Table 1: Timeline of key events related to the regionalization of health services delivery in Ontario

| Year | Events |
|---|---|
| 1990 | • New NDP government elected in Ontario. |
| 1991 | • Premier's Council on Health Strategy releases report on devolution , which was entitled "Local Decision-Making for Health and Social Services."<br>• Release of provincial auditor's report, which highlights "questionable practices by hospitals" and "loose procedures" by the Ministry of Health. |
| 1992 | • Health Minister Frances Lankin announces hospital restructuring.<br>• Ministry / Ontario Hospital Association Joint Policy and Planning Committee (JPPC) established.<br>• Release of the final report of the Southwestern Ontario Health System Planning Commission (Orser Report).<br>• Steering Committee of the Public Hospitals Act Review releases its report entitled "Into the 21st Century."<br>• Government holds public hearings on the Public Hospitals Act.<br>• Treasurer Floyd Laughren announces a one per cent cost escalation for hospitals in fiscal 1992-93, and a two per cent increase in each of the subsequent two years. |
| 1994 | • The Task Force on Devolution of the Premier's Council on Health, Well-being and Social Justice releases two reports – "Devolution of Health and Social Services in Ontario: Refocusing the Debate" and "A Framework for Evaluating Devolution."<br>• No action on the Task Force's recommendation to establish demonstration or pilot projects involving the devolution of services. |
| 1995 | • New Progressive Conservative government elected. |

Table 2: Factors that influenced agendas related to the regionalization of health services delivery in Ontario

| Agendas / decisions | Factors |
| --- | --- |
| Governmental agenda | **Problems**<br>• Lack of locally sensitive planning in the healthcare system (an argument for deconcentration, decentralization or devolution)<br>• Lack of involvement of local communities in decision-making about their healthcare system (an argument for decentralization or devolution) |
| Decision agenda | **Problems**<br>• Same as for governmental agenda<br>**Policies**<br>• Devolution of authority proposed by the Premier's Council on Health, Well-being and Social Justice<br>• Needs-based funding, which was seen as an obvious policy to accompany regionalization, would have resulted in substantial re-allocations (in an era with large deficits and an economic downturn)<br>**Politics**<br>• No politically powerful champions pushing for devolution<br>• Liberal government committed to decentralization, not devolution, and later the NDP government committed to expenditure reduction under the social contract given the large deficit and economic downturn (so re-allocations would be a zero-sum game)<br>• Hospital branch within the Ministry of Health not supportive of devolution<br>• Ontario Hospital Association committed to retaining the autonomy of hospitals (not giving authority to regional structures) and hospital executives committed to retaining their direct access to the Deputy Minister (not working through regional structures)<br>• Physicians oppose local decision-making |
| Policy choice | • **No go** |

Table 3: Timeline of key events related to needs-based funding for health regions / districts in Ontario

| Year | Events |
| --- | --- |
| 1959-1969 | • Government uses line-by-line budgeting system to fund hospitals. |
| 1969 | • Ministry of Health replaces line-by-line budgeting with global funding, which is meant to encourage flexibility in achieving efficiency gains. |
| 1988 | • Global funding system modified. Case-based funding added as a secondary approach to funding acute care operating expenses. |
| 1990 | • New NDP government elected in Ontario. |
| 1991 | • Release of provincial auditor's report, which highlights "questionable practices by hospitals" and "loose procedures" by the Ministry of Health.<br>• Ministry of Health commissions McMaster University professor Stephen Birch to produce a report on how hospital budgets would change if needs-based funding were implemented in Ontario. No action on the basis of the report's recommendations. |
| 1992 | • Health Minister Frances Lankin announces hospital restructuring and releases "Health Services Planning Framework: A Tool for Planning," which offers planning guidelines to hospitals and health planners. The Framework means that the Ministry will allocate hospitals beds on the basis of population size, with the target being the district with the lowest number of hospital beds (and not allocate funding on the basis of health-related measures of need).<br>• Government announces a one per cent increase to hospitals for 1992-93, and a two per cent a year increase in each of the subsequent two years.<br>• Ministry / Ontario Hospital Association Joint Policy and Planning Committee (JPPC) established.<br>• Treasurer Floyd Laughren announces that hospital budgets will be frozen at current levels until 31 March 1995. |
| 1995 | • New Progressive Conservative government elected. |

