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**Analysis of Actors and Discourse in the Amendment of
Ontario's *Regulated Health Professions Act, 1991*, to
Support Interprofessional Collaboration**

A thesis submitted to the Faculty of Graduate and Postdoctoral Studies in partial fulfillment
of the requirements for the degree of Master of Arts in Public Administration

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Abstract

Identifying how policy proposals are selected by policy-makers is an important question for scholars. This thesis evaluates the use of discourse and the role of actors in the exchange of ideas to support interprofessional collaboration (IPC) among Ontario's regulatory colleges. A variation of discourse analysis was developed, based on the seven areas of reality that are constructed by language, to evaluate the interactions between state and policy actors. I argue that actors did not appear to engage in meaningful discourse because the state established the parameters of the consultative processes, which suggests the expert consultative processes were tools to legitimize the policy process for Bill 179. The state appears to have increasingly greater control of both the content and context of policy-making in this field. Further evaluation of the interactions between health professional organizations and the state is needed to better understand the importance of discourse in the health policy process.

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Acronyms

AOM	Association of Ontario Midwives
BDDT-N	Board of Directors of Drugless Therapy - Naturopathy
CDHO	College of Dental Hygienists of Ontario
CFPC	College of Family Physicians of Canada
CMA	Canadian Medical Association
CMO	College of Midwives of Ontario
CMRTO	College of Medical Radiation Technologists of Ontario
CNO	College of Nurses of Ontario
CPO	College of Physiotherapists of Ontario
CPSO	College of Physician and Surgeons of Ontario
CSDMS	Canadian Society of Diagnostic Medical Sonographers
DI	Discursive institutionalism
EHR	Electronic health records
FHRCO	Federation of Health Regulatory Colleges of Ontario
FHT	Family Health Team
HI	Historical institutionalism
HPLR	Health Professions Legislation Review
HPRAC	Health Professions Regulatory Advisory Council
IPC	Interprofessional collaboration
IPE	Interprofessional education
MOHLTC	Ministry of Health and Long-Term Care
MRT	Medical radiation technologists
NP	Nurse practitioner
NPAO	Nurse Practitioners' Association of Ontario
OAMRT	Ontario Association of Medical Radiation Technologists
OAND	Ontario Association of Naturopathic Doctors
OCFP	Ontario College of Family Physicians
OCP	Ontario College of Pharmacists
ODA	Ontario Dental Association
OMA	Ontario Medical Association
OPA	Ontario Pharmacists' Association
OPhA	Ontario Physiotherapist Association
OSDMS	Ontario Society of Diagnostic Medical Sonographers
RCDSO	Royal College of Dental Surgeons of Ontario
RCPSC	Royal College of Physicians and Surgeons of Canada
RHPA	Regulated Health Professions Act, 1991
RI	Rational-choice institutionalism
RNAO	Registered Nurses Association of Ontario
SI	Sociological institutionalism

1 Introduction

Public policy is a constant struggle among actors over ideas and ideals (Fischer & Gottweis, 2012; Stone, 2012). Health policy is no exception. The Canadian health care system was built upon the values of Canadians and it is an area that most politicians consider sacrosanct; any considerable change that could alter the basic principles of this system would risk shortening the careers of politicians (Simpson, 2012). A significant amount of time and resources have been invested in the debate about the potential methods to reform and fund the Canadian health care system. Additionally, since the late 1990s, both federal and provincial governments have established numerous commissions and advisory committees to assess and to recommend methods to fix or reform the Canadian health care system (Marchildon, 2012). The outcome of these debates and government initiatives have led to multiple, and often conflicting, recommendations that have produced policy confusion. Mendehlsohn (2012) argues that there are too many proposed initiatives or strategies under review to allow meaningful health care reform, yet new proposals are constantly emerging.

Scholars (see Fischer & Gottweis, 2012; Kingdon, 2011; Stone, 2012) have struggled to determine how proposals and alternatives emerge in the policy arena and how one proposal or alternative is selected over others. This question continues to be important to public policy scholars because the factors that influence the policy process are constantly changing and can differ from one situation to another. It is important to continually evaluate these factors, particularly the evolving relationship between the state and policy actors, because argumentation and discourse that occur between and among these actors have been recognized as a crucial component of the policy process (Fischer & Gottweis, 2012). For the purpose of this thesis, policy actors will be defined as individuals or groups without formal

government positions that seek to influence the creation and implementation of public policies (Smith, 2005; Kingdon, 2011; Young & Everitt, 2004). On the other hand, state actors hold formal government positions. These discursive interactions between both groups facilitate the exchange of proposals and/or alternatives. Who participates in the discourse, when, how, and why matters to the policy process because the discursive interaction can influence which proposal and/or alternative is selected to address the policy issue.

The purpose of this thesis is to gauge the importance of the discursive interactions between state and policy actors in shaping health policy. To accomplish this task, this thesis will evaluate a particular case in the province of Ontario: the amendment of the *Regulated Health Professions Act, 1991* (RHPA) to facilitate and support interprofessional collaboration (IPC) among Ontario's regulatory colleges. These amendments led to the development of *Bill 179, The Regulated Health Professions Statute Law Amendment Act, 2009* (herein referred to as Bill 179), which represented a significant commitment on the part of the Ministry of Health and Long-Term Care (MOHLTC) to support a particular initiative that had been cited by many scholars as a possible framework to improve the delivery of health services.

The justification to analyze this case was threefold. First, I wanted further my knowledge on health policy; I have a strong understanding of the Canadian health care system but my undergraduate studies offered little exposure to health policy. As a research assistant, I was introduced to the literature that supported the implementation of IPC in the delivery of health services. While there was a substantial amount of research available on the benefits and barriers of this delivery model, there was little information on how or why IPC became prevalent in the health reform debate. As previously stated, the concept of IPC is not new, thus, analysis of this case may identify how an idea, that had been floating around for

over a century (Baldwin, 2007), was finally able to capture the attention of policy makers. Second, health policy is a complex and interesting political arena where any one decision can have a significant impact on any, or all, of the four levels of health policy: systematic (i.e. shape of the system), programmatic (i.e. the nature of health care programmes), organizational (i.e. use and allocation of resources), and instrumental (i.e. management of health human resources). As such, there is a high degree of interrelatedness within health policy (Barker, 1996), which makes for an interesting case to analyze the factors that may influence the policy process. Third, the MOHLTC has made notable progress in implementing IPC models in the delivery of health services. As such, it is expected that there will be a considerable amount of documented information available to study the policy process as it relates to IPC.

The remainder of this chapter will provide background information on issues relevant to the case study examined here. First, it will evaluate the organization of the delivery of health services in Ontario, with a particular focus on the site of care and the regulation of health care professions. Then, it will provide a brief discussion of IPC. This chapter will demonstrate how previous decisions shaped the existing health care system and contributed to the challenges inherent in the system. This background information will be important in understanding and answering the research question of this thesis (section 1.2).

1.1 Understanding Health Care and Health Policy in Ontario

Institutionalization of Health Care: Organizing the Delivery of Health Services

A common misconception of the Canadian health care system is that it is a single, uniform system across the nation. In fact, the health care system is actually composed of 14 different health care regimes because of the division of legislative powers outlined in the

British North American Act (the BNA Act), 1987¹. Each province and territory is responsible for the delivery of health services within its own jurisdiction, while the federal government provides direct health services to certain population groups (i.e. the Canadian Forces, Aboriginal populations, inmates, refugees, etc.). Provinces must adhere to a set of criteria and conditions, outlined by the *Canadian Health Act, 1984*, to receive federal cash contributions under the Canadian Health Transfer² (Marchildon, 2007). This arrangement allows provinces or territories to tailor health services to the needs of their population while maintaining a basic level of care across the nation.

The existing health care system in Ontario is the result of more than 50 years of argumentation and deliberation between state and policy actors. There were significant challenges in the initial development of a national health insurance program in Canada due to varying opinions among political leaders about the details of an insurance program (Taylor, 2009). As such, policy-makers concentrated their efforts on institutionalizing health care within acute-care hospitals (Armstrong & Armstrong, 2003).

There were several reasons why health services were concentrated in acute-care hospitals. In the early 1900s, health care practitioners working in hospital-based institutions were systematically offered better scientific knowledge (Armstrong & Armstrong, 2003) and better informed of new developments in their field. Thus, hospitals had better reputations and developed more effective treatments for illnesses compared to other health care

¹ At the time of Confederation, governments focused little on health care because it was considered to be a private matter (Naylor, 1986); hospitals were built and run by private organizations, primarily churches and charitable bodies, and revenue was collected through fees paid by patients and their families (Armstrong & Armstrong, 2003; Naylor, 1986; Taylor, 2009). The BNA Act assigned the exclusive powers to make any laws respecting the establishment, maintenance, and management of health care institutions. Health care became largely a provincial/territorial matter, while the federal government held most of the taxation powers (Armstrong & Armstrong, 2003; Marchildon, 2007).

² CHT transfer payments are made on an equal per capita basis, and include both cash and tax point transfers; cash levels are set in legislation by the federal government.

institutions or home visits made by physicians. In addition, the surgical and diagnostic tools needed to perform many of the new diagnostic services essential to treating acute illnesses, as well as access to antibiotics and other drugs, were located in hospitals because they required specific skills, considerable space, and were expensive to own and operate within private (individual) practices. As such, both physicians and nurses offered more of their services in hospitals (Armstrong & Armstrong, 2003; Taylor, 2009).

Regulating Health Professionals in Ontario: The “Umbrella” Framework

The concept of self-regulation has been a fundamental characteristic of health care professionals in Ontario since the late 1860s (O’Reilly, 2000). The medical profession advocated for the regulation of its profession to protect the public interest from fraudulent health care providers, but the Government of Ontario had little interest in managing health care professions; at the time, many held the belief that there should be minimal state interference in the enhancement of public welfare, including health care. However, the Government of Ontario believed that the medical profession had the technical knowledge to govern all health professions (Hamowy, 1984; O’Reilly, 2000) and allowed the regulation of health professionals through the establishment of a medical board, composed primarily of physicians, to govern the five main health professions at the time: physicians, surgeons, nurses, pharmacists, and dentists (O’Reilly, 2000). The board was delegated the task of establishing the requirements for licensure, certification, and registration of these professions. It is termed “self-regulation” because the province chose to delegate its authority to regulate the delivery of health services to another group, in this case the professions (Aldridge, 2008). Further developments in the organization of health professions did not occur, however, until the 1960s. At this time, technological advances and further

understanding of the human body triggered the emergence of a wide range of health care practices, including technologists who could operate the new medical instruments and health providers who used specialized techniques, such as spinal manipulation and muscle massage, to deliver health services (Aldridge, 2008; O'Reilly, 2000).

It was also around this time that the notion of using self-regulation to protect the public from fraudulent health providers had evolved into “turf wars” between the medical profession and other health professions, such as nurses, chiropractors, pharmacists, etc. (Aldridge, 2008; Coburn, 2006; O'Reilly, 2000; Willis, 2006). Prior to the 1960s, physicians enjoyed a high degree of dominance over other professions because the general management of care was largely within the scope of practice of medicine. Self-regulation allowed the medical profession to legislatively define an exclusive scope of practice for their members, as well as the members of other health professions. As such, the medical profession was able to make decisions about who delivered care, and how, which could be viewed as a powerful source for political influence in health care (Aldridge, 2008). This monopoly over the delivery of health services permitted the medical profession to resist the entry of newer professional groups and, ultimately, maintain their dominance over all health professions. In addition, this dominance over other health professions was reinforced by the fact that they had a strong relationship with the provincial government and legislatures (Coburn, 2006; Tuohy, 1999) that transcends issues related to the scopes of practice; they are frequently consulted for their expertise on all matters related to health. Thus, the medical profession had a high level of influence in the development of a health care system and insurance plan. Relinquishing any part of the scopes of practice of the medical profession would, theoretically, weaken their political influence.

