Key messages for policymakers

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

. . .

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

Historical context

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

1) an early e ort (in 1945) failed to introduce a national health-insurance plan that would have covered many types of care for Ontarians (not

of which were preceded by Saskatchewan, in 1947 and 1962, respectively, and supported nancially by the federal government), however, hospitals remained independent and private not-for-pro t entities and physicians remained working in independent private practice;

3) hospital-care insurance and medical-care insurance were combined programmatically under the Ontario Health Insurance Plan (OHIP) in 1972, and OHIP is administered under the terms of the *Canada Health Act, 1984*, which combined separate pieces of federal legislation in 1984, formally banned any form of user fee for medically necessary hospital-based and physician-provided care, and led to an unsuccessful strike by Ontario's physicians;
4) the federal government began in 1995 to reduce its nancial support for the health system in Ontario (and in other provinces and territories), but dramatically increased its support through health accords in 2003 and 2004 in return for action in particular areas (e.g., wait times) and public reporting about progress;
5) the provincial government created Local Health Integration Networks in 2006 to plan, integrate and fund care (including hospital-based care) in their respective regions; and
6) the *Excellent Care for All Act, 2010* created an agency (Health Quality Ontario) and a set of mechanisms (e.g., mandatory Quality Improvement Plans) to support quality improvement in the health system.

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

Year	Jurisdiction	Milestone
1945	Canada	Government of Canada fails in its attempt to introduce a national health-insur-

Year	Jurisdiction	Milestone
1959	Ontario	Ontario Hospital Insurance Plan becomes the new name of the Ontario Hospital Services Commission (15)

Continued on next page

Year	Jurisdiction	Milestone
2000	Canada	First Ministers' Meeting Communiqué on Health con rms First Ministers' commitment to strengthening and renewing Canada's publicly funded healthcare services through partnership and collaboration, and outlines the vision, principles and action plan for health-system renewal (26)
		e action plan includes collaboration on speci c priorities such as access to care; health promotion and wellness; supply of physicians, nurses and other health personnel; home and community care; pharmaceuticals management; health information and communication technology; and health equipment and infrastructure (26)
2002	Canada	Standing Senate Committee on Social A airs, Science and Technology (Kirby committee) publishes its recommendations for reforming health systems in Canada (27)
		Commission on the Future of Health Care in Canada (Romanow commission) publishes its recommendations (28)
2003	Canada	First Ministers announce the First Ministers Accord on Healthcare Renewal (29)
		Health Council of Canada is established to monitor and report on progress of accord-related reforms (16)
2004	Canada	Government of Canada splits the Canada Health and Social Transfer into the Canada Health Transfer and the Canada Social Transfer.(16) First Ministers announce a 10-year plan to strengthen healthcare (16)
	Ontario	Government of Ontario passes the *Commitment to the Future of Medicare Act*,(30) which rea rms its commitment to the principles of the *Canada Health Act, 1984*
2005	Ontario	Government of Ontario, as part of its commitments related to the accord, publishes its Wait Time Strategy, which provides increased funding for hip and knee joint replacements, cataract, cardiac and cancer surgeries, and extended MRI hours of operation; and provides for the development of a 'wait times' website and a surgical registry for the ve key areas (31)
		Government of Ontario announces the creation of the Ministry of Health Promotion to focus on programs dedicated to healthy lifestyles (and to operate alongside the Ministry of Health and Long-Term Care), although this ministry was later re-absorbed into the Ministry of Health and Long-Term Care
2007	Canada	Federal, provincial and territorial governments, as part of their commitments to the accord, introduce the Patient Wait Times Guarantees initiative (31)
2007	Ontario	Government of Ontario passes the *Local Health Integration Act*,(32) which creates 14

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

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

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

Geographic and socio-demographic context

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

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

Sources: 43; 44

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

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

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

has been in Toronto's surrounding centres, particularly Brampton (61%), Vaughan (58%), and Markham (45%), which have required signi cant investments in infrastructure and a large in ow of health professionals.

ese main population centres frequently provide care to those living in rural communities, which are de ned as those with a population of less than 30,000 that are more than 30 minutes away from a community with a population of more than 30,000.(2)