Table 4: Factors that influenced agendas related to needs-based funding for health regions / districts in Ontario

| Agendas / decisions | Factors |
|---|---|
| Governmental agenda | **Problems**<br>• No financial framework (even virtual regional budgets) within which District Health Councils could provide advice to the Ministry of Health about the allocation of any funding made available to the district |
| Decision agenda | **Problems**<br>• Same as for governmental agenda<br>**Policies**<br>• Needs-based funding, which was seen as an obvious policy to accompany the regionalization being proposed by the Premier's Council on Health, Well-being and Social Justice, would have resulted in substantial re-allocations across districts and hence substantial reductions in some hospital budgets<br>**Politics**<br>• No politically powerful champions pushing for devolution and/or needs-based funding<br>• Liberal government committed to decentralization, not devolution, and later the NDP government committed to expenditure reduction under the social contract given the large deficit and economic downturn (so re-allocations would be a zero-sum game)<br>• Minister of Health focused on hospital accountability and cost containment in light of the auditor's report and economic downturn<br>• Hospital branch within the Ministry of Health developing their own funding formula (for any marginal increases in hospital budgets) based on case-mix costing (as an adjunct to global budgets)<br>• Ontario Hospital Association committed to retaining the financial autonomy of hospitals (not giving real or virtual budgets to District Health Councils)<br>• Physicians oppose local decision-making about resource allocation |
| Policy choice | • **No go** |

Table 5: Timeline of key events related to alternative-payments plans for physicians in Ontario

| Year | Event |
|---|---|
| 1990 | • New NDP government elected. |
| 1991 | • Joint Management Committee established. |
| 1994 | • Release of a report commissioned by the Federal/Provincial/Territorial Conference of Ministers of Health, which was entitled "Paying the Piper and Calling the Tune: Principles and Prospects for Reforming Physician Payment Methods in Canada" and which recommends abolishing the fee-for-service (FFS) system and remunerating physicians for protecting and improving patients' health. |
| 1995 | • New Progressive Conservative government elected.<br>• Release of a report commissioned by the Federal/Provincial/Territorial Conference of Ministers of Health -- "A Model for the Reorganization of Primary Care and the Introduction of Population-Based Funding" (Victoria Report), which provides strategic directions for moving doctors off the existing FFS remuneration system and having them work in new agencies called primary care organizations. |
| 1996 | • Health Minister Jim Wilson announces new directions for primary-care reform. An implementation committee will be formed to guide the establishment of pilot projects that will evaluate two different approaches to primary care delivery – capitation and reformed FFS. |
| 1998 | • Health Minister Elizabeth Witmer and OMA President William Orovan announce the launch of five pilot projects to evaluate the effectiveness of primary care networks. |
| 1999 | • Health Services Restructuring Commission releases a new report that urges the province to replace the FFS system for paying physicians with a rostering model. |
| 2000 | • Finance Minister Ernie Eves announces the provincial government's plan to have 80 per cent of eligible family doctors working in primary care networks within four years. |
| 2001 | • Premier Mike Harris and Health Minister Tony Clement announce the establishment of the Ontario Family Health Network, an arms-length agency reporting to the Ontario Ministry of Health and Long-Term Care and charged with facilitating the province-wide rollout of Family Health Networks. |
| 2002 | • Ernie Eves sworn in as new Premier of Ontario. |
| 2003 | • Health Minister Tony Clement announces the establishment of Family Health Groups, a new model of physician group practice. |