By the mid-1970s, the public began to question the privileges afforded to the medical profession. The issue of public accountability, in particular, received significant media attention after the College of Physicians and Surgeons of Ontario refused the government's request that physicians who used extra billing provide advance notice to the public³ (Aldridge, 2008). In addition, emerging reports began to recommend alternative forms of health care that deviated from the traditional way in which physicians delivered care (O'Reilly, 2000). The culmination of these events reminded the public of the significant medical dominance inherent in the province's health care system, which raised concerns about the ability of the medical profession to protect the public's interest (Aldridge, 2008). As such, the professions previously dominated by the medical profession (i.e. nurses, pharmacists, and dentists) were able to distance themselves from the influence of the medical profession by obtaining the authority to regulate their own members (Naylor, 1986; O'Reilly, 2000) through the *Health Disciplines Act, 1974* (Geekie, 1975). At the same time, this piece of legislation allowed the government to more directly govern health professions (Geekie, 1975), which further diminished the medical profession's influence in the political arena to a certain extent. The profession's pre-existing relationship with the government still allowed it to enjoy significant influence on the development of health policies and the role of other health professions, however (Naylor, 1986; O'Reilly, 2000).

By the 1980s, there was significant interest in restructuring the province's health professions legislation which had created, essentially, a hierarchical relationship between physicians and other professions. Political leaders were concerned about the quality and cost-effectiveness of services, unwarranted upgrading of qualification of established professions, the sudden proliferation of new health care occupations, and a lack of regulation

³ This event occurred prior to the implementation of the Canada Health Act.

in the qualifications of those new health care occupations (Health Professions Legislation Review [HPLR], 1989; Leslie, 2012; O'Reilly, 2000). In 1982, the Health Minister announced that a review would be completed by an external team under the direction of Allan Schwartz, a Toronto lawyer who had, on occasion, acted as a policy advisor to the Minister of Health (O'Reilly, 2000). The Health Professions Legislation Review (HPLR) was mandated to provide recommendations in the form of draft legislation, which would: (1) identify which health professions should be regulated or de-regulated; (2) develop a new legislative structure to govern health professions; and (3) settle outstanding issues in several professions (HPLR, 1989; O'Reilly, 2000). The final report maintained the value of using a self-regulatory framework for Ontario's health care providers. Self-regulation was preferred because the review committee believed it directed both the nature and the quality of health services (HPLR, 1989; Leslie, 2012), compared to other available mechanisms.

The HPLR proposed draft legislation with a unique model for the regulation of health professions in Canada, a model that is still in use in Ontario. Often called the "umbrella" framework, it uses two layers of legislation. The first consists of a common statute that applies to all professions (i.e. internal organizational structure of regulatory bodies). The second consists of statutes that govern distinct professions by legislating their scope of practice statement, which describes the general role of the profession, the methods it uses to deliver services, as well as any authorized or controlled acts that the profession may be able to perform (Aldridge, 2008; Epps, 2011; Federation of Health Regulatory Colleges of Ontario [FHRCO], n.d.). In addition, the HPLR recommended the establishment of the Health Professions Regulatory Advisory Council [HPRAC] and regulatory colleges to govern the members of each regulated health profession (HPLR, 1989; O'Reilly, 2000; RHPA, 1991).

The purpose of HPRAC is to continually evaluate the regulation of health professions, provide recommendations for amendments to the RHPA, and advise the Minister of Health (at the request of the Minister) on any matter related to the regulation of the health professions (HPRAC, 2009). Every year, a number of professions are reviewed to determine if they should be regulated under the RHPA. A key component of their recommendations and advice is to conduct consultations with the affected health professions. HPRAC will organize forums to discuss the Minister's request and invite all interested stakeholders, including health professions, to provide a written submission of their views and perspectives on the regulatory issue. As a result, this process allows stakeholders an important venue to shape the policies and their outcomes as it relates to the regulation of health care professions.

In contrast, the regulatory colleges are mandated by the RHPA to regulate health professionals in the public's interest. They are responsible for ensuring patient safety and quality care by:

- “Setting and enforcing standards and guidelines for the practise and conduct of their members;
- Making sure that regulated health professionals meet their training and educational standards before they can practise or use a professional title;
- Developing programs to help members continually improve their skills and knowledge, upholding the quality of care; and
- Acting when you have a concern about your health care.” (FHRCO, n.d)

Most regulatory colleges also support the interests of their members by advocating on their behalf in consultations with the HPRAC, MOHLTC, or the Government of Ontario. At this time, 27 professions are regulated in Ontario by the RHPA and their individual Acts (Table 1-1).

There are several advantages of this self-regulatory framework (Epps, 2011). First, regulatory bodies have more expertise and the technical knowledge in their area of practice (in comparison to the state or independent agencies) to govern individual health care

providers. As such, they are better able to appreciate the profession's practice while ensuring conduct is in the patient's best interest. Second, administrative costs with respect to the development and interpretation of standards, monitoring, and enforcement of a profession are internalized and more efficient through the regulatory bodies. Third, there is greater flexibility in amending the regulations that govern health care professions because of the "umbrella" framework. Depending on the nature of the amendment, changes can be made to the general statute, the statutes of the affected professions, or both. Finally, standards of practice can be raised because self-regulatory bodies require particular ethical standards of conduct on the part of their members. Thus, this framework allows for "flexible" regulation of the growing number of health occupations emerging in Ontario's health care system.

Audiologists and Speech-Language Pathology Act, 1991	Medicine Act, 1991
Chiropractic Act, 1991	Midwifery Act, 1991
Chiropractic Act, 1991	Naturopathy Act, 2007**
Dental Hygiene Act, 1991	Nursing Act, 1991
Dental Technology Act, 1991	Occupational Therapy Act, 1991
Dentistry Act, 1991	Opticianry Act, 1991
Denturism Act, 1991	Optometry Act, 1991
Dietetics Act, 1991	Pharmacy Act, 1991
Homeopathy Act, 2007**	Physiotherapy Act, 1991
Kinesiology Act, 2007	Psychology Act, 1991
Massage Therapy Act, 1991	Psychotherapy Act, 2007**
Medical Laboratory Technology Act, 1991	Respiratory Therapy Act, 1991
Medical Radiation Technology Act, 1991	Traditional Chinese Medicine Act, 2006

***Regulatory college under transition*

Table 1-1: Individual Acts governing the Regulated Health Professions in Ontario (FHRCO, n.d.)

Shifting from Acute to Chronic Care: The Rationale for Team-Based Care

Hospitals are still a key institutional feature of Ontario's health care system but the changing nature of disease and illness in the population is putting significant pressure on the existing system, which is intended to provide acute care (Rachlis, 2012; Mendehlsohn, 2012). Recently, the Canadian population has become increasingly concerned about the

sustainability of their health care system in the wake of an aging population and the prevalence of chronic diseases that have become complex (Health Care Innovation Working Group [HCIWG], 2012; Romanow, 2002; Soroka, 2011). Patients often require multiple health care providers to address their complex health care needs (Xyrichis & Lowton, 2008; HCIWG, 2012), many of which are not being met by the existing health care system (Rachlis, 2012). In addition, many patients have expressed a heightened desire to obtain care within the community or at home, particularly those with complex, chronic conditions (HCIWG, 2012; Hildebrandt, 2013). More services are being delivered outside of the hospital (i.e. in the community and at home) to better address the needs of patients but considerable more work is required to ensure that services can be sustained in these alternative sites of care (Rachlis, 2012; Mendehlsohn, 2012). As a result, there has been significant debate about the best approach to adapt the current health care system to achieve this goal (MacKinnon, 2013), such as the implementation of team-based care models. According to various scholars and stakeholders, team-based care can improve patient outcomes, increase access to care, provide a more holistic approach for chronic disease management, and improve the supply and distribution of health care providers (Alberto & Hearth, 2009; Bridges, et al. 2011; CHSRF, 2012; Durier-Copp & Wranik, 2007; Hall, 2005; HCIWG, 2012; Romanow, 2002; Van, et al 2012; Xyrichis & Lowton, 2008).

In the early 2000s, a series of reports called for an action plan that would initiate health care reform by encouraging collaborative strategies for the delivery of health services through team-based care (CHSRF, 2006; HCIWG, 2012; Interprofessional Care Strategic Committee [ICSC], 2007; Romanow, 2002). The *2003 First Ministers' Health Accord* and the *2004 10-Year Plan to Strengthen Health Care* outlined the First Ministers' commitment to accelerate these collaborative strategies by ensuring funding and the appropriate planning

and management of health human resources (Health Canada, 2006a, 2006b). The 2004 Plan continued to accelerate the planning and management of health human resources and identified the “...need to foster closer collaboration among health, post-secondary education and labour market sectors.” (Health Canada, 2006b, par. 13)

Recently, there has been considerable emphasis to implement IPC models of care within hospital and community setting, yet scholars have documented this formalized type of team-based care since the early 1900s (Baldwin, 2007). The enthusiasm for IPC has come and gone in waves over the last century but has gained tremendous momentum in recent years through government support and increased awareness among patients, family members, and health care professionals (Solomon, 2010). “What is new is an emphasis on policy change and the call for a fundamental change in the way we do business—a change in culture.” (Solomon, 2010, p. 48)

An array of IPC models has emerged in this literature (CHSRF, 2012), including some that are led by nurses. However, there still is no agreement on a standard definition for IPC; this has created uncertainty with regard to the competencies required for IPC (Canadian Interprofessional Health Collaborative [CIHC], 2010). Quite often, the term IPC is interchanged with many other team-based care terms including: multidisciplinary; interdisciplinary; multi-professional; and collaborative practice. But all these terms share the idea that patients are directly involved in their treatment plan and are viewed as members of that health team. This thesis will continue to use the term “IPC” because of its prevalence in the literature and as it is used explicitly in Bill 179.

The Interprofessional Care Strategic Implementation Committee [ICSIC] (2010) uses the term interprofessional care, which they define as “the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality

care within and across settings.” (ICSIC, 2010, p. 1) This definition has also been adopted by the Health Professions Regulatory Advisory Council [HPRAC], but it acknowledges that interprofessional care is a much narrower concept in comparison to IPC. Interprofessional care takes place at the clinical level and focuses on developing teamwork among health professionals from different disciplines, working together to provide optimal and quality patient-centred care. IPC refers to the cooperation among health professionals, as well as the regulatory colleges of which they are members, to achieve interprofessional care. As such, IPC takes place at the regulatory level, as well as at the clinical level (HPRAC, 2009).

IPC is expected to expand the traditional composition of health care teams by transcending the idea that the roles and identities of individual health care professions are “prescribed”; instead, these roles and identities are negotiated and assigned by the team. Team members are expected to share knowledge and resources, such as tools, methods, and procedures; social care providers, patients, and family members are also expected to share as team members (Alberto & Herth, 2009). However, the previously mentioned definitions continue to overlook these alternative team members. Barr, et al., provide a definition that does address this element but not some of the key features in the previous definitions. They define IPC as “... an active relationship between two or more health or social care professions who work together to solve problems or provide services.” (Barr, et al. 2005, in Zwarenstein & Reeves, 2006, p. 48) On the other hand, many scholars are beginning to accept the definition provided by the Canadian Interprofessional Health Collaborative [CIHC] (Bridges, et al., 2011), which defines IPC as a “... partnership between a team of health providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues.” (CIHC, 2010, p. 24) Thus, no one definition has been able to capture the nature of IPC. For the purpose of this thesis, I will use

the definition provided by the ICSIC and adopted by the HPRAC with the assumptions that IPC occurs among health and social care professions at both the regulatory and clinical level, and includes the participation of patients and family members as key members of the interprofessional team (IPT).