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

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

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

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

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

Political context

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

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

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

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

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

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

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

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

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

Notable examples and their implications
Institutions (government structures)

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

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

Continued on next page

Economic context

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

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

In the 2014-15 scal year, the provincial government spent 43 cents of each dollar of revenue (not counting borrowing) on the health system ($

Economic indicator	Ontario			Canada
	2000	2010	2013	2013
Private-sector health spending2 (millions)	13,742	20,068	21,308	50,799
Private-sector health spending2 ($ per capita)	1,176	1,527	1,572	1,445
Private-sector health spending as a proportion of total health spending[2]	34%	32%	32%	29%

Sources: 14; 59; 61-71

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

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

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

Sources: 14; 72-74

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

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

Health status of the population

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

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

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

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

Sources: 77-79

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

	Ontario			Canada
	2000	2010	2011	2011
Mortality (and age-standardized rate per 100,000 population)				
Premature mortality[1]	33,789 (287.9)	33,474 (229.0)	33,231 (221.2)	

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

Source: 80

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

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

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

Source: 79

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

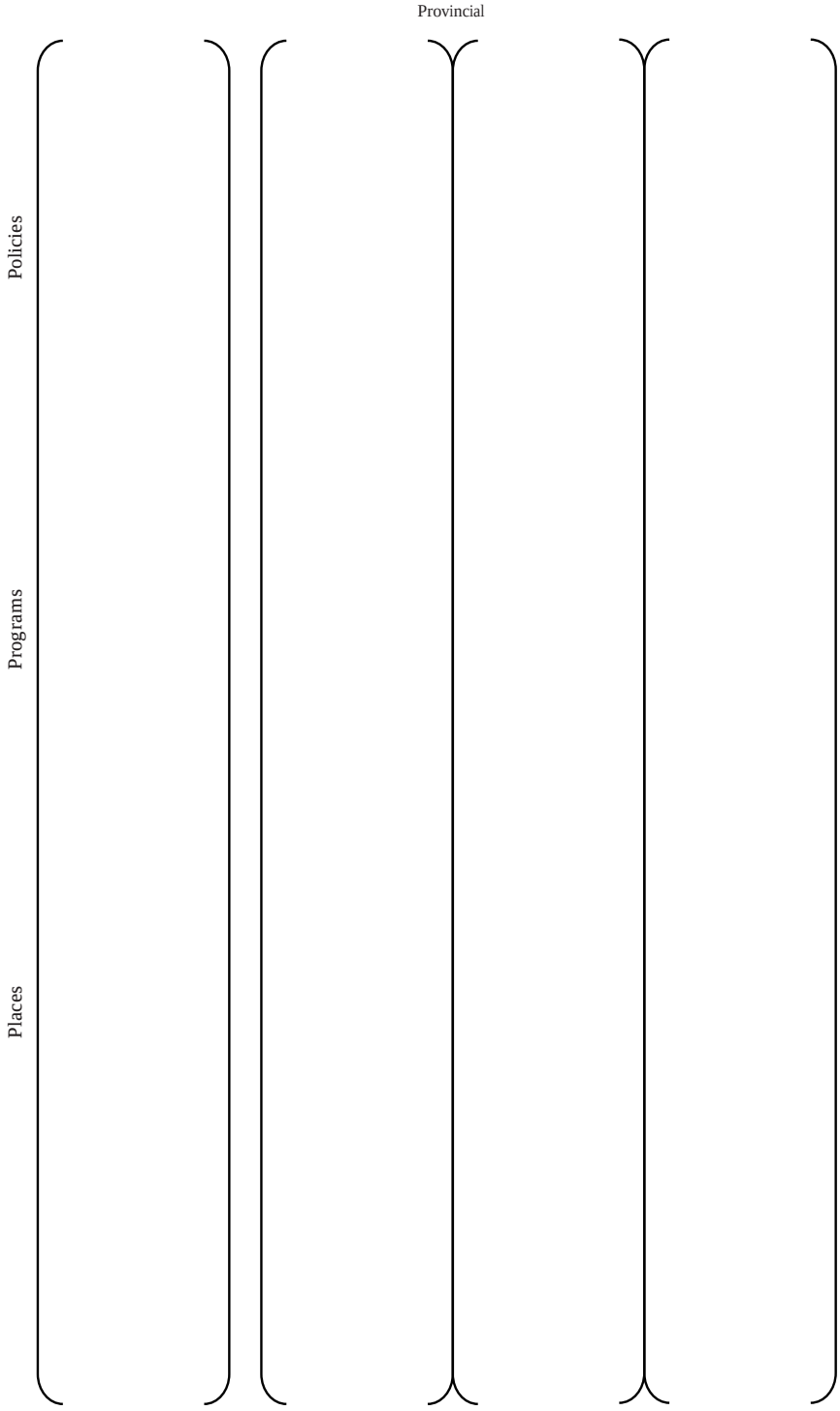
and the name of the country in the 'advanced search.' For example, Chapters 1-5 and 10-12 are broadly comparable to chapters appearing in these published or planned books, and the approach to providing Ontario data for the year 2000, year 2010 and the most recent year for which data are available, as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