Table 6: Factors that influenced agendas and decisions related to alternative-payments plans for physicians in Ontario

| Agendas / decisions | Factors |
| --- | --- |
| Governmental agenda | **Problems**<br>• Long-standing perception that FFS remuneration (compared to alternative methods) creates the wrong incentives for primary care (e.g., a focus on services not value for money), which had been reinforced by many reports over the years<br>• Additional concerns about shortages in primary-care physicians and a declining interest among physicians in a comprehensive model of primary care |
| Decision agenda | **Problems**<br>• Health Services Restructuring Commission issues a report in December 1999 that argues strongly for replacing FFS remuneration of physicians with capitation payment for primary care practices, and the report is endorsed by the Ontario College of Family Physicians and the new Coalition for Primary Health Care<br>**Policies**<br>• Five pilot Primary Care Networks, which involve a choice of two remuneration methods -- 1) reformed FFS with thresholds based on the number and characteristics of enrolled patients and 2) capitation with payments based on the number and gender of patients served -- was launched in May 1998 (after much negotiation) by the OMA and Ministry of Health, and the OMA is committed to awaiting the results of the evaluation of their effectiveness<br>**Politics**<br>• The Progressive Conservative party is re-elected to a second term in June 1999 and one of their first orders of business in the health sector is to negotiate a new four-year agreement with the OMA, which is ratified by the OMA in May 2000 and which includes an allowance for the government to re-allocate money from the FFS pool of funds to alternative-remuneration methods if physicians volunteer to use these methods (thereby allowing reform to be financed using existings funds) |
| Policy choice | **Institutions – policy legacies**<br>• Canada Health Act's focus on the public financing of primary care that is provided by physicians made it difficult to expand the policy debate to include other primary care providers.<br>• Ontario Health Insurance Plan's focus on remunerating individual physicians made it difficult to use the same administrative system to fund groups of providers.<br>• A series of policies -- the 1991 Memorandum of Agreement between the Government of Ontario and the OMA which introduced FFS billing thresholds for physicians, the 1993-94 Social Contract which introduced a "hard cap" on overall FFS billings by physicians, and Bill 26 in 1996 which provided for the unilateral imposition of specialty-specific FFS billing thresholds -- led to some negative connotations for FFS among primary-care physicians.<br>• Bill 127 in 1998 made it possible for nurse practitioners to perform certain medical services within a multi-disciplinary healthcare team.<br>• Five pilot Primary Care Networks, which involved a choice of two remuneration methods -- 1) reformed FFS with thresholds based on the number and characteristics of enrolled patients and 2) capitation with payments based on the |

| | |
|---|---|
| | number and gender of patients served -- were launched in May 1998 (after much negotiation) by the OMA and Ministry of Health.<br>• The Government of Ontario introduced in 1999 and 2000 (with the support of the OMA) sessional payments for emergency room physicians working in rural areas.<br>**Institutional – policy networks**<br>• The Joint Management Committee provides a privileged role for physicians in policymaking about primary care<br>**Interests – societal interest groups**<br>• The OMA is caught between a desire for change among some of its members and a desire to retain the status quo among others<br>• Nurses and occasionally other professional groups are advocating for alternative-payment plans<br>**Ideas – knowledge or beliefs about "what is"**<br>• Concerns about shortages in primary-care physicians and a declining interest among physicians in a comprehensive model of primary care<br>**Ideas – knowledge and values combined**<br>• Long-standing perception that FFS remuneration (compared to alternative methods) creates the wrong incentives for primary care (e.g., a focus on services not value for money), which had been reinforced by many reports over the years<br>**External – release of major report**<br>• The Health Services Restructuring Commission report, which is published in December 1999 and endorsed by the Ontario College of Family Physicians and the new Coalition for Primary Health Care, argues strongly for replacing FFS remuneration of physicians with capitation payment for primary-care practices, which creates some legitimacy for less radical changes<br>**External – political change**<br>• The Progressive Conservative party is re-elected to a second term in June 1999 and one of their first orders of business in the health sector is to negotiate a new four-year agreement with the OMA, which is ratified by the OMA in May 2000 and which includes an allowance for the government to re-allocate money from the FFS pool of funds to alternative-remuneration methods if physicians volunteered to use these methods<br>**External – economic change**<br>• Relatively healthy public finances made it possible to offer significant financial returns to physicians who join a Family Health Network |