The literature dedicates significant attention to identifying the benefits of IPC for both patients and health care providers. However, the literature also identifies many barriers that might prevent the implementation and practice of IPC. Table 1-1 summarizes the benefits and barriers in four categories: organisational; team; health care providers; and patient and family members (adapted from Mickan, Hoffman & Nasmith, 2010). Few studies have been able to draw inferences on the effectiveness of IPC (Zwarenstein, Goldman & Reeves, 2009; Zwarenstein & Reeves, 2006), but systematic reviews of the literature demonstrate an overall positive experience for all those involved with IPTs and improved access and quality of health services to patients (Zwarenstein & Reeves, 2006). Studies have identified benefits for both the patient and health practitioners (Table 1-2) when IPTs were effective (Bandali, Zhu & Gamble, 2011; Barr, 1998; Cromer, Hojat, Peker & Aprile, 2009; Dobson, et al., 2006; Dolovich, et al., 2008; Gilbert, Yan & Hoffman, 2010; Goldman, et al., 2010; Grumbach & Bodenheimer, 2004; McLean, 2008; Sommers, et al., 2000, Van, et al., 2012). As such, these studies have called for further work to ensure the effective implementation of IPC models within the existing health care system. In particular, scholars have called for a review of the legislation and regulations governing Canadian health professions to facilitate IPC (Conference Board of Canada, 2007; Grimes & Tholl, 2010; Health Professions Regulatory Advisory Council [HPRAC], 2006; ICSC, 2007; Lahey & Currie, 2005). As discussed in the following section, scholars have identified significant barriers to IPC that result from the legislation and regulations of health care professions.

IPC	Benefits	Barriers
Organizational	<ul style="list-style-type: none"> - Improved coordination of health services and HHR; - Reduce hospitalisation and costs; - Decreased length of stay; - Better management of resources (i.e. medication and HHR); - Reductions in the frequency of diagnostic testing; - Improved access to services and specialists; decrease wait times; - Ability to treat a greater number of patients; and - Continuing care across the health care settings. 	<ul style="list-style-type: none"> - Education: <ul style="list-style-type: none"> - Implementing IPE⁴ into existing curriculum; - Administrative resistance to new programs; - Time constraints; - Matching academic schedules and student skills levels across professions; - Economic, legislative and regulatory implications; and - Difficulties in altering current hospital practices and policies.
Team	<ul style="list-style-type: none"> - Greater understanding of roles and responsibilities; - Increased contact with one another; greater willingness to seek a second opinion; - Positive interactions with patients, family members, and other health care providers. - Greater amount of respect and trust; and - More innovation: willingness to investigate new practices/options. 	<ul style="list-style-type: none"> - Ineffective teams have poor communication; - ‘Turf-guarding’ and role ambiguity resulting from overlapping scopes of practice; - Traditional professional hierarchy and medical dominance; and - Implications of job turnover, particularly in community settings;
Health care provider	<ul style="list-style-type: none"> - Improved job satisfaction and enhances well-being; - Greater role clarity; - More manageable case load; - Less stress and greater sense of fulfillment 	<ul style="list-style-type: none"> - Need further training, certification, and accreditation requirements; - Professional and cultural beliefs, attitudes, and language; and - Professional regulations/legislations.
Patients and family members	<ul style="list-style-type: none"> - Improved patient outcomes and overall health; - Better acceptance of treatment plan; and - Chronic illness: fewer symptoms, reduced number of clinic and hospital visits. 	<ul style="list-style-type: none"> - Continued reliance on physician expertise.

Table 1-2: The benefits and barriers to IPC

(Dewa, Carmen, Guscott & Anderson, 2009; Dobson, et al., 2006; Freeth, et al., 2005; Gilbert, 2005a, 2005b; Goldman, et al., 2010; Grimes & Tholl, 2010; Grumbach & Bodenheimer, 2004; Hall, 2005; Krass, et al., 2007; McDonough & Doucette, 2001; McLean, et al., 2008; Mickan, Hoffman & Nasmith, 2010; Pecukonis, Doyle & Bliss, 2008; Reader, Flin & Cuthbertson, 2007; Reeves, et al., 2009; Sommers, et al., 2000; Tsuyuki, et al., 2002; Xyrichis & Lowton, 2008).

⁴ Interprofessional education (IPE) occurs “when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (Centre for the Advancement of Interprofessional Education [CAIPE], 2012).

Regulatory Colleges and Professional Associations as Interest Groups

Since the initial professionalization of medicine in the 1860s, there has been a strong and interdependent relationship between the state and health professions; policy-makers do not generally have the expertise or technical knowledge to develop policies that would result in the desired policy outcome in health care, let alone govern individual health care providers. This relationship has yielded a unique consultation process that is reserved for the state and members of health professional organizations⁵; these consultations are mediated by HPRAC, at the request of the Minister of Health. Before I continue the discussion on the consultative processes between the state and health professional organizations, I will explain the purpose of collective action in the policy arena.

Collective action is defined as the behaviors and actions of a group to reach a common goal (Smith, 2005); collective action involves an array of different actors, including pressure groups, interest groups, social movements, and advocacy groups. According to Pross (1992), pressure groups have four main characteristics. They are: (1) formally organized; (2) able to articulate and aggregate common interests; (3) willing to act in the political system; and (4) desire to influence those who have power rather than exercise that power (Pross, 1992; Young & Everitt, 2004). Pressure groups are "... important in offering different venues for citizens to shape political debate and policy outcomes." (Smith, 2005, p. 9) The difference between pressure and interest groups is that the latter conveys a sense of general, non-political activities. On the other hand, some scholars prefer the term "advocacy groups" because "...it encompasses groups acting for the best interest of members as well as groups acting to promote their opinions on an issue in which they do not have a direct interest."

⁵ This thesis defines a health professional organization as a group composed of members from a distinct health profession that seeks to promote the interests of the public or health profession. This includes regulatory colleges and professional associations.

(Young & Everitt, 2004, p. 5) For the purpose of this thesis, I will continue to use the term “interest groups” because it includes a broader range of groups (does not limit the definition to groups that seek political activities) and is most commonly used in the literature.

In the case of health professions in Ontario, the umbrella framework of the RHPA organized each profession into interest groups by delegating regulatory bodies to govern the members of that profession. Because these groups are established through legislation, they are (theoretically) expected to represent the public’s interests in all matters related to the regulation of that profession⁶. On the other hand, each profession has established a non-profit professional association that represents the profession’s interests. Most associations have representation at the federal and provincial levels of government (because of the different jurisdictions in Canada’s health care system) that work to address these interests.

Interestingly, beyond the general literature on interest groups in the policy process, few scholars have evaluated the relationship of health professional organizations and the state, and the implications of these relationships in the health policy process. Studies completed by Coburn (1993), Coburn, Rappolt & Bourgeault (1997), and O’Reilly (2000) have identified a significant change in the dynamics of these relationships in the health policy process. They demonstrate that the self-regulation of other health professions has removed the need of the medical profession’s “intermediary role” between the state and other health professions, which has contributed to the decline of medical dominance in health. Instead, Coburn, Rappolt & Bourgeault (1997) and O’Reilly (2000) argue that the Government of Ontario is increasingly controlling both the context and content of medical care. More importantly,

⁶ According to Pross (1992), with this arrangement, “...the state acknowledges ‘the political need to afford a measure of autonomy to those whose activities have been brought within the scope of the law’, and admits that the state lacks the administrative capacity to ‘fine tune’ the relations between a professional group and the public.” (p. 4)

these studies have determined that health professional organizations have become more complex in their mandate. They are required to support not only their members, but are also expected to take into account the public interest (Coburn, 1993). In other words, the line that separates regulatory colleges from professional associations has become blurred.

1.2 Research Question and Potential Contributions

It is important to note that this thesis will not evaluate the effectiveness, benefits, or barriers of IPC. Other studies have already extensively studied this area of IPC. Instead, this thesis will focus on the discursive interactions between the state and policy actors, which led to the amendments of the RHPA to support IPC. Health professional organizations are usually the main policy actors in the discursive interactions that relate to the regulation of health professions and I expect that they will have a significant role. The following questions will be addressed in this thesis: What role did discourse play in the process that led to the amendment of the regulations that govern Ontario's health professionals under Bill 179? Specifically, I identify the state and/or policy actors involved in these discursive interactions, their relationships to one another, and what they said to whom, why, and how to determine whether there were important differences in their relative positions concerning IPC.

This is an important research question because few scholars have evaluated the relationship between health professions, as well as the relationship between health professions and the Government of Ontario, since Coburn (1993), Coburn, Rappolt & Bourgeault (1997), and O'Reilly (2000). In addition, the existing literature on the regulation of Canadian health professions has focused on case studies of single professions in a single province, or a single profession across many provinces (Adams, 2009). To my knowledge,

this is one of the first projects to use case studies of multiple professions across many jurisdictions.

As such, three important contributions can be achieved in addressing the research question. First, this thesis can contribute to the literature on professional regulation by evaluating the relationship between regulatory colleges, professional associations, and the Government of Ontario. Few scholars have evaluated this relationship and it is important for political scientists to understand the nature of this relationship in order to shed light on the complicated health policy process (Barker, 1996). There is also little information about the consultative processes that we established by the HPRAC. Analysis of this case study may be able to provide some insight into understanding the processes and how interest groups participate. Second, this thesis will contribute to the understanding of how ideas and interests are represented in the policy process. This thesis will provide further analysis of the factors that may influence the public policy process and how proposals or alternatives are promoted to address the policy issue at hand. Finally, this thesis adopts a theoretical framework that has not been applied extensively within this field (discussed in Chapter 2). Using this theoretical framework may provide an additional tool for policy analysts to evaluate the policy-making process and to improve the implementation of public policies.

2 Theoretical Framework

Political scientists no longer question whether institutions matter in understanding public policy and policy change. In fact, "...it has become nearly passé to argue that institutions matter. Virtually all political scientists readily agree to this rather innocuous statement." (Steinmo & Tolbert, 1998, in Hammond & Butler, 2003, p. 146) There are many different methods to study the area of public policy but it is clear that the focus on institutions is imperative to analyze the social processes that occur within a nation and their role in determining social and political outcomes (Hall & Taylor, 1996). Specifically in the field of health care policy, various scholars have demonstrated how institutions have shaped and developed Canada's health care system and continue to influence the direction of health care reform (see Coveney, 2010; Naylor, 1986; Marmor, Okma & Lathman, 2010; Taylor, 2009; Tuohy, 1999; Wilsford, 1994) as well as the individual provincial health care systems (Adams, 2009; Epps, 2011). In particular, O'Reilly (2000) has clearly demonstrated the path-dependent influence of institutions and ideas in the development of the RHPA in Ontario. As such, the value of using an institutional approach in health care policy research has been well established. Since there are a number of institutions and institutional processes prevalent in the regulation of health care professions in Ontario, I will also apply institutionalism in the analysis of this thesis.

This thesis aims to evaluate the role of political actors and interest groups in the agenda-setting and policy development processes that led to Bill 179. The decision to focus on the role of actors in the policy process owes to the importance of discourse and argumentation that prelude policy (in)action (Fischer & Gottweis, 2012; Schmidt, 2012; Stone, 2012). As we will identify in the remainder of this section, I turn to a new branch of

neo-institutionalism, discursive institutionalism (DI), as the overarching theoretical framework guiding this thesis, arguing that the three main approaches of neo-institutionalism are insufficient.

This chapter will begin by identifying how institutions, ideas, and interests are central to understanding institutional change and the premise of the institutional approaches identified in this chapter. In order to justify the use of DI, I will identify the basic assumptions and limitations of DI and the three prominent neo-institutional approaches: historical, rational choice, and sociological institutionalism. This chapter will demonstrate how DI embraces the core premises of these schools of thought and addresses their limitations to provide a more suitable framework that captures a more realistic view of policy making by capturing the actor's role in facilitating the exchange of ideas and interests in the policy process.

