) *Excellent Care for All Act, 2010* that, under the terms of related regulations or policies, included long-term care homes under the mandate of the Patient Ombudsman and requires long-term care homes to submit annual Quality Improvement Plans to HQO.

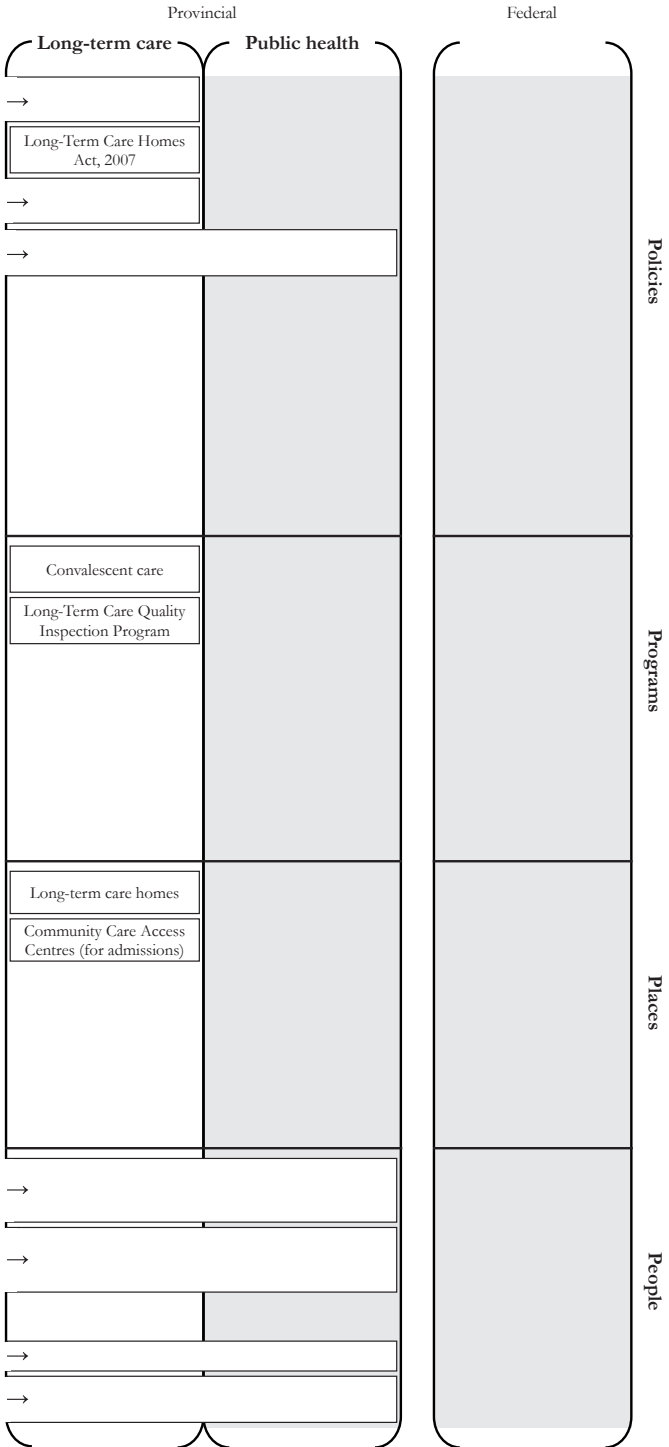
The regulated health professionals (e.g., registered nurses and physiotherapists) providing care in long-term care homes are governed by the *Regulated Health Professionals Act, 1991*. Additional unregulated health workers (e.g., personal support workers) are also heavily involved in care. We return to these groups below.

## Programs constituting or involving long-term care

In the long-term care sector, there are not programs in the same way as there are in other sectors, however, the nursing and personal care provided to residents and the social and recreational activities organized for residents can be thought of as programs. Also, residents can access programs available more broadly in the health system. For example, residents needing prescription drugs can obtain them through the ODB Program and residents with long-term physical disabilities can benefit from the Assistive Devices Program, just as home and community care clients and primary-care patients can.