Table 7: Timeline of key events related to for-profit delivery of medically necessary services in Ontario

| Year | Event |
|---|---|
| 1989 | • Passage of Bill 147, Independent Health Facilities Act (IHFA). |
| 1996 | • Passage of Bill 26, Savings and Restructuring Act, which amends the IHFA<br>o Eliminates the preference for Canadian-owned, not-for-profit independent health facilities<br>o Enhances the power of the Minister of Health to designate new services and facilities under the Act. |
| 2002 | • Premier Ernie Eves' announces (as part of a budget announcement) that his government plans to allow MRIs and CT scanners in private clinics, and that these clinics will be able to provide both medically necessary (i.e., insured) and non-medically necessary (i.e., uninsured) streams of these services.<br>• Health Minister Tony Clement announces plans to provide up to 20 new MRI machines and five new CT scanners, which will be allowed to operate through existing independent health facilities.<br>• Regulation changes are made to allow provision of MRI and CT scanners outside of private not-for-profit hospitals.<br>• Ministry of Health and Long-Term Care issues a request for proposals for five new MRI and 5 new CT scanners.<br>• Passage of Bill 179, Government Efficiency Act, which amends the IHFA by removing the cap on the price of an IHF license, thereby giving IHF operators the opportunity to sell their facilities to the highest bidder. |
| 2003 | • Health Minister Tony Clement releases the names of three bidders who were selected to provide MRI and CT scans (KMH Cardiology and Diagnostic Centres, Kingston MRI. Inc., and DC Diagnostic Care Inc.). |

Table 8: Factors that influenced agendas and decisions related to for-profit delivery of medically necessary services in Ontario

| Agendas / decisions | Factors |
|---|---|
| Governmental agenda | **Problems**<br>• Release in late 1999 of the Fraser Institute's report about the numbers of CT and MRI scanners per capita in Canada compared to other OECD countries, which is then publicized by the Canadian Association of Radiologists (CAR) at a press conference in January 2000<br>• Ontario Association of Radiologists (OAR) surveys Ontario hospitals about their waiting times for a number of diagnostic procedures<br>• CAR and OAR identify shortfalls in technologists, not just machines |
| Decision agenda | **Problems**<br>• Same as for governmental agenda<br>• Ontario Health Coalition, physician groups, unions, women's groups and others highlight problems with waiting lists (as part of a general set of access problems that they trace back to hospital restructuring, movement of physiotherapy out of hospitals and therefore out from under the Canada Health Act, opening up of home care sector to for-profit contractors, and slowed rates of expenditure growth during the Harris years)<br>**Policies**<br>• Minor changes to the IHFA that allow for the provision of CT and MRI scanners in for-profit facilities and for both medically necessary (i.e., insured) and "non-necessary" (i.e., uninsured) services<br>**Politics**<br>• Eves elected party leader and he advocates "free market" values and specifically privatization of what previously been "publicly" delivered services, not just in health care but across a variety of sectors (e.g., electricity)<br>• Tony Clement, the newly appointed health minister, advocates the same values |
| Policy choice | **Institutions – policy legacies**<br>• Canada Health Act covers hospital-based and physician-provided services so services that can be provided outside of hospitals (and with no or partial roles for physicians) are no longer be bound by the Act's first-dollar, one-tier coverage<br>• Independent Health Facility Act covers private healthcare facilities that receive both a facility fee and a physician fee from government in return for providing 'medically necessary' services<br>**Interests – societal interest groups**<br>• The Ontario Association of Radiologists (OAR) lobby for more machines but they oppose "robbing Peter" (hospitals) of technologists "to pay Paul" (private providers)<br>• The Ontario Health Coalition, physician groups, unions, women's groups and others lobby for improved access to services generally<br>• The Ontario Health Coalition decries the large role for for-profit delivery (based on their literature review on the topic) in a 22-city campaign involving their own representatives as well as representatives of the Ontario Council of Hospital Unions and the Council of Canadians |

| | |
|---|---|
| | • The Ontario Hospital Association highlights the potential for poaching of staff, queue-jumping, and spill-over effects to the hospital sector (from over-diagnosis)<br>**Interests – elected officials**<br>• Premier and Health Minister express interest in pursuing more for-profit delivery of what had been publicly delivered services<br>**Ideas – views about "what ought to be"**<br>• "Free market" values and specifically privatization of what had previously been publicly delivered services, not just in health care but across a variety of sectors (e.g., electricity)<br>**External – political change**<br>• New Conservative party leader elected and becomes premier<br>• New health minister who wanted to make his mark<br>**External – technological change**<br>• New indications for CT and MRI scans |