2.1 The Three I's of Institutional Change: Institutions, Ideas, and Interests

Since the mid-1970s, there has been a renewed interest in institutions as units of analysis (Campbell & Pedersen, 2001; Hall & Taylor, 1996; Lecours, 2005). Traditionally, this approach had focused on the comparative analysis of formal political institutions (i.e. formal or informal procedures or routines within an organizational structure) but failed to understand the role of political behaviour. Scholars began to favour approaches that recognized the importance of behaviour in political science. James March and Johan Olsen argued that there was a need to reassert some of the main features of institutions into political science (Campbell & Pedersen, 2001; Peters, 2012), resulting in the theory of neo-institutionalism. The key point proposed by neo-institutionalists "...is that scholars can achieve greater analytic leverage by beginning with institutions rather than with

individuals.” (Peters 2012, p. 174) They argued that social processes should be the central approach to understanding political life and that there existed a reciprocal relationship between institutions and society whereby one influences the development of the other (March & Olsen, 1984, 2009; Peters, 2012). The emphasis of this relationship prompted the splintering of the traditional approach into multiple branches that shared a common emphasis on institutions (Campbell & Pedersen, 2001; Cerami, 2008; Fischer, 2003; Hall & Taylor, 1996; Lecours, 2005; March & Olsen, 1984, 2009; Peters, 2012).

According to Lecours (2005), institutions can be described in two forms: materialist and normative or ideational. The materialist definition identifies institutions as material structures; the parliament, cabinets, courts, constitutions, federal arrangements, armies, etc., within a nation. In other words, institutions referred to the government (Lecours, 2005). Many new institutionalists continue to accept the materialist definition but also depart somewhat by including the rules and processes found within the political arena in the definition of institutions. This departure became more significant with the inclusion of the sociological perspective, which views institutions in terms of norms and values (Hall & Taylor, 1996; Lecours, 2005; March & Olsen, 2009). This normative, or ideational, definition included the rules, processes, routines, norms and values of the political arena. This distinction between the materialist and the normative or ideational views of institutions is a fundamental divide within the key branches of new institutionalism (Thelen, in Lecours 2005) and will be explored later in this chapter.

According to March & Olsen (1984), institutions possess an inherent legitimacy and a “logic of appropriateness” that influences the behaviours of its members. According to Peters (2012), this signifies that “...if an institution is effective in influencing the behaviour

of its members, those members will think more about whether an action conforms to the norms of the organization than what the consequences will be for him- or herself.” (p. 30)

This argument suggests that the study of policy processes cannot ignore how actors adapt to the institutions that they create. This feature of neo-institutionalism is important to answer the question of this thesis as it demonstrates the potential of the institutions, inherent to professional regulation, to influence the behaviours of its members.

Neo-institutionalists accept that institutions are established when an idea becomes accepted by a group; institutions derive their structure of meaning and logic of appropriateness from the society in which they are formed (Béland, 2005; Béland & Cox, 2011; Fischer, 2003; Hall & Taylor, 1996; Peters, 2012). Ideas, in this sense, are best described by Béland & Cox (2011) as causal beliefs and “products of cognition” (p. 3). Ideas are produced in our minds from any of our sensory perceptions and create connections that attribute meaning to our surroundings. Ideas are more than just the ‘building blocks’ of an institution; they are central to explaining stability and change in our society. They are the means through which individuals understand the world and the materials that constitute it (Blyth, 2011; Fischer, 2003), including institutions.

Ideas can shape our opinions and values, which form the basis of our social, and even political, philosophies (Béland & Cox 2011) that guide our actions (Fischer 2003). However, some would argue that although ideas are important, they cannot sustain themselves and are dependent on the interactions of individuals (Fischer, 2003; Schmidt, 2008). Unless an actor finds value in an idea, ideas themselves have little power (Béland & Cox, 2011). But once an idea is accepted by the members of an institution, its power to change organizational structures is immeasurable (Fischer, 2003).

Scholars agree that interests are equally capable of shaping behaviour (Béland & Cox, 2011; Fischer, 2003; Hay, 2004), not as a direct reflection of material interests, but rather as a reflection of their perceptions and understanding of these material interests (Hay, 2004). In other words, ideas render interests actionable but it is interests, not ideas, that influence and shape behavior. The distinction between ideas and interests is important because it emphasizes the policy actor's role of interpreting ideas and using those ideas to form their interests. So while interests do greatly influence institutions, they are ineffective without the consensual agreement among policy actors about the ideas that should be represented by those institutions (Béland & Cox, 2011; Coleman & Skogstad, 1990). This is another important feature of neo-institutionalism that will help frame this thesis by evaluating how interests influenced the policy actors involved in the policy process that led to Bill 179. In other words, how policy actors influenced the institutions inherent to professional regulation to reflect their ideas and interests.

In sum, there is a causal relationship between institutions and ideas, ideas and interests, and interests and institutions (Béland & Cox, 2011; Hall & Taylor, 1996). Although it would appear that ideas have the greatest influence over institutions and interests, they are ineffective without the collective agreement of a group. I argue that institutions, ideas, and interests have a mutually dependent relationship in the development and advancement of public policies but the interactions of policy actors with each other are crucial in order to generate and exchange those ideas and interests (Figure 2-1). Blyth (2002) suggests that some scholars (particular in the field historical institutionalism) argue that institutions “structure” individuals’ preferences, whereas others argue that preferences of individuals “structure” institutions. I posit that both assumptions are correct; institutions influence

preferences, and preferences influence institutions, which feed into the actors' interpretation of their institutional environment. Interests stem from ideas, contained and exchanged through the interactions among actors, and actors use their perception of the institutional environment to shape their interests, and consequently, their (in)actions in achieving institutional change. Thus, institutions are not simply neutral structures that represent the agents' interests; they stabilize the constant struggles of actors "...to impose and contest the ideas that make them possible in the first place." (Blyth, 2011, p. 99) Through the institutions, actors attempt to create stability and clarify uncertainty; they are the "carrier(s) of ideas" (Schmidt, 2012) who can, in turn, influence and modify the policy actors' interests.

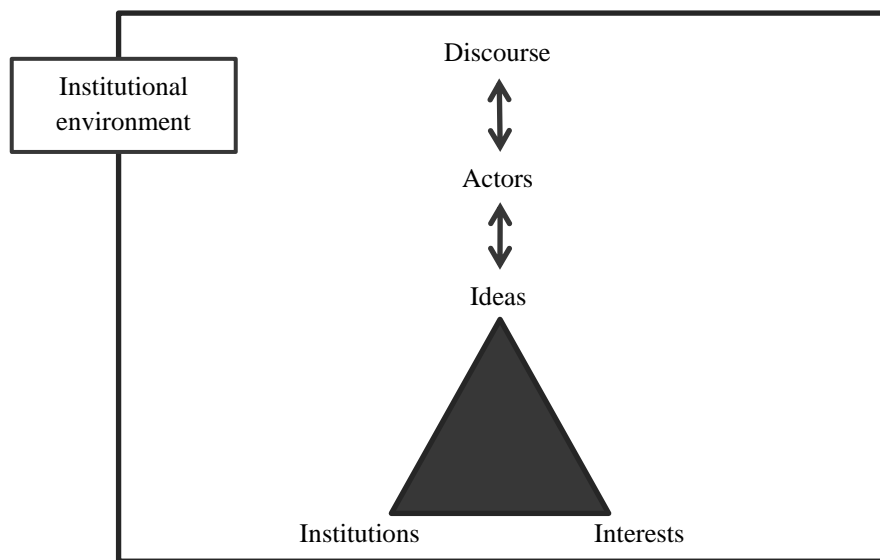


Figure 2-1: Conceptual diagram of the factors required for change in public policy

The emphasis on the actor's role in facilitating the exchange of ideas through discourse complements research on group politics and the rise of collective action, as discussed in the previous section. These interest groups can play a significant role in the health policy process (Barker, 1996); scholars have already established the influence of the interest groups representing the medical profession on the state and delivery of health services (Coburn,

1993; Coburn, Torrance, & Kaufert, 1983; Naylor, 1986; O'Reilly, 2000; Taylor, 2009).

Since the relationship between professional interest groups and the state have changed (Coburn, 1993), it is possible that greater analytic leverage can be achieved by beginning with the individual, or group, rather than with institutions, as previously stated. The interactions between interest groups and the state can develop our perceptions of our surroundings and shape our ideas and interests, as they relate to the institutions inherent in our society.

2.2 Discursive Institutionalism

Scholars acknowledge that the policy process is not a straightforward prescription of techniques and existing approaches. Neo-institutionalist theories, however, do not take into consideration the language and argumentation used in policy development (Fischer & Forester, 1993; Fischer & Gottweis, 2012; Kingdon, 2011; Stone, 2012). For this reason, I turn to DI as a theoretical framework for this thesis. DI is still considered to be a fairly new institutionalist approach and heavily promoted by Vivian Schmidt (2002, 2008, 2011, 2012) but previous scholars such as Colin Hay (2004) have discussed some related concepts in terms of constructivism. However, constructivism and DI differ in the manner in which they evaluate ideas; constructivism focuses more on ideas as the substantive content of discourses whereas DI focuses on the interactive processes involved in the discourse (Schmidt, 2008). This distinction is important because it not only emphasizes the importance of what was said, but who said what to whom, how, and why. DI also emphasizes the role of ideas in establishing institutions but is less concerned about the equilibrium state and puts more emphasis on the need for a common set of values among the actors (Peters, 2012).

“Institutions – whether understood as RI’s incentive-based structures, HI’s historically

established patterns or SI's socially constituted norms – frame discourse.” (Schmidt, 2008, p. 314) Thus, there is little emphasis of institutions as structures, but rather as common understandings and beliefs (Peters, 2012).

The main focus for DI is the use of discourse to generate and exchange ideas (Peters, 2012). In this view, discourse is an interactive process by which ideas are conveyed through argumentation that leads to action (Schmidt, 2011, 2012). The interactions may involve different groups (political or non-political) and individuals engaging in a “... “communicative” discourse of deliberation, contestations, and legitimization of the policies.” (Schmidt, 2012, p. 86) In this view, the inclusion of discourse allows researchers to demonstrate how ideas are shaped, how ideas feed interests, and how ideas and interests lead to collective action (Schmidt 2002, 2008, 2011, 2012).

Ideas do not just magically result in collective action through discourse; ideas must be carried by actors, “...who articulate and communicate their ideas through discourse in exchanges that may involve discussion, deliberation, negotiation, and contestation.” (Schmidt, 2012, p. 91) Actors are responsive to the discourse; that is, they assess and interpret the content and processes of the discourse and establish meaning to the environmental context, which emphasizes that “...who is speaking to whom about what where and why...” (Schmidt, 2012, p. 91) matters. Thus, a major postulate of DI is that there is a reciprocal relationship between actors and institutions (Peters, 2012). Interactions between actors can shape the nature of institutions and, consequently, constrain the actions of the actors who created the institution (Bhatia & Coleman, 2003). What is unclear is the extent of the discourse and the number of actors needed to establish that institution. But once the institution is created, it can “...provide stability in behaviour and decision than if the

individuals were not involved with these structures.” (Peters, 2012, p. 121) The more structured the institution, the more likely it is to enforce a particular behaviour of those actors but DI recognizes that the institutional context is malleable and change within an institution can be achieved when the core ideas and values supporting the institution change within the discourse (Schmidt, 2002, 2008); this may occur in the same manner as institutionalization. As such, DI is better able to identify the factors that can facilitate the establishment, or change, of an institution.

As with other theoretical frameworks, DI has its limitations. First, there is an overemphasis on ideas and a lack of attention to interests. Individual behaviour can be influenced by interests, regardless of its motivation (i.e. individual or public interest). Discourse can function as a source of preferences for participants in the policy process (in other words, fuel interests) but if the preferences are vague, they cannot duly explain the policy choices of the actors (Peters, 2012). Second, it argues that the best way to facilitate change is to create new approaches from elements of existing ideas (Schmidt, 2002, 2008, 2012), similar to the approach of incremental change in historical institutionalism (Peters, 2012), but it struggles to address institutional change as a result of external shock or major change.