Figure 6.5: Long-term care





Also, some beds or units are funded programmatically (and separately from other parts of a long-term care home). For example, short-stay convalescent care is a separately funded program, with clients having to take the first available convalescent care bed (and not having the choice of their preferred long-term care home as is the case for long-term stays).(17) As well, there are other types of program-funded units or beds in long-term care homes, including (at the time of writing) four designated units for behaviour supports and one designated unit for peritoneal dialysis (which have their own CCAC-administered wait lists), and many beds for residents receiving peritoneal dialysis (in 28 long-term care homes that receive funding from the Ontario Renal Network), with residents having to accept the long-term care home where the program-funded unit or bed is located (and again not having an unrestricted choice of their preferred long-term care home).(18; 21)

Finally, the Long-Term Care Quality Inspection Program,(22) operated by the Ministry of Health and Long-Term Care under the terms of regulations established through the *Long-Term Care Homes Act, 2007*,(23) provides a level of continuous government oversight that is virtually unknown in other parts of the health system. The ministry is mandated to conduct unannounced inspections of every long-term care home at least annually (to identify any instances of non-compliance with the *Long-Term Care Homes Act, 2007* and its regulations) and to publicly report on all inspections (annual, complaint, critical incident or ‘other’) through the ministry’s website. The ministry has announced plans to transition to a risk-based framework that would enable it to focus its intensive inspections on high-risk long-term care homes.(24)

## Places and people involved in long-term care

The places and people involved in this sector are more straightforward than other sectors. There is only one key ‘place’ – long-term care homes – although CCACs act as a gatekeeper to these homes, and complex continuing care facilities (or units within hospitals) complement them for those requiring long-term, medically complex care. The people include the long-term care home residents themselves, their families and caregivers, and volunteers, as well as health professionals (including those mentioned above), a variety of unregulated health workers (e.g., personal support workers and activity/recreation staff), and other staff (e.g., dietary and

housekeeping). Residents and their families play a particularly important role through each long-term care home's Residents' Council and Family Council, which are mandated under the *Long-Term Care Homes Act, 2007*, to independently advise residents about their rights and responsibilities. They also advise long-term care homes about their operations and review key financial and inspection reports. These councils are represented by the Ontario Association of Residents' Councils and by Family Councils Ontario. The health professionals are represented by their respective professional associations, unionized staff are represented by their unions, and long-term care homes are represented by the Ontario Long Term Care Association.

### Governance, financial and delivery arrangements in long-term care

The governance arrangements specific to long-term care are addressed under 'policies above,' but the unique organizational/commercial authority operating in the sector warrants some elaboration (Table 4.9). The Ministry of Health and Long-Term Care has the exclusive authority to issue licences or approvals for long-term care homes to long-term care home operators (and each licence or approval is for a specific number of beds). Licences can be granted to for-profit operators (individuals, partnerships or corporations) and to not-for-profit operators (not-for-profit corporations without share capital, which can include charities and hospitals). Approvals (instead of licences) are granted to municipal governments (which in turn are operating under the *Municipal Act, 2001*, or in the case of Toronto the *City of Toronto Act, 2006*).<sup>(25; 26)</sup> Long-term care home operators can either manage their long-term care homes on their own or contract with another operator (typically a for-profit operator) to manage their homes, although the ministry must approve the contractor. The buying, selling and relocation of licences is strictly controlled by the ministry (e.g., not-for-profit operators cannot sell their licences to for-profit operators unless the former is bankrupt). Municipal governments are prohibited from selling their approved beds to either for-profit or not-for-profit operators.

Turning to financial arrangements, approved long-term care home operators can only receive funding from the government and LHIN for a long-term care home if they have signed a Direct Funding Agreement or a Long-Term Care Service Accountability Agreement with the ministry or LHIN, respectively.<sup>(27)</sup> These agreements are specific to a long-term care

home so operators with multiple homes have multiple agreements. Long-term care homes can also receive funding from other government sources, including provincial social assistance plans, other provincial government departments, and (as noted above) municipal governments (Table 4.9).