Table 9: Timeline of key events related to waiting-list management for cardiac care in Ontario

| Year | Events |
| --- | --- |
| 1987 | • Reduction of approximately 200 residency positions over 5 years. |
| 1988 | • Creation of the Metropolitan Toronto Cardiovascular Triage and Registry Program.<br>• Investigation into cardiac surgery practices at St. Michael's hospital.<br>• Ontario Ministry of Health commits $18 million for the purposes of creating a cardiac centre at Sunnybrook Hospital in Toronto (and provides targeted financial support for other hospitals). |
| 1989 | • OMA launches an ad campaign about a crisis in the health care system.<br>• Media reports that two people died early in January 1989 because their surgery was cancelled (nine times for one patient and 11 times for the other).<br>• Media reports that Canadians were being sent to Ohio cardiac centres to receive heart surgery.<br>• Ministry establishes a multidisciplinary provincial working group on cardiovascular services (the Keon Committee) at least in part in response to the St. Michael's Hospital Report.<br>• Ministry announces new money for cardiovascular care (i.e., "…$250,000 for the province-wide working group on cardiovascular care, $160,000 for computerization of the Metropolitan Toronto Cardiovascular Triage and Registry Program, and $300,000 for the development of the registry province-wide." |
| 1990 | • Provincial Adult Cardiac Care Network is formed (and later renamed the Cardiac Care Network of Ontario). |

Table 10: Factors that influenced agendas and decisions related to waiting-list management for cardiac care in Ontario

| Agendas / decisions | Factors |
|---|---|
| Governmental agenda | **Problems**<br>• Patients are dying on waiting lists, with:<br>  o Immediate cause argued to be a lack of resources<br>  o Root causes argued to include: a) lack of a systems approach (e.g., surgeons with lists in their pockets); and b) competition among hospitals<br>  o Consequences of problem argued to be a decline in public confidence |
| Decision agenda | **Problems**<br>• Research shows that wait lists were growing<br>• Feedback shows that more money didn't have an effect:<br>  o Care isn't allocated on basis of need (i.e., lack of equity) with 'squeaky wheels getting the grease'<br>  o Hospitals not demonstrating high enough through-put (i.e., lack of efficiency)<br>**Policies**<br>• Metropolitan Toronto Triage System, which has the following attributes: 1) voluntary; 2) centralized; 3) focused on cardiac surgery; and d) independent of the provincial Ministry of Health and led by physicians<br>**Politics**<br>• Growing public concerns, which are causing political embarrassment to the Health Minister and the governing party more generally |
| Policy choice | **Institutions – policy legacies**<br>• Metropolitan Toronto Triage System (and St. Michael's Hospital report on it)<br>**Institutions – policy networks**<br>• Policy network first created through the Metropolitan Toronto Triage System and then through the Provincial Working Group on Cardiovascular Services<br>**Interests – societal interest groups**<br>• Cardiologists and cardiac surgeons<br>**Interests – elected officials**<br>• Health Minister seeking to reduce political harms arising from media coverage of deaths on waiting lists and, in the longer run, restore public confidence<br>**Ideas – knowledge or beliefs about "what is"**<br>• Beliefs regarding best solution, including research on risk score<br>**Ideas – views about "what ought to be"**<br>• Efficiency (i.e., needed to meet target volumes in throughput in a high cost area)<br>• Equity (i.e., needed to allocate on basis of need not "squeakiness of the wheel")<br>**External – media coverage** |