In sum, DI provides a more comprehensive interpretation of the complex interactions and role of actors in public policy change. It accounts for the formation and change of structures through discursive argumentation (Schmidt, 2008, 2012), not found in other approaches, to examine the factors that influence the public policy process. It not only calls attention to both the substantive content of ideas, but also to the processes of discourse and

argumentation, recognizing that language and argumentation can shape our realities and lead us to action (Fischer & Gottweis, 2012; Schmidt, 2002, 2008, 2011, 2012).

2.3 The Trinity of Neo-Institutionalism: Historical, Rational Choice and Sociological Institutionalism

To understand the relevance of DI in relation to the other approaches of neo-institutionalisms, this section will examine the three most prominent schools of thought (Campbell & Pedersen, 2001; Hall & Taylor, 1996; Lecours, 2005): historical institutionalism (HI), rational choice institutionalism (RI), and sociological institutionalism (SI). These approaches differ on how they construe institutions and their role in achieving social and political outcomes (Hall & Taylor, 1996; Lecours, 2005; March & Olsen, 2009). As stated by March & Olsen (2009), “They focus attention on different aspects of political life, on different explanatory factors, and on different strategies for improving political systems.” (p. 160) However, they maintain certain core assumptions from the institutional perspective. First, institutions create elements of order and predictability. Institutions establish societies by bringing together individuals with a common interest and create identities or roles for those members. They enable, constrain, and enforce particular behaviours among political actors (Hall & Taylor 1996; March & Olsen 1984, 2009), which would otherwise lead to a disorganized society. Second, the relationship between structures, political action, and institutional continuity and change is dependent on comprehensible and routine processes, which “... produce recurring modes of action and organizational patterns” (March & Olsen, 2009, p. 160-161) that shape the purpose of the institution.

The following sections will elaborate the basic assumptions found within the three main approaches in neo-institutionalism. In addition, I will compare the limitations of these

schools of thought, how they describe and conceive of the role of the agent, and how they explain institutional change (or continuity). The analysis of these points will assist us in justifying why DI is an appropriate analytical framework for this thesis.

2.3.1 Historical Institutionalism

HI focuses on how institutions structure actions and outcomes (Schmidt, 2011). Its central assumption is that political interactions should be studied in the context of the institutions and sequentially over a period of time (instead of in isolation). “To understand the actions of all these political players, one must take cognizance of the historical development of the institution, and the original, distinct culture and problems in which it arose.” (Sanders, 2008, p. 39) The historical sequence of policy choices made in the past will impact the behaviour of political actors during the policy making process far into the future (Béland, 2005; Peters, 2012). From this view, institutions are characterized as factors that constrain future policy making (Campbell, 1998). Thus, historical institutionalist argue that it is important to study not only the operation and development of institutions, but also their path-dependencies and unintentional consequences resulting from the historical evolution of those institutions (Schmidt, 2011).

Earlier in this chapter, we discussed the materialist and normative or ideational definitions of change. Historical institutionalists support both views but put greater emphasis on the normative/ideational perspective. Institutions are, by and large, defined by historical institutionalists as “... the formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or political economy.” (Hall & Taylor, 1996, p. 938) Once the institution is established, the HI approach views political structures

as filters for policy-relevant ideas; new ideas must be able to serve the interests of the members and “fit” into the preconceived behaviours and processes (Blyth 2002).

HI strongly emphasizes the relationship between institutions and the behaviour of the individual. According to Hall & Taylor (1996), there are two approaches to explain how institutions affect the behaviour of the individual: the ‘calculus’ and ‘cultural’ approach. The calculus approach focuses on human behaviour based on strategic calculation. Hall & Taylor state that: “They assume that individuals seek to maximize the attainment of a set of goals given by a specific preference function and, in doing so, behave strategically.” (p. 939) From this perspective, institutions provide individuals with varying degrees of certainty about the behaviour of other individuals. In contrast, the cultural approach stressed that behaviour is bounded by the individual’s worldview. As stated by Hall & Taylor (1996): “That is to say, without denying that human behaviour is rational or purposive, it emphasizes the extent to which individuals turn to established routines or familiar patterns of behaviours to attain their purposes.” (p. 939) As such, institutions provide the individual with templates for interpretation and action.

HI proposes that institutions constantly adapt to keep up with the changing context upon which the institution was built. However, change cannot be achieved arbitrarily within the institutions because their histories are fixed into the rules and routines protected internally by its members and validated by external individuals. The change within the environmental context may occur much faster than the institutions’ ability to change. As such, there is a possibility of a constant gap in between the function of the institutions and its desired level of functioning (March & Olsen, 2009).

For this reason, the approach of HI is better suited to explain the persistence of institutions rather than explain how institutions might change (Fischer, 2003; Peters, 2012; Stone, 2012). Nonetheless, HI offers two possibilities for institutional change. First, HI's view on historical development provides an argument for path-dependency and how institutions produce paths for future policy development. The term 'path' is used because decisions are bounded by structures that confine, channel, and shape outcomes. Institutions and processes are the result of the culmination of previous decisions and existing institutions. And since structural forces dominate policy processes, researchers argue such change is most likely to be incremental (Pierson, 2000; Wilsford, 1994) but historical institutionalists rely heavily on the second view: punctuated equilibrium or critical junctures (Peters, 2012). Since institutions are expected to maintain equilibrium, sufficient force is able to cause institutions to shift away from equilibrium; institutions must change in order to resume their state of equilibrium. Historical institutionalists argue that such force occurs rapidly, or punctuated in a specific time, and followed by periods of stasis. This punctuation can result in critical junctures, or "...moments when substantial institutional change takes place thereby creating a 'branching point' from which historical development moves on a new path." (Hall & Taylor, 1996, p. 942) However, both punctuated equilibrium and critical junctures can only be identified *after* they occur. Historical institutionalists are unable to *predict* change as they do not have criteria to determine if there is sufficient force to generate change (Peters, 2012).

Critics have emphasized the limitations of this approach. First, the HI approach can appear to be deterministic or mechanistic because of its focus on continuity and path-dependency (Schmidt, 2011). Their views on change focus on exogenous rather than internal

change initiated by the actors. HI provides no capacity to predict change and fails to explain the role of the individual in shaping the institution or the role of ideas within institutional change (Peters, 2012; Schmidt, 2008). As Peters (2012) states: “Institutions may adopt and embody ideas, but it is not clear that they actually determine the nature of the institutions.” (Peters, 2012, p. 87) HI appears to assume that actors will accept institutional constraints on behaviour by choosing to participate within the institution. Thus, behaviour is determined at the initial creation of the institution and HI does not explain how policy actors can shape the nature of institutions.

2.3.2 Rational Choice Institutionalism

Rational choice theory assumes that individuals are autonomous actors striving to maximize their own utility (Peters, 2012; Stone, 2012) and social processes are seen as a series of collective action dilemmas (Hall & Taylor, 1996). As such, individual behaviours produce outcomes that are collectively sub-optimal. RI maintains this assumption and argues that individual behaviour can be affected by the interactions between other individuals and that institutions play a role in facilitating these interactions. The key of this argument is that rational actors have fixed preferences and calculate strategically to maximize their preferences. The role of institutions is to reduce the uncertainty of the multiple competing individual preferences and interests (Schmidt 2011). Thus, RI assumes that the actors create the institution in order to realize the value of its functions for the actors, “...which is most often conceptualized ... in terms of gains from cooperation.” (Hall & Taylor, 1996, p. 945) According to Blyth (2002), the concept of ideas is varied in RI but plays an important role in the development of preferences and interests. First, ideas are seen as tools to promote

cooperation among actors who have not yet realized their interests. Second, they offer the context in which actors define their interests.

Rational choice institutionalists view institutions in two forms: as exogenous constraints and as focal arrangements that induce coordination around them (Shepsle, 2008). In the first view, institutions are the ‘game form’. Shepsle (2008) states that “An institution is a script that names the actors, their respective behavioural repertoires (or strategies), the sequence in which the actors choose from them, the information they possess when they make their selections, and the outcome resulting from the combination of actor choices.” (p. 24) This ‘game form’ is transformed into a game when the actors’ preferences are incorporated. In the second view, institutions are not given exogenously but provided by the actors; the institutions are developed based on how the actors want to play the game but the common feature of both these views is the greater reliance on rules as institutions (Shepsle, 2008). Without rules actors would behave too randomly and require means of structuring behaviours (Peters, 2012). As such, individuals create institutions if there is a logical need for that institution and its functions provide value and benefits to those individuals.

Sened (in Peters 2012) argues that these individuals have that capacity to manipulate their structure and act “...to impose their will on others [but must also be able to] anticipate that they will be better off with the institution than without it.” (Peters, 2012, p. 62) RI postulates that actors play a prominent role in creating and shaping the nature of institutions but it is not clear how institutions shape individual behaviour, if at all. Yet, if RI assumes that institutions shape interactions, an actor can use the institution as a map to navigate towards their preferred outcome. Thus, while the institution may not shape individual

behaviour, it may affect the actors' decisions throughout their attempts to achieve their goals (Hall & Taylor, 1996; Peters, 2012).

Although RI places greater emphasis on the role of the actor, it has not fully developed the concept of institutional change. For some rational choice institutionalists, change is not important because RI focuses more on explaining outcomes due to specific institutional arrangements. Other rational choice institutionalists model change within the RI approach similarly to that of HI; change may occur when existing institutions fail to maintain equilibrium through external factors. Even then, RI's description of the relationship between institutions and actors may help explain change within a stable environment and how individual preferences may lead to institutional change (Hall & Taylor, 1996; Peters, 2012).

In addition to its limitation in explaining institutional change, Simon and March's argument regarding 'bounded rationality' reminds us that there are limits on actors' ability to adapt optimally, or even satisfactorily, to complex environments (Forester, 1984; Simon, 1991). A rational-comprehensive position assumes that decision makers have a well-defined problem, all of the necessary information about alternatives, their consequences, the values and preferences of all actors, and adequate time, skill, and resources to make a decision. On the other hand, Simon and March argued that actual decision makers have none of the previously listed information. In fact, they had ambiguous and poorly defined problems, incomplete information on all aspects of the decision-making processes, and insufficient time, skills, and resources to choose the best alternative (Forester, 1984). Thus, it is unlikely that an actor is able to make 'rational' choices.

2.3.3 Sociological Institutionalism

Whereas HI and RI evaluate the establishment of institutions, SI analyzes the effects of institutions, their values, and the relevance of those values in social processes (Hall & Taylor, 1996; Peters, 2012; Schmidt, 2008). Sociological institutionalists argued that the forms and procedures of organizational life stem from culturally specific practices, "...with institutions cast as the norms, cognitive frames, and meaning systems that guide human action as well as the cultural scripts and schemata diffused through organizational environments, serving symbolic and ceremonial purposes rather than just utilitarian ones." (Schmidt, 2011, p. 51) Based on this definition, there is greater emphasis on symbolism and cognitive elements in SI than HI or SI (Amenta & Ramsey, 2010; Hall & Taylor, 1996; Peters, 2012; Schmidt, 2008).

As such, sociological institutionalists accept the normative/ideational definitions for institutions. In this view, institutions are symbolic manifestations of a society's needs but have the capacity to defend their values and to protect their functions when threatened. SI views institutions as systems of meaning, and that "...their behaviour and the behaviour of individuals within them depend upon the meanings incorporated and the symbols manipulated." (Peters, 2012, p. 133) That is, individuals interpret their surrounding and create meaning to their social processes. An institution provides "... the cognitive script, categories and models that are indispensable for action..." (Hall & Taylor, 1996, p. 948) and may be used to define individual behaviour.