The key infrastructure in the sector includes the 636 long-term care homes and the 117 hospital-based complex continuing care facilities (see Table 4.1),(28) which collectively housed 143,727 residents in 2014-15.(29) Of the licensed/approved long-term care homes, 51% are private for-profit, 22% are not-for-profit, and 27% are public (see Table 4.9).(30; 31) In 2015, 7,923 nurses worked in the sector (Table 5.4). In 2014, the majority of staff in long-term care homes were personal support workers (73% of staff) working in care teams under the leadership of registered nurses (9% of staff) and registered practical nurses (18% of staff).(30)

## Public health

The key player in public health is the local public health agency (officially called a board of health), of which there are 36 in the province: 22 organizationally independent of municipal government, seven that are part of a regional administration governing multiple municipalities (Durham, Halton, Niagara, Oxford, Peel, Waterloo and York), three that are part of a single-tier administration created from the merger of a regional administration and its constituent municipalities (Haldimand-Norfolk, Hamilton and Ottawa), and four that are part of a municipal administration (Chatham-Kent, Huron, Lambton and Toronto). A local public health agency is either an autonomous corporation or a department within a larger municipal corporation. Each agency is governed by a board of health (hence the official name) and administered by a medical officer of health (i.e., a physician with specialty training in public health and preventive medicine or other recognized public health training) or by a chief executive officer (advised by a medical officer of health). The agency provides (primarily) prevention, education, health assessment and disease surveillance, enforcement of some public health legislation, and limited clinical services, with the goal of promoting health and preventing disease among the citizens of a defined geographic area (called a public health unit). Each governing board of health is largely comprised of elected representatives from local municipal councils. The medical offer of health or

chief executive officer reports to the board of health and oversees unit staff. The provincial government and municipal governments share responsibility for funding local public health agencies. A LHIN may contain from one to seven local public health agencies and a single local public health agency may span multiple LHINs – five in the case of Toronto Public Health. Complicating matters further, the local public health agencies are grouped into six regions (south west, central west, central east, eastern, north east, and north west) (Figure 6.6). The Government of Ontario is taking steps toward establishing a tighter connection between local public health agencies and both LHINs and primary care.(1)

Other important players in public health are the Ministry of Health and Long-Term Care's Population and Public Health Division, the province's chief medical officer of health, and Public Health Ontario, as well as the Ministry of Children and Youth Services and the Ministry of the Environment and Climate Change. The division and/or the chief medical officer of health deal with public health issues at the provincial level, communicate directly with the public about public health issues, and (in the case of the chief medical officer of health) report annually to the legislature on the state of public health. Indeed, the chief medical officer of health is one of only three such officers in Canada who can independently issue public reports without political 'interference,' with the other two being the B.C. and federal governments. Public Health Ontario provides scientific and technical advice and support in six areas (health promotion, infection prevention and control, chronic disease and injury prevention, environmental and occupational health, surveillance and epidemiology, and emergency preparedness and incident response) and operates 11 public health laboratories around the province. Legally, Public Health Ontario is known as the Ontario Agency for Health Protection and Promotion. The latter name derives from its founding legislation (*Ontario Agency for Health Protection and Promotion Act, 2007*). In 2011 it adopted the operating name of Public Health Ontario. Its main clients are government, local public health agencies, and health professionals and organizations.

## Policies that govern public health

While the delegation of public health responsibilities to local boards of health goes back to the mid-1880s, the salient policies that govern or

Figure 6.6: Public health unit boundaries<sup>1</sup>



Source: Adapted from 71

Note:

<sup>1</sup> The part of the province shown within the oval has been magnified to show an appropriate level of detail.



organize public health today (Figure 6.7) include the:

- 1) *Health Protection and Promotion Act, 1990* that established boards of health for all local public health agencies and the authorities of the medical officers of health serving each board;
- 2) *Health System Improvements Act, 2007*, which was an omnibus act that included the *Ontario Agency for Health Protection and Promotion Act, 2007* that created what is now called Public Health Ontario; and
- 3) *Health Protection and Promotion Amendment Act, 2011* that established the authority of the provincial chief medical officer of health to direct boards of health and their medical officers of health in cases of a pandemic, public health event or emergency with health impacts (although this is one of many acts amending the *Health Protection and Promotion Act, 1990*, albeit a particularly visible one).