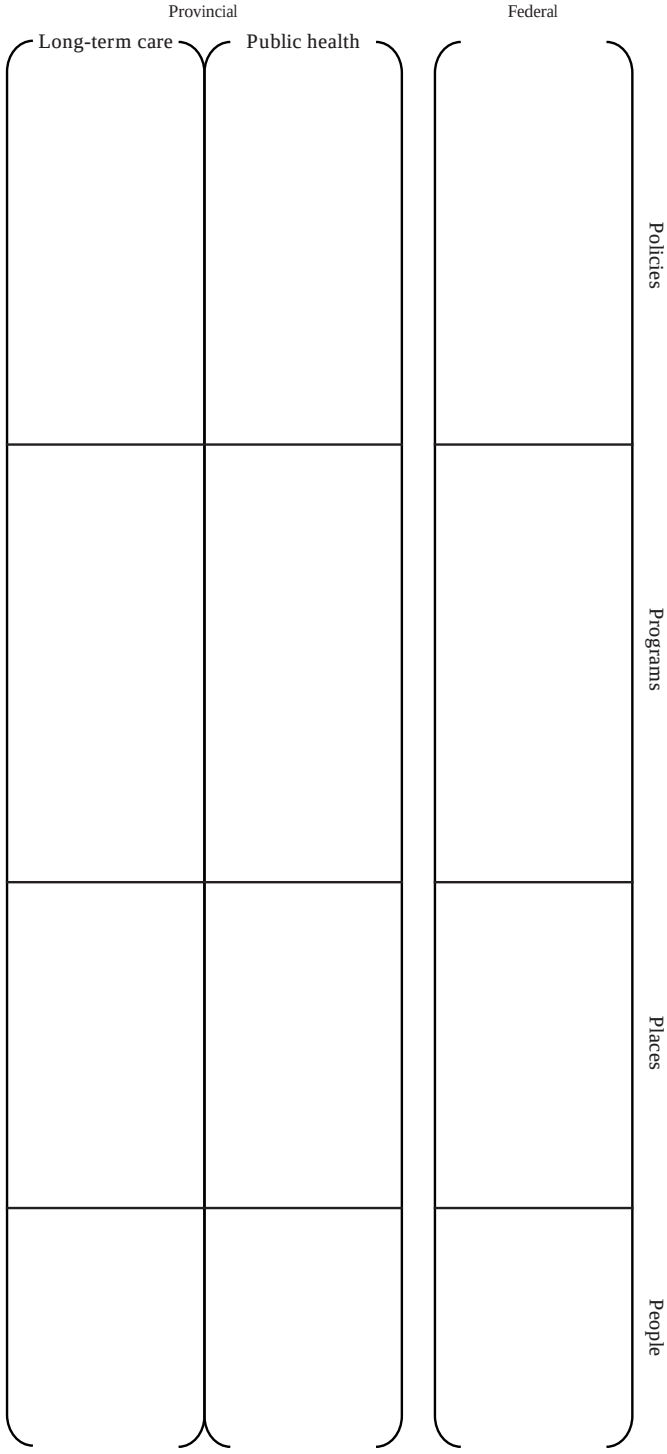
To facilitate comparisons over time, tables or gures that present nancial data for multiple years have been adjusted for in ation using Statistics Canada's Consumer Price Index (2002 = 100). Speci cally, we applied the Consumer Price Index for Ontario using the 'healthcare' component (e.g., 2002 = 100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