Their emphasis on institutions as cognitive frames is better suited to explain how actors perceive a situation instead of analyzing the structures and processes that mirror those same ideas and beliefs (Peters, 2012). Other researchers state that this approach works best

in the analysis of situations where actors required some form of guidance for their behaviour (Amenta & Ramsey, 2010). Regardless of the application of this approach, SI provides a clear connection for the interactive and mutually constitutive relationship between institutions and the individual: these relationships are established through the socialization of individuals into particular roles that internalize norms and behaviours (Hall & Taylor, 1996). This demonstrates how SI explains the manner in which institutions affect behaviour (Hall & Taylor, 1996; Peters 2012).

The process of institutionalization is of great concern to the study of SI, which employs the concept of 'roles' to explain how institutions change (Hall & Taylor, 1996; Peters 2012). By changing the number of roles, an institution is able to establish firmer or weaker relationships between actors and institutions. Similar to HI, SI argues that institutionalization occurs as a means to adapt to change in the environment and find ways to conform to external forces. However, SI emphasizes that institutions adopt structures and processes valued in the broader cultural environment. Thus, there are 'limits' to how much institutions can conform to those external forces and this approach may be dysfunctional to the individuals' ultimate goals (Hall & Taylor, 1996). Another strand in SI argues that institutions will attempt to mould its environment to its needs rather than respond to the changes (Peters, 2012). In either situation for institutional change, it appears that understanding and specifying the environmental conditions in which the institution will be created or dissolved is an important element to understanding institutional change within this perspective. But like HI, SI is better at explaining how particular actors' behaviours are enforced by the institution than how institutions are shaped by the actors (Peters, 2012).

2.4 Conclusion

There were two purposes for the analysis of the HI, RI, and SI. First, it demonstrated that these approaches are unable to explain *how* institutional change occurs, just that it does. Second, the role of the actor is limited within the process of institutional change. HI and SI acknowledge that exogenous factors can initiate change but does not identify if actors have a role in changing those institutions; both approaches have a greater focus on how institutions influence individual behaviour, but not how individuals can influence institutions. On the other hand, RI focuses on the influence of actors on the institutions, and besides limiting the actors' alternatives for action, does not adequately demonstrate how institutions influence the actors' behaviours. RI views institutions as the rules of the game that actors can use to achieve their end goals. The commonality of these approaches is their agreement that institutions greatly influence the development of public policies but these main approaches have limited explanations for the roles of actors in the process of institutional change.

Scholars (see Campbell & Pederson, 2001; Schmidt, 2012; Peters, 2012) argue that DI is part of the second movement in institutional analysis, whereby scholars attempt to identify complementary approaches in order to develop a new approach for analyzing institutions.

This stems from the increasing recognition among scholars that institutions and institutional change are more complex than any paradigms portrays by itself and that it is time to begin exploring how paradigms complement and connect with each other in ways that might eventually generate new insights, if not a new problematic, for analyzing institutions. (Campbell & Pederson, 2001, p. 2)

As we have seen, DI supports many of the assumptions regarding institutions, ideas, and interests found in HI, RI, and SI (Table 2-1). However, DI has greater emphasis on discourse, ideas, and the role of actors in facilitating the discourse, to address the question of

how dynamic institutional change can be achieved. It also describes the role of actors in shaping institutions, not just the influence of institutions on the actors' behaviours.

Within this chapter, I argue that neo-institutionalist approaches have poorly addressed how actors influence their institutions to adapt to their ideas and interests. These approaches have examined external factors for change but few provide a comprehensive examination of the internal factors for achieving institutionalization. RI does identify a more prominent role for actors but Simon and March's argument about bounded rationality clearly demonstrates the limits of this approach. Alternatively, HI and SI view actors as passive individuals that change their behaviours to match those of the institution. However, institutionalization occurs for the benefit of actors and when those institutions are no longer satisfactory, actors will initiate a process to achieve institutional change; herein lies the importance of discourse.

	Historical Institutionalism	Rational Choice Institutionalism	Sociological Institutionalism	Discursive Institutionalism
Object of Explanation	Historical rules and regularities	Rational behaviour and interests	Cultural norms and frames	Ideas and discourse
Logic of Explanation	Path-dependency	Calculation	Appropriateness	Communication
Problems of Explanation	Historical determinism	Economic determinism	Cultural determinism or relativism	Ideational determinism or relativism
Ability to Explain Change	Static: continuity through path dependence	Static: continuity through fixed preference	Static: continuity through cultural norms	Dynamic change and continuity through ideas and interactions

Table 2-1: A comparison of the four described approaches in neo-institutionalism, adapted from Schmidt (2011).

3 Methodology

The research design adopted for this study is a combination of an instrumental, single-case study and discourse analysis. The primary goal of this thesis is to evaluate the discursive interactions that occurred among policy actors during the agenda setting and policy development steps of the policy process that led to Bill 179.

The decision to focus on the first two steps of the policy process resulted from the argument about the importance of deliberation and argumentation among actors as precursors to action, but also for the establishment of the policy agenda and the content of policies (Fischer, 2003; Fischer & Gottweis, 2012; Kingdon, 2011; Schmidt 2011, 2012; Stone, 2012). This focus will result in a better understanding of the policy process involved in reviewing the regulations governing Ontario's health care practitioners, how policy issues are identified, and how proposals are selected. Keeping this focus in mind, the following section will explain the research design, data collection, data analysis and limitations.

3.1 Research Design

The original intent of this thesis was to complete a pan-Canadian policy analysis of the regulation of health care professions. Realizing this goal was beyond the scope of a Master's thesis, the research design of this study was adjusted to allow me to develop the more ambitious project at the Ph.D. level. The decision to use a single case study was influenced partly because of time restraints, but also because it provided an opportunity to conduct a pilot test in preparation for the pan-Canadian analysis mentioned earlier. Notwithstanding, this case study differs slightly from similar approaches because of its receptiveness to the theoretical framework guiding the research and data analysis.

The case study method is a popular approach in public administration research because it is able to establish a narrative of the events that influence the public-policy process. It allows researchers to evaluate how processes interact with individuals, groups, or organizations, if they cannot be analyzed as stand-alone processes (Lowndes, 2010; McNabb, 2008). “Thus, if we learn how these processes interact in one person or organization, we will know more about how the processes as factors in themselves and perhaps apply these (what we have learned) to other similar type persons or organizations.” (Lang & Heiss, in McNabb, 2008, p. 288)

McNabb (2008) identifies three types of single-case studies: intrinsic, instrumental, and collective studies. *Intrinsic* case studies are conducted by researchers who want to develop a better understanding of the case subject simply because they are interested in the topic. *Instrumental* case studies are conducted when the researcher wants gain greater insight into a phenomenon occurring within the case study; the case study itself is a secondary interest. Finally, *collective* case studies are conducted through the assessment of a group of individual case studies to develop a greater understanding of the phenomenon. This thesis will only evaluate one case study: the interactions among policy actors in the policy process that led to the creation of Bill 179. While this thesis is interested in the case of policy development to support IPC, it is second to the interest on the phenomenon of the policy actor’s interactions in setting the policy agenda and content of the policy, through discourse, specific to the issue of IPC. Thus, this thesis would fall under McNabb’s description of an instrumental case study.

Analysis of case studies can be completed by conducting interviews, observations, or document and text analysis. Due to resource limitations, this thesis will focus on the analysis

of documents and texts readily available online. Case studies that use documents and texts as units of analysis are traditionally completed using content analysis (McNabb, 2008).

Content analysis is a systematic, quantitative or qualitative, description of written communications to make inferences about the variables uncovered in a text (McNabb, 2008; Singleton & Straits, 2010). This approach uses categories or variables to code the content of written communications. It allows researchers to develop a structure method of quantifying the content of documents and texts. The disadvantage of this approach is that it loses the contextual meaning of these written communications and cannot assess the implied meanings of the content (McNabb, 2008). Content analysis would not be an appropriate approach for this thesis because it is essential that the context of the materials is preserved to ensure effective analysis of the interactions that occurred among policy actors prior to the ascension of Bill 179. However, it is still necessary to establish the content of these written communications to achieve the objectives of this thesis.

A related approach to content analysis is discourse analysis, a method of analyzing the linguistic structures in written or oral interactions (Gee, 2011; McNabb, 2008; Vromen, 2010; Wood & Kroger, 2000). The importance of discourse has been touched upon briefly in Chapter 2; put very simply, we need to understand how discourse construct our realities in order to understand human beings and their actions (Fischer, 2003; Johnstone, 2008). Both emphasized and marginalized discourse can produce, or contain within it, power effects that lead to the establishment of identities, expectations, and responsibilities that discipline society; it can also democratized processes of institutionalization (Feindt & Oels, 2005). Herein lays the importance of discourse analysis; it focuses on the discourse to understand what happens when people draw on their knowledge and past experience with language to

establish meaning to their surroundings (Fairclough & Fairclough, 2012; Feindt & Oels, 2005; Gee, 2011; Johnstone, 2008; Schmidt, 2010; Scollon, 2008; Wood & Kroger, 2000).

As stated by Potter (1997):

[Discourse analysis] has an analytic commitment to studying discourse as *texts and talk in social practices*. That is, the focus is not on language as an abstract entity such as a lexicon and set of grammatical rules (in linguistics), a system of differences (in structuralism), a set of rules for transforming statements (in Foucauldian genealogies). Instead, it is the medium for interaction; analysis of discourse becomes, then, analysis of what people do. (In Wood & Kroger, 2000, p.3-4)

According to Wood & Kroger (2000), there are three basic assumptions that establish the foundation of discourse analysis. The first assumption is that discourse is a form of action that builds things in our world. An utterance can take many different forms depending on the style used to deliver the message. For example, the phrase “I’m not going to fail this class” can be seen as a factual statement (the speaker has actually passed the class) or a statement to act (the speaker will work harder to pass the class). Discourse analysts look beyond the content of the discourse to see how language is *used* to achieve a particular function or effect. In this case, the speaker is using language to initiate a change in behaviour or habits. The second assumption is that the discourse is the actual focus on the analysis and not a resource to explain a phenomenon. “Ethnomethodologists ... view this as a shift away from using features of talk to explain behaviour (talk as resource) to a focus on the features of talk as the behaviour to be explained (talk as topic).” (Wood & Kroger, 2000, p. 8) The third assumption involves recognizing the variability of discourse. Discourse can construct different interpretations of the context and the various functions of discourse can have their own orientation. The variation of these interpretations and orientations can be present among a group of individuals or within the single individual.

Thus, discourse analysis is concerned with action, construction, and variability of the verbal and written interactions in social practices and processes. Discourse analysis allows researchers to evaluate the content of the material within its contextual meaning and considers the role of each agent in producing, delivering, and interpreting the material. Also taken into consideration is the motivation of the text, the type of language used, the material's structure and its interaction with other materials (Gee, 2011; Johnstone, 2008; McNabb, 2008; Vromen, 2010; Wood & Krogger, 2000). For these reasons, this thesis will adapt the principles of discourse analysis to develop an approach that will analyze the case study within the DI framework.

3.2 Data Collection

Discourse analysis takes into consideration both spoken and written sources of discourse. Researchers acknowledge that it is not practical to evaluate spoken discourse in 'real time', as it is taking place, and prefer to study records of discourse via transcripts (Johnstone, 2008; Wood & Kroger, 2000) such as those obtained from legislative assembly debates, meetings, and news reports. Materials encompassing written discourse can include statements and reports from professional associations, regulatory colleges, and the Government of Ontario, and newspaper articles.

The decision to use readily available and electronic documents and texts as units of analysis for this thesis is due to limited time and the absence of funding. These documents and texts are available free of charge on the authors' websites; the general public is able to access the documents and texts at any time. Semi-structured interviews as a method for data collection would have provided more in depth information about the interactions that occurred among policy actors and the purpose, or reasoning, of the policy actors' actions.

This method, however, would require the identification of interviewees, organizing the time and location of the interview, conducting the interviews, transcribing audio into text, and finally, conducting the data analysis. Additionally, interviews would require the approval of ethics, which could add another layer of challenges to the thesis. It was not believed that all of these tasks could be completed in less than two years.