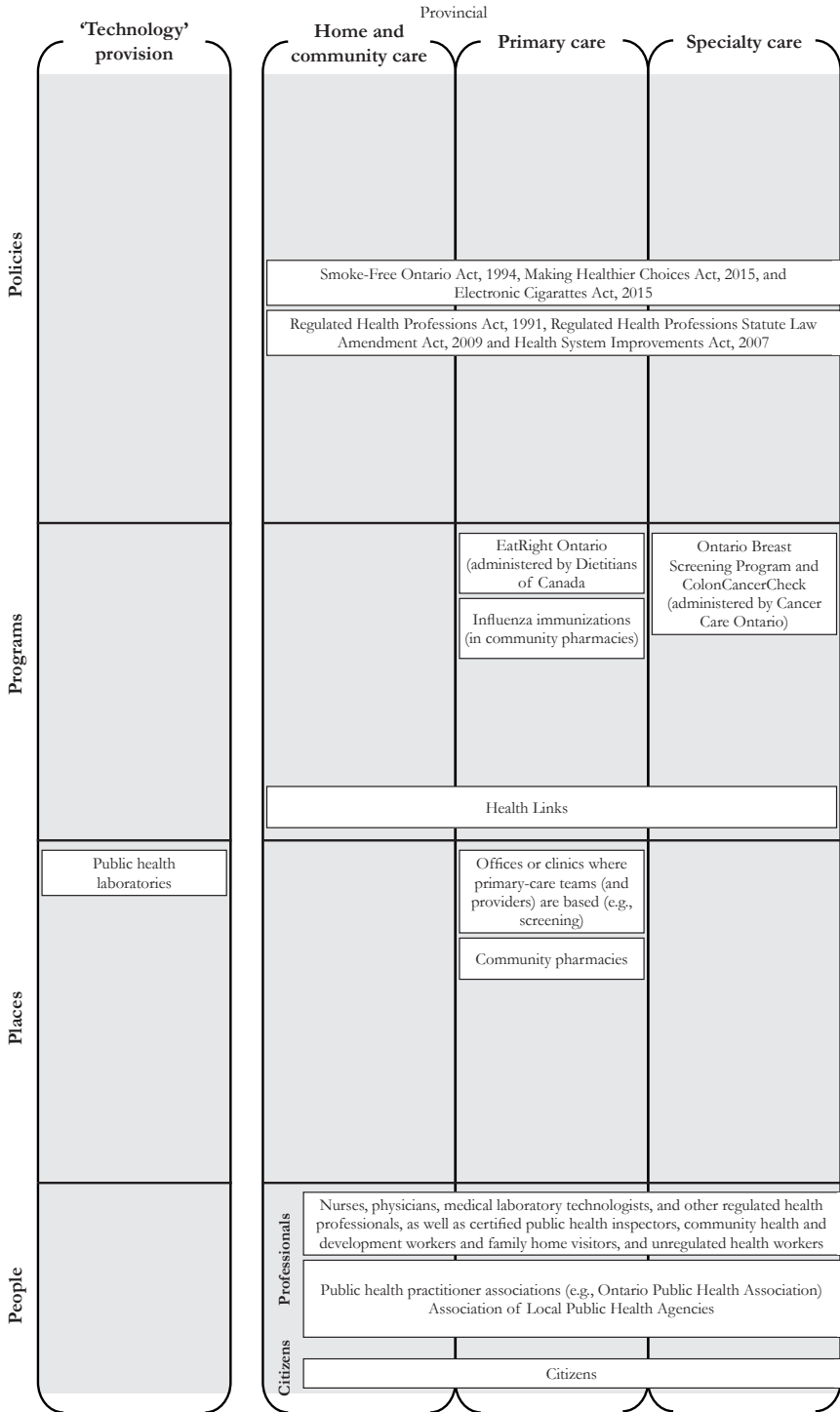
The *Smoke-Free Ontario Act, 1994* is an example of legislation that seeks to achieve a public-health goal, although there are many others, examples of which include: *Immunization of School Pupils Act, R.S.O. 1990*; *Safe Drinking Water Act, 2002*; *Mandatory Blood Testing Act, 2006*; *Skin Cancer Prevention Act, 2013*; and *Child Care and Early Years Act, 2014*.(32-36)

The health professionals working in public health (primarily nurses but also physicians, dietitians and dental hygienists, among others) are governed by the *Regulated Health Professions Act, 1990*, the *Regulated Health Professions Statute Law Amendment Act, 2009*, and their respective regulatory colleges. Public health inspectors, on the other hand, are governed under the *Health Protection and Promotion Act, 1990* and its regulations. Nationally, the *Public Health Agency of Canada Act, 2006* created the Public Health Agency of Canada, which seeks to strengthen intergovernmental collaboration on public health and facilitate national approaches to public health policy and planning. It also funds many small-scale public health projects in Ontario.