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

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

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





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

References

1. Ministry of Health and Long-Term Care. Patients rst: Action plan for health care. Toronto: Queen's Printer for Ontario; 2015. http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_patients rst.pdf (accessed 25 August 2016).
2. Ministry of Health and Long-Term Care. Rural and northern health care framework. Stage 1 report. Toronto: Queen's Printer for Ontario; 2011.
3. Statistics Canada. Immigration and ethnocultural diversity in Canada, catalogue no. 99-010-X2011001 (National Household Survey, 2011). Ottawa: Statistics Canada; 2013. http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.pdf (accessed 26 August 2016).
4. Statistics Canada. Canada year book 2012. Chapter 13: Ethnic diversity and immigration. Ottawa: Statistics Canada; 2012. http://www.statcan.gc.ca/pub/11-402-x/2012000/pdf/ethnic-ethnique-eng.pdf (accessed 24 August 2016).
5. Statistics Canada. Ontario (Code 35) (table). National Household Survey (NHS) Pro le. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004-XWE. Ottawa: Statistics Canada; 2013. https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E (accessed 26 August 2016).
6. Statistics Canada. Census program. Table 4 - Number of people and proportion of the population reporting French by selected language characteristic, New Brunswick and Ontario, 2006 and 2011. Ottawa: Statistics Canada; 2015. https://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-314-x/2011003/tbl/tbl3_1-4-eng.cfm (accessed 2 November 2016).
7. Statistics Canada. Table 202-0802 - Persons in low income families, annual, CANSIM (database). Ottawa: Statistics Canada; 2013. http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=2020802&&pattern=&stByVal=1&p1=1&p2=-1&tabMode=dataTable&csid= (accessed 25 August 2016).
8. Statistics Canada. Windsor, CMA, Ontario (Code 559) (table). National Household Survey (NHS) Pro le. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004-XWE. Ottawa: Statistics Canada; 2013. http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E (accessed 26 August 2016).
9. Statistics Canada. Labour force characteristics, seasonally adjusted, by province (monthly) (Quebec, Ontario, Manitoba). Ottawa: Statistics Canada; 2016. http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/lfss01b-eng.htm (accessed 24 August 2016).
10. Statistics Canada. Education in Canada: Attainment, eld of study and location of study. National Household Survey, 2011. Catalogue no. 99-012-X2011001. Ottawa: Statistics Canada; 2013. http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-012-x/99-012-x2011001-eng.pdf (accessed 26 August 2016).
11. Gildiner A. What's past is prologue: A historical-institutionalist analysis of public-private change in Ontario's rehabilitation health sector, 1985-1999 [PhD dissertation]. Toronto: University of Toronto; 2001.
12. World Bank. Health expenditure, public (% of total health expenditure). Washington: World Bank Group; 2015. http://data.worldbank.org/indicator/SH.XPD.PUBL (accessed 26 August 2016).
13. Statistics Canada. Table 102-0122 - Health-adjusted life expectancy, at birth and at age 65, by sex and income, Canada and provinces, occasional (years), CANSIM (database). Ottawa: Statistics Canada; 2012. http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1020122 (accessed 25 August 2016).
14. Statistics Canada. Table 326-0020 - Consumer Price Index, monthly (2002=100 unless otherwise noted), CANSIM (database). Ottawa: Statistics Canada; 2016. http://www5.statcan.gc.ca/cansim/a26?id=3260020 (accessed 24 August 2016).
15. Lavis JN, Arcus K, Forest P-G, Abelson J, Mendelsohn M. Commissioning a new political bargain for Canada's health-care system. Hamilton: Program in Policy Decision-Making; 2002.
16. Health Canada. Canada's health care system. Ottawa: Health Canada; 2014. http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php - a3 (accessed 25 August 2016).

25.

51. Parliament of Canada. Forty-second, party standings in the House of Commons. Ottawa: Parliament of Canada; 2015. http://

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

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

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

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

80.