| | |
|---|---|
| | • Intense media coverage of deaths on waiting lists |

Table 11: Timeline of key events related to prescription-drug plans in Ontario

| Year | Event |
|---|---|
| 1973 | • Provincial government introduces the Ontario Drug Benefit (ODB) plan to provide prescription-drug coverage to low-income seniors and individuals on social assistance. |
| 1974 | • Provincial government extends ODB plan to all seniors regardless of their income. |
| 1992 | • Provincial government establishes the Drug Programs Reform Secretariat to reform provincial drug programs to make them more accessible to more Ontario residents, to improve the quality of prescribing, and to make the programs more affordable.<br>• Toronto lawyer launches a campaign to make "the most expensive drug in history" available and affordable for patients with Gaucher's disease.<br>• Drug Programs Reform Secretariat holds the first of 18 information forums with groups having a special interest in drug programs reform. |
| 1993 | • AIDS Action Now! (AAN) releases a videotape of James Thatcher, who died of AIDS shortly after the videotape was recorded, pleading for more funding for AIDS drugs.<br>• Federal government implements Bill C-91, giving full patent protection to pharmaceutical companies.<br>• Premier Bob Rae tells the media that his government is considering a plan to extend the ODB plan to low-income citizens.<br>• Ruth Grier, provincial health minister, announces the development of an online submission and adjudication process for the ODB plan. |
| 1994 | • AAN holds the first of four high-profile demonstrations to demand a catastrophic drug plan for individuals with life-threatening illnesses.<br>• AAN activists confront Premier Bob Rae privately and warn that he will be "…burned in effigy and his government denounced as uncaring…" in a large demonstration that was planned for World AIDS day [1 December 1994] unless a new drug plan is announced.<br>• Premier Bob Rae announces that the provincial government has decided to extend the ODB plan (with as yet unspecified cost-sharing arrangements) to include patients not already covered under the ODB plan or by private insurance. |
| 1995 | • Trillium Drug Program officially begins. |

Table 12: Factors that influenced agendas and decisions related to prescription-drug plans in Ontario

| Agendas / decisions | Factors |
|---|---|
| Governmental agenda | **Problems**<br>• Drug program expenditures growing exponentially, which was driven in part by the emergence of "break-through" drugs and the open-ended nature of the Special Drugs Program |
| Decision agenda | **Problems**<br>• Drug program expenditures were growing exponentially, which was driven in part by the emergence of "break-through" drugs and the open-ended nature of the special drugs program<br>• Consultation by the Drug Secretariat identified the unmet needs of those aged 55-64 who had no job or had lost their drug benefits at a time when the economy was in rough straits (although they had embarked on the consultation to get feedback on the idea of user charges for the ODB plan)<br>**Policies**<br>• Drug program that:<br>o extended the ODB plan to anyone paying an income-related sliding-scale deductible<br>o had no eligibility requirement linked to a particular illness (like AIDS or Gaucher's disease), health status (like end of life care) or drug class (like the drugs covered by the Special Drugs Programme)<br>o provided full-family access to the full Ontario Drug Benefits formulary (some of which required special approval to ensure indications were met)<br>**Politics**<br>• Emotionally charged campaign by AIDS Action Now!, which included a press conference with a plea from a dying AIDS patient and a threat to burn in effigy a mock-up of Bob Rae |
| Policy choice | **Institutions – policy legacies**<br>• Ontario Drug Benefit (ODB) plan, with a formulary and fully operational administrative process, was already in place<br>• HealthNet, which provided an online submission and adjudication process for the ODB plan, was already in place<br>**Interests – societal interest groups**<br>• Emotionally charged campaign by AIDS Action Now! (AAN), which included a press conference with a plea from a dying AIDS patient and a threat to burn in effigy a mock-up of Bob Rae<br>• Additional campaign by a Toronto lawyer with Gaucher's disease<br>**Interests – elected officials**<br>• Pending election (which was fought and won by another political party within seven months of the decision)<br>**Interests – public servants**<br>• Public servants who had identified an unmet need (those aged 55-64) and managed a program that worked (ODB plan)<br>**Ideas – knowledge or beliefs about "what is"**<br>• Drug program expenditures growing exponentially<br>• Unmet needs of those aged 55-64 who had no job or had lost their drug benefits at a time when the economy was in rough |

| | |
|---|---|
| | straits<br>**Ideas – views about "what about to be"**<br>• Equity across income groups, disease groups, and age groups<br>**External – economic change**<br>• Tough economic times so a free plan or even a small deductible weren't feasible policy options<br>**External – technological change**<br>• Development of "breakthrough" drugs for conditions like AIDS and Gaucher's disease<br>**External – new diseases**<br>• AIDS<br>**External – media coverage**<br>• Media coverage of AAN demonstrations |