While not acts or regulations (i.e., legal instruments), local public health agencies are also governed by:

- 1) Ontario Public Health Standards and associated protocols, which were published in 2008, came into effect in 2009, and are being thoroughly reviewed in 2016;
- 2) Ontario Public Health Organizational Standards; and
- 3) accountability agreements between the provincial government and boards of health, which include accountabilities related to the

Figure 6.7: Public health





implementation of the above standards.

The two sets of standards can be considered to be voluntary instruments according to the taxonomy of policy instruments described in Chapter 2 (although significant elements of the standards are typically seen to be mandatory), while the accountability agreements (effectively a contract) can be considered an economic instrument.

### Programs delivered by or related to public health

The many programs delivered by local public health agencies can be grouped according to how they are described in the Ontario Public Health Standards:

- 1) family health (part of what Public Health Ontario includes in health promotion);
- 2) infectious diseases prevention and control (what Public Health Ontario calls infection prevention and control);
- 3) chronic disease and injuries (what Public Health Ontario calls chronic disease and injury prevention, and what is partly included in health promotion);
- 4) environmental health (part of what Public Health Ontario calls environmental and occupational health, with elements of the latter also addressed in the workers' compensation system); and
- 5) emergency preparedness (which Public Health Ontario calls emergency preparedness and incident response).

Assessment and surveillance is an example of a foundational standard that applies across programs. While public health is typically considered to be focused on population-based strategies, not individually focused treatment, some of these programs, particularly the Family Health Program, offer clinical services (e.g., dental care to eligible children whose parents cannot afford it, and the diagnosis and treatment of sexually transmitted infections).

Some public health programs (Table 6.4) do not involve local public health agencies directly, such as:

- 1) EatRight Ontario, a website maintained by Dietitians of Canada;
- 2) Universal Influenza Immunization Program, through which influenza immunizations are provided in primary-care settings and community pharmacies, in addition to local public health agency clinics; and
- 3) breast and colon cancer screening programs delivered by CCO.

Also, some national public health infrastructure (e.g., Public Health Agency of Canada and the National Collaborating Centres for Public Health that it funds) supports public health practitioners in Ontario.

## Places and people involved in public health

Public health programs can be delivered in many places, and many public health ‘places’ are not open to the public. Public health ‘places’ range from homes (e.g., home visits by a public health nurse or family home visitor), schools (e.g., dental screenings), restaurants (e.g., inspections)

Table 6.4: Public health programs

Programs <sup>1</sup>	Services <sup>2</sup>	Who delivers/funds	Who is covered
Chronic disease and injuries			
Chronic-disease prevention programs <sup>3</sup>	Focus on healthy eating <sup>4</sup> and healthy weights; tobacco control; physical activity; alcohol use; exposure to UV radiation; food affordability; and work stress	Local public health agencies <sup>5</sup> funded by the Ministry of Health and Long-Term Care (MOHLTC) and municipalities	Any eligible person in the local public health unit (a geographic area)
Injury and substance misuse prevention programs	Focus on alcohol and other substances (e.g. harm-reduction programs); falls across the lifespan; on- and off-road safety; and other areas for injury prevention based on local epidemiology	Local public health agencies funded through the MOHLTC and municipalities	Any eligible person in the local public health unit
Family health			
Reproductive health	Focus on services related to preconception health; healthy pregnancies (e.g. prenatal care and services); reproductive health outcomes; and preparation for parenting	Local public health agencies funded through the MOHLTC and municipalities	Any eligible person in the public health unit
Children's health	Focus on positive parenting and healthy family dynamics; breastfeeding; healthy eating and healthy weight; physical activity, growth and development; and child oral health	Local public health agencies funded through the MOHLTC and municipalities	Eligible children and families in the public health unit
Elementary school dental screenings	Visual screening lasting 30-60 seconds	Local public health agencies funded through the MOHLTC and municipalities	All children in elementary schools
Healthy Smiles Ontario	Preventive care and basic and urgent treatments (e.g., check-ups, cleaning, fillings, X-rays, and scaling) for children in low-income households without access to any form of dental coverage	Local public health agencies funded through the MOHLTC and municipalities	Children 17 years and younger meeting eligibility requirements