Data collection was conducted in two phases: the initial search of documents and texts within relevant websites and online archives, followed by a “snowball” search of materials identified through the first phase. The identification of websites and online archives was possible through the literature review conducted on the regulation of health care professions in Ontario. This review identified the following website and online archives as potential sources for both written and spoken documents and texts: the Legislative Assembly of Ontario; the Health Professions Regulatory Advisory Council (HPRAC); all Ontario regulatory colleges, various national professional associations (i.e. Canadian Medical Association, Canadian Nurses Association, etc.); and various health professional organizations in Ontario (i.e. Ontario Medical Association, Ontario Nurses’ Association, Registered Nurses Association of Ontario, etc.).

First, the Legislative Assembly of Ontario website provides the transcripts of the debates and proceedings throughout the development of Bill 179 that may provide insight on the role of ideas and interests within this process. Second, the regulatory colleges and their members would be the most affected by any policy change to the RHPA, and, as such, may have reports or responses on their positions related to this case study. Other sources that will be explored are the national and provincial (Ontario) associations for medicine, nursing, dentistry, and pharmacy. These professions have played a significant role in the development

of Ontario's regulatory framework for health care professions (O'Reilly, 2000), thus, one of the longest-established regulated professions in Ontario with more resources than "newer" professional associations or regulatory colleges. As the "core professions", they are often the main focus of IPC research and may be the most influential in this case study.

A rigorous and consistent process was followed to complete data collection. Each website and online archive was searched using a combination of key words, including: interprofessional collaboration; interdisciplinary; multidisciplinary; team-based care; collaborative care; family health teams; Bill 179; Regulated Health Professions Statute Law Amendment Act; Health Professions Regulatory Advisory Council; and the Standing Committee on Social Policy. These keywords did not necessarily locate the relevant documents and texts but it did direct the search to the appropriate areas. The second phase of the data collection was completed by identifying references within the documents and texts located in the first phase, thus, adding a "snowball" approach to the collection of data. Documents and texts were included in the analysis if they related to the idea of IPC or collaborative care, within a 15-year time frame (1994-2009) prior to the ascension of Bill 179. A total of 110 documents and texts were located from the websites of various policy actors, 3 Official Report of Debates from the Legislative Assembly of Ontario, and 5 reports from the HPRAC for this case study.

3.3 Data Analysis

The key of data analysis within a case study is to reduce the volume of data in each step by organizing the data into mutually exclusive categories. According to McNabb (2008), the process of data analysis should adhere to the following steps: organize the data; generate categories, themes, and patterns; code the data; apply the ideas, themes, and

categories; search for alternative explanations; and write and present the report (McNabb, 2008). These steps were used to complete the data analysis of this thesis and to construct the narrative of the case study. The computer software NVIVO was used in order to facilitate consistent data coding and application of ideas, themes and categories. This software is commonly used in qualitative research to conduct discourse analysis because it allows the exploration of issues and trends in both spoken and written documents.

Additionally, a component of this thesis will assess the interactions of the policy actors within the case study. As described in the research design section (section 3.1), the analysis of discourse can help us understand the actions of policy actors. In order to assess how interactions shape meaning and prompt (in)action, a series of questions were developed based on the seven areas of reality that are constructed by language, as described by Gee (2011):

- *Building significance*: language establishes how and what different things mean.
- *Building activities*: language can engage participants in a sequence of actions.
- *Building identities*: people enact and recognize roles and responsibilities within the situation, depending on their understanding of the language.
- *Building relationship*: relationships may emerge among individuals; language signals the type of relationships we have, want to have, or are trying to have with the audience, groups, or institutions.
- *Building politics*: social goods may be relevant or irrelevant to the situation; language can dictate how power is distributed within the situation.
- *Building connections*: language can connect things (relevant or irrelevant) to each other; interconnectivity of texts and individuals.
- *Building significance for sign systems and knowledge*: different languages (i.e. English versus French) and different types of a language (i.e. language of politicians and health care practitioners) may influence the situation.

These seven areas of reality to reflect the type of questions that many other discourse analysts employ in their own research (see Fairclough & Fairclough (2012), Johnstone (2008), Scollon (2008), and Wood & Kroger (2000)). Using these areas of reality, a list of questions (adapted from Gee, 2011) was developed to assist in the analysis of the written discourse. Table 3-1 lists the questions related to each building take.

Component	Questions
Building significance	<ul style="list-style-type: none"> - What are the meanings of the words and phrases that are important in the discourse? - What meanings and values are attached to the places, times, bodies, people, objects, artifacts, and institutions that are relevant to the discourse? - How does intertextuality (quoting to or alluding to other materials) attach meanings and values to other materials (both spoken and written) in the discourse? - In regards to the intertextuality of the materials, how are the meanings connected and integrated with each other? - What ideas and/or discourse are (re-)produced in the situation and how are they being established, maintained, or transformed?
Building activities	<ul style="list-style-type: none"> - What is the main activity (or set of activities) occurring within the discourse? - Which participants are involved in the activity? - What sub-activities compose this activity? - What actions are involved in either the sub-activities or activity?
Building identities	<ul style="list-style-type: none"> - What identities (roles, positions) are held by participants of the activity? - What personal, social, and culture knowledge and beliefs, feelings, values of the identity are relevant, taken for granted in, or under construction in the discourse? - How are the identities created, stabilized, or transformed within the discourse? - How are the identities (ir)relevant to the discourse of the situation? How is the relevance of the identity established, maintained, or transformed?

Component	Questions
Building relationships	<ul style="list-style-type: none"> - What social relationships seem to be relevant to, taken for granted in, or under construction within the discourse? - How are these social relationships established, maintained, or transformed? - How does intertextuality of materials create, establish or transform relationships with individuals, discourses, and other materials? - In terms of the identities, activities, and relationships, how is the discourse (ir)relevant to the situation? How is the discourse made (ir)relevant and why?
Building politics (the distribution of social goods)	<ul style="list-style-type: none"> - What social goods (i.e. status, power, gender, class, identities, etc.) are (ir)relevant to the discourse? How are they connected to the discourse? - How are the social goods made (ir)relevant to the discourse and in what way?
Building connections	<ul style="list-style-type: none"> - What connections (pre- and post-event) are made within the discourse to other people, ideas, texts, things, institutions, and discourses outside the current situation? - How is intertextuality used to create, maintain, or transform these connections? - How do these connections help (or not) to constitute coherence within the situation? What is the nature of this coherence?
Building significance for sign systems and knowledge	<ul style="list-style-type: none"> - What sign systems (i.e. speech, writing, images, gestures) are (ir)relevant to the discourse and how are they made (ir)relevant? - What systems of knowledge (i.e. education, language, experience) are (ir)relevant, and in what ways? - What national languages (i.e. English or French) (ir)relevant to the discourse? - What social languages (i.e. professional) (ir)relevant in the discourse? How are they (ir)relevant and in what way? - How is intertextuality used to engage sign systems and knowledge?

Table 3-1: Questions to conduct the discursive analysis of materials, adapted from Gee (2011).

3.4 Limitations

A number of limitations were encountered throughout the course of this study. The first two limitations have been mentioned briefly throughout this chapter: lack of funding/resources and time. The decision to use online materials resulted from a lack of funding to complete this thesis; the documents and texts collected for this study did not have any associated costs. The study could have been expanded to include semi-structured interviews, which may have been conducted over the phone or through Skype to cut down travel costs. However, there was still the issue of the costs associated with equipment (a recording device) and transcription. Second, the intention of this study was to create a platform for a pan-Canadian analysis on the regulation of IPC in health care and time became a factor for this study. It was important to complete the study within 2 years to continue the research at the doctoral level. It would have been challenging to obtain ethics approval and organize/conduct interviews within that time frame.

The third limitation arising in this study is access to documents and text. For some policy groups, documents and texts are only accessible to their members; the general public is restricted to the type of information that they can obtain through the websites. Additionally, there may be certain documents (i.e. emails, newsletters, and position statements) that are delivered directly to the members that are not posted on their websites. On the other hand, not all groups continue to maintain their documents and texts on the website after a certain time; some websites did not provide documents and texts prior to 2010. It is not clear if these documents and texts were removed (i.e. if the website was redeveloped) or if the website was newly established. Thus, the documents and texts collected for this case study may not be reflective of the whole interaction.

The fourth limitation relates to the subjective nature of the qualitative research design. Although there is a clear and concise process to ensure the validity and reliability of discourse analysis (McNabb, 2008), analysts must use their own interpretations of the materials to complete the analysis. As such, replication of the results may be problematic; the subjectivity of the researcher would make it difficult to produce similar, let alone the same, results. All measures were taken to ensure that the process to complete analysis followed the principles as outlined by McNabb (2008).

4 Results

Chapter 4 will provide a descriptive analysis of the collected materials (Appendix A) to establish the content of the discourse that occurred among interest groups in the agenda setting and policy development stages of Bill 179. In the previous section, I defined discourse as the interactive process by which ideas are conveyed among actors through argumentation; this definition will be used throughout the remainder of this thesis.

Identifying who said what to whom, how and why within the discourse could provide us with further insight into the role of actors in the policy process and the importance of discourse in achieving institutional change. This chapter begins with a description of the activities that occurred relating to the development of Bill 179 and the materials that were published from those activities. Subsequently, I will identify the actors involved in those activities and the content of the discourse, which will assist with the discursive analysis in the following chapter.

4.1 How to Get Involved: The Activities and Materials

Three major activities were identified in the policy process that enabled the interactions among policy actors as it related to IPC: the day-to-day activities of the interest groups; the consultative process with HPRAC; and the consultative process with the Standing Committee on Social Policy. The timeline of the consultative process between policy actors, HPRAC, and MOHLTC is described in Figure 4-1.

The day-to-day activities of the interest groups require constant communication with their members and the general public. To achieve this goal, health professional organizations produce position statements, annual reports, and newsletters. In part, this activity is meant to ensure the interest groups' transparency and accountability but also to offer the general

public their positions on various health care system or policy issues. In a sense, these means of communication can raise the issues' awareness, identify a strategic plan or initiatives with respect to those issues, and justify the interest groups' (in)action. In most cases, these documents only provide a general overview of the plan or initiative but will often provide interested individuals other sources to become more informed (i.e. through a web link, reference to other documents, or provide contact information to the lead person).