*Continued on next page*

Programs <sup>1</sup>	Services <sup>2</sup>	Who delivers/funds	Who is covered
Family health – continued			
Healthy Babies, Healthy Children Program	Provides a mix of services including newborn screening, assessment, referrals and other support services (e.g., public health nurse or family home visitors)	Local public health agencies funded by the MOHLTC and municipalities; Ministry of Children and Youth Services	Pregnant women, and families with young children up to the age of six in the local public health agency
Infectious diseases prevention and control			
Infection prevention and control	Infection prevention and control practices in settings associated with a risk of infectious diseases (e.g., hospitals, long-term care homes, and licensed day nurseries)	Local public health agencies funded by the MOHLTC and municipalities	Any eligible person or setting in the local public health unit
Infectious diseases	Follow-up of reportable infectious diseases to prevent further spread; and collecting and reporting on surveillance data on these infectious diseases	Local public health agencies funded by the MOHLTC and municipalities	Any eligible person in the public health unit
Rabies prevention and control	Assessment/surveillance; knowledge-awareness promotion; regional prevention/control strategies; and the development of local rabies contingency plans	Local public health agencies funded by the MOHLTC and municipalities	Any eligible person in the public health unit
Sexual health, sexually-transmitted infections and blood-borne infections	Assessment/surveillance; clinical services for priority populations addressing contraception, pregnancy and infection; provision of (or ensuring access to) medications for treatment; and provision and/or distribution of harm-reduction materials/equipment (e.g. sterile drug using equipment, condoms)	Local public health agencies funded by the MOHLTC and municipalities	Any eligible person in the public health unit
Tuberculosis prevention and control	Assessment/surveillance of persons with active and latent TB infections; health promotion; disease prevention/protection for identified priority populations and those working with them; and provision of (or ensuring access to) medications for treatment	Local public health agencies funded by the MOHLTC and municipalities	Any eligible person and priority populations in the public health unit
Vaccine-preventable deaths	Assessment/surveillance of children's immunization status; provision of immunization programs in public health clinics, school- and community-based clinics, and outreach clinics to priority populations; distribution of publicly funded vaccines to primary-care clinics, pharmacies, and local public health agency clinics; conducting cold-chain inspections in these settings and broader vaccine-safety measures; and education	Local public health agencies funded by the MOHLTC and municipalities	Any eligible person in the public health unit

*Continued on next page*

Programs <sup>1</sup>	Services <sup>2</sup>	Who delivers/funds	Who is covered
Environmental health			
Food safety	Food safety communication strategies; safe food-handling training programs; inspection of food premises; and provision of Food Safety Program	Local public health agencies funded by the MOHLTC and municipalities	Any eligible person in the public health unit
Safe water	Identification of water contaminants and illnesses, associated risk factors, and emerging trends; education and training for owners/operators of, and inspections of, drinking-water systems and recreational water facilities	Local public health agencies funded by the MOHLTC and municipalities	Any eligible person in the public health unit
Laboratory testing	Clinical and environmental testing (e.g., water, food-borne illness tests); clinical consultation, education and training programs for laboratory professionals; and evaluation of new laboratory technologies	Public Health Ontario-operated laboratories funded by the MOHLTC	Public Health Ontario
Health-hazard prevention and management	Identification and management of exposures of health concern and public health risks; and public awareness program associated with indoor/outdoor air quality, extreme weather, climate change, radiation exposure, and other emergent issues	Local public health agencies funded by the MOHLTC and municipalities	Any eligible person in the public health unit
Emergency preparedness			
Public health emergency preparedness	Identification and assessment of hazards and risks to public health; development of plans to sustain time-critical public health services; raising public awareness; and staff education and training	Local public health agencies funded by the MOHLTC and municipalities	Internal to public health agencies
Other provincial programs			
EatRight Ontario	Website providing advice and articles on food, nutrition, healthy eating, and phone/email feedback from registered dietitians	Maintained and delivered by Dietitians of Canada and funded by MOHLTC	Anyone in Ontario can use the website or call for advice
Universal Influenza Immunization Program	Influenza immunization at local participating primary-care clinics, pharmacies, and local public health agency clinics	Ontario pharmacies, immunizations funded through the MOHLTC	Anyone over 4 years of age with a valid health card
ColonCancer Check	Organized colon cancer at-home screening program for colorectal cancer for those at average risk for colorectal cancer	Cancer Care Ontario (CCO) funded by MOHLTC	Ontarians aged 50 and over with a valid health card

*Continued on next page*

Programs <sup>1</sup>	Services <sup>2</sup>	Who delivers/funds	Who is covered
Other provincial programs – continued			
Ontario Breast Screening Program	Organized breast screening program providing mammography and breast magnetic resonance imaging (MRI) (depending on level of risk) services to women at risk for breast cancer	CCO funded by the MOHLTC	Women aged 50 to 74 (average risk) and aged 30 to 69 years (identified high risk), valid health card

Sources: 65; 72-77

Notes:

<sup>1</sup> The Ontario Public Health Standards (OPHS) and Protocols outlines those programs and services that all boards of health in Ontario are required to provide, including assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection. Program standards and protocols are grouped under five program areas: chronic disease and injuries (three protocols), family health (five protocols), infectious diseases (11 protocols), environmental health (five protocols), and emergency preparedness (one protocol). The assessment, planning, delivery, and management of public health programs and services under these standards and protocols are the responsibility of each local board of health.(78)

<sup>2</sup> Given that the specific programs and services encompassed within assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection can vary in design based on local needs and epidemiology, we have described the focus of the services in each of the five program areas in general terms.

<sup>3</sup> Chronic diseases of public health importance include cardiovascular diseases, cancer, respiratory diseases, and Type 2 diabetes.(78)

<sup>4</sup> For example, the Northern Fruit and Vegetable Program provides two servings of fruits and vegetables a week to elementary and intermediate school-aged children in 191 northern Ontario schools. It is delivered by the Algoma, Porcupine and Sudbury public health units and the Ontario Fruit and Vegetable Growers' Association, and funded through the MOHLTC.(79)

<sup>5</sup> The work of local public health agencies may include working with municipalities and/or community partners (including, but not limited to, non-governmental organizations; governmental bodies such as the ministries of agriculture and food, children and youth services, education, environment, or transportation; school boards and/or staff, school councils, and students of elementary, secondary, and post-secondary educational institutions; parents; employers and employees in workplaces; and other relevant stakeholders).(78)

and community (e.g., immunization campaigns) to the offices or clinics where nurses, physicians, dentists and other health professionals work and to long-term care homes. Public health laboratories are an example of a public health 'place' that is not open to the public.

The people involved in public health include all citizens (given public health touches all of our lives, whether we know it or not), regulated health professionals (public health nurses, physicians and others), public health inspectors, and a variety of unregulated health workers (e.g., community health and development workers and family home visitors). The health professionals are represented by their respective professional associations or practitioner groups (e.g., Ontario Public Health Association), unionized staff are represented by their unions, and local public health agencies are represented by the Association of Local Public Health Agencies.

### Governance, financial and delivery arrangements in public health

Governance, financial and delivery arrangements look quite different for public health compared to other sectors. Governance arrangements are unique in their connections to municipal government (where this



holds true) and their lack of connection to LHINs (although the latter is expected to change), and more detail has already been provided about these arrangements under ‘policies’ above. Financial arrangements are unique in the near 100% public financing of local public health agencies (which in 2013 represented 8% of health expenditures by government) and the cost-sharing between provincial and local governments. In the absence of a needs-based funding formula as is used in many other sectors, each board of health determines its agency budget and municipal governments are then expected to contribute 25% of the cost of most programs, and the provincial government matches up to 75% of the cost. Some programs are up to 100% funded by the provincial government. Infrastructure in the sector comprises the 36 local public health agencies, 105 satellite offices of these local public health agencies, and 11 public health laboratories (Table 4.1), but the health professionals working in the sector tend not to be identified as such in the high-level health-workforce descriptions we provide in Chapter 5.

## Conclusion

The division of labour among the six sectors comprising Ontario’s health system can be seen as integral to a well-functioning system or a reflection of an unhelpful siloing of care in the system, depending on your perspective. And the historical legacies of Ontario’s hospital and medical (physician) insurance system have meant that the specialty sector tends to be dominated by hospitals and specialists, and primary care is thought of as synonymous with family physicians. Only in the past decade has significant attention been given to primary care and, more recently, to home and community care and to efforts (through Health Links) to provide continuity of care across home and community, primary and specialty care. The *Patients First Act, 2016* will integrate CCAC functions into the LHINs, connect primary care to the LHINs (in the context of LHIN sub-regions), and encourage local public health agencies to connect to the LHINs and to primary care, all of which could help to keep the benefits of a division of labour while avoiding unnecessary siloing

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