The consultative process with HPRAC was very prominent in the materials collected for this thesis; a significant portion included the interest groups' responses to HPRAC and the Minister's request for the consultative processes. As discussed in the introduction, HPRAC was established by the RHPA to provide advice to Ontario's Minister of Health in regards to the regulation of health professions through the consultative process involving various interest groups. Interest groups were invited to participate in the consultative process, which included, but not limited to, written responses, public hearings, and focus groups. However, HPRAC only provides advice at the request of the MOHLTC; it cannot produce reports that are unrelated to the Minister's request or for other groups. Once the request is received, HPRAC is able to initiate the consultative process. In the specific case related to IPC, the consultative process between the interest groups and HPRAC was initiated through the release of HPRAC's consultation guide, which outlined the Minister's request to HPRAC to:

Recommend mechanisms to facilitate and support [IPC] between health Colleges ... beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession [and to] take into account, when controlled acts are shared, of public expectations for high quality services no matter which health profession is responsible for delivering care or treatment. (HPRAC, 2008a, p. 45)

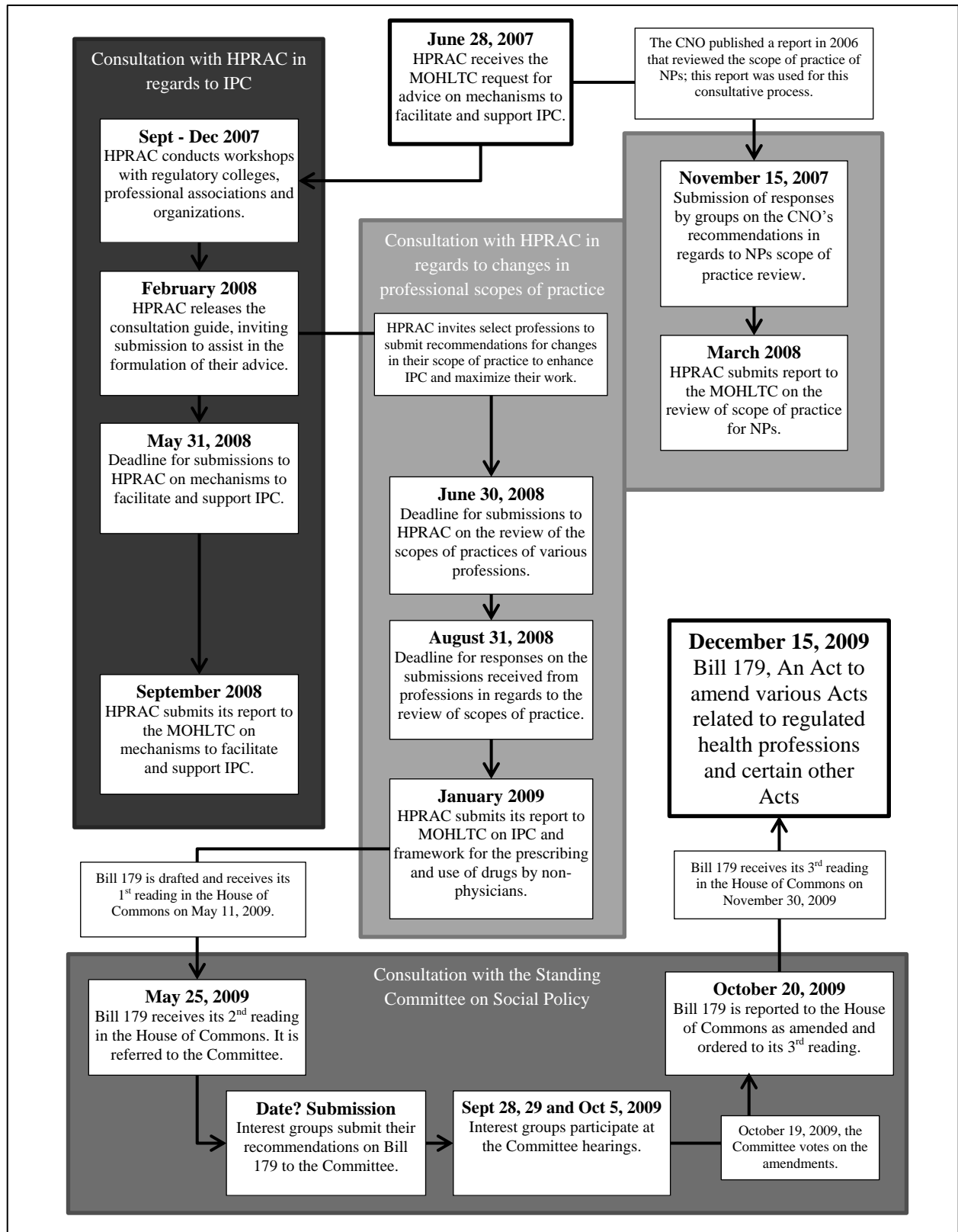


Figure 4-1: The timeline of the consultative processes with HPRAC and the Standing Committee on Social Policy.

The consultation guide invited all stakeholders (including regulatory colleges, interest groups, individual health professionals, community groups, members of the public, and other interested organizations) to submit responses to assist HPRAC in framing their consultations and research activities. HPRAC does not provide a rationale for the extensive process but consultations with interest groups such as the regulatory colleges, professional associations, and health professionals could provide better expertise on the regulatory issue and legitimize the consultative process.

Two consultative processes emerged which encompassed the items listed by the Minister's request: the first, to recommend mechanisms to facilitate and support IPC between regulatory colleges, and the second, a review of the scope of practice of regulated health professions. The first consultative process simply requested submissions from various groups to address the request; data collection obtained 25 written submissions from regulatory colleges and professional association to HPRAC in regards to this consultative process⁷. It is important to note that other materials may exist but were inaccessible during the data collection of this thesis, as identified by the limitations in the previous chapter. Following the submissions, HPRAC formulated a written response to address the Minister's first request but no further consultation on this topic was evident. The second consultative process was more robust and lengthy. HPRAC invited responses for recommendations to change scopes of practice to enhance IPC and assist members to work to the maximum of their scope of practice. Once responses were received by HPRAC, they were made available on the HPRAC website to allow individuals and health professional organizations to review those submitted responses. A report was then developed by HPRAC, for the Minister of

⁷ HPRAC does not provide information on the number of submissions received over time. This thesis was unable to determine if the number of submissions was significant or not.

Health, to synthesize the results of the consultative process. The final reports from these consultative processes are published on the HPRAC websites after it received the Minister's approval⁸.

A third consultative process occurred between the Legislative Assembly of Ontario's Standing Committee on Social Policy (herein referred to as the "Committee") and policy actors. This event provided policy actors another opportunity to share their ideas and interests with each other, and policy-makers. Only eight written submissions to the Committee were located on the health professional organizations' websites; unlike HPRAC, the Legislative Assembly of Ontario did not provide an electronic copy of the submissions on their website. However, the Committee hearings were transcribed and made available to the general public. The Official Report of Debates identified 47 participants at the hearings who provided their oral statements to the Committee. Oral presentations were restricted (no more than 10 minutes for each presentation, including questions) but participants were also able to provide a written submission that outlined their recommendations.

The list of materials that emerged from these activities and collected for this study can be found in Appendix A. It is important to note that the majority of these documents were submissions to HPRAC, or the Committee, although it was easier to locate the HPRAC submissions because they were available on the HPRAC website⁹.

4.2 The Policy Actors

Historically, four professions have had the greatest influence in developing the self-regulatory framework in Ontario: physicians, nurses, dentists, and pharmacists (O'Reilly,

⁸ While most of these written submissions were available on the HPRAC and health professional organizations' websites, those published prior to 2008 were difficult to locate (as described by the limitations of this thesis).

⁹ There is a possibility that HPRAC must make the submissions publicly available for a period of time but there was no mention of this type of requirement on their website or in their documents.

2000). Analysis of the collected materials demonstrated that these professions were also the key, if not the dominant, actors in the consultative processes. The regulatory colleges and professional associations representing these professions (Table 4.1) provided the most amount of information to the general public about the policy issues through their websites (Appendix A). While the majority are provincial associations, some national associations also developed key documents and position statements related to this policy issue. They may not directly participate in the consultative process for Bill 179 but they may have influenced their provincial counterparts' and respective regulatory colleges' positions on IPC and team-based care; the Canadian Medical Association and the Canadian Nurses Association identified their support for IPC and collaborative care in documents dated earlier than those of the Ontario Medical Association (OMA) and Registered Nurses' Association of Ontario (RNAO). In addition, many of Ontario's regulatory colleges and professional associations participated in the consultative processes by submitting a response to HPRAC or presenting at the Committee's hearings (Table 4-2).

Group	Regulatory College	Professional Association
Medical	College of Physicians and Surgeons of Ontario Ontario College of Family Physicians	<i>Canadian Medical Association</i> <i>College of Family Physicians of Canada</i> Ontario Medical Association
Nursing	College of Nurses of Ontario	<i>Canadian Nurses Association</i> Nurse Practitioners' Association of Ontario Registered Nurses' Association of Ontario
Pharmaceutical	Ontario College of Pharmacists	<i>Canadian Pharmacists Association</i> Ontario Pharmacists' Association
Dental	Royal College of Dental Surgeons of Ontario	

Table 4-1: The regulatory colleges and professional associations representing the four main health care professions involved in the consultative process with HPRAC.

Profession	Regulatory College	Professional Association
Chiropody/ Podiatry		Ontario Podiatric Medical Association Ontario Society of Chiropodists
Chiropractic		Ontario Chiropractic Association
Dentistry and Dental Hygiene	Royal College of Dental Surgeons of Ontario College of Dental Hygienists of Ontario	Ontario Dental Association
Dietary	College of Dietitians of Ontario	Dieticians of Canada
Diagnostic Medical Sonography	<i>Not a regulated profession</i>	Canadian Society of Diagnostic Medical Sonographers Ontario Society of Diagnostic Medical Sonographers
Massage Therapy		Ontario Massage Therapists' Association
Medical Laboratory Technology	College of Medical Laboratory Technologists of Ontario	
Medical Radiation Therapy	College of Medical Radiation Technologists of Ontario	Ontario Association of Medical Radiation Technologists
Medicine	College of Physicians and Surgeons of Ontario Ontario College of Family Physicians	Ontario Medical Association Section on General and Family Practice (Ontario Medical Association) Ontario Society of Physicians for Complementary Medicine
Midwifery	College of Midwives of Ontario	Association of Ontario Midwives
Naturopathy¹⁰		Board of Directors of Drugless Therapy - Naturopathy Ontario Association of Naturopathic Doctors
Nursing	College of Nurses of Ontario	Registered Nurses' Association of Ontario Nurse Practitioners' Association of Ontario
Optometry	College of Opticians of Ontario	Ontario Association of Optometrists
Pharmaceutical	Ontario College of Pharmacists	Ontario Pharmacists' Association Independent Pharmacists of Ontario
Physiotherapy	College of Physiotherapists of Ontario	Ontario Physiotherapy Association
Psychotherapy	Transitional Council of the College of Psychotherapists and Registered Mental Health Therapists of Ontario	Canadian Association for Psychodynamic Therapy Ontario Association for Marriage and Family Therapy Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists
Respiratory Therapy	College of Respiratory Therapists of Ontario	
Social Work	Ontario College of Social Workers and Social Service Workers	Ontario Association of Social Workers

¹⁰ At the time, the Transitional council of the College of Naturopaths of Ontario was not active.

Profession	Regulatory College	Professional Association
The HPRAC submissions of the groups highlighted in blue were not located on publicly available websites.		
Groups highlighted in red did not participate at the Committee hearings.		

Table 4-2: Submissions to HPRAC in regards to the Minister’s request on mechanisms to facilitate IPC among regulatory colleges.

In particular, the interest groups representing the professions most affected by Bill 179 (i.e. physicians, nursing, pharmacists, medical radiation technology, and diagnostic medical sonography) participated in both the HPRAC and Committee activities. Certain interest groups participated in the HPRAC consultative processes but not in the Committee hearings (Table 4-2). It is likely these interest groups chose not to participate at the hearings because either Bill 179 did not threaten their interests or their mandates did not match the discourse. This would include the involvement of national associations in a provincial policy process but three national associations did, in the case of Bill 179: the Canadian Society of Diagnostic Medical Sonographers, Dietitians of Canada, and the Canadian College of Naturopathic Medicine¹¹.

Other policy actors, besides the regulatory colleges and professional associations, also participated in these activities. Data collection found a HPRAC submission on behalf of the psychotherapy academic institutions by the Alliance of Psychotherapy Training Institutions. Additionally, the HPRAC website listed submissions from the Ontario Hospital Association, Georgian College, Children’s Treatment Network of Simcoe York, and a McMaster University professor (independent submission). Alternative participants at the Committee hearings included two academic institutions (the Canadian Memorial Chiropractic College and the Canadian College of Naturopathic Medicine), the Nurse Practitioner Network of the Central East LHIN, the Lyme Action Group, two private companies (PharmaTrust and

¹¹ It is likely these national associations had a greater interest in the outcomes of this discourse than other professional association, as it could strengthen the role of their members in different provinces/territories.

Shoppers Drug Mart), and two private citizens. However, it is important to note, that the regulatory colleges and professional associations were the main contributors to the HPRAC consultative process and avid participants at the Committee hearings.

4.3 Making a Statement: Analysis of the Discourse

It was frequently cited in the material that there was a need to increase access to services to ensure a more efficient and effective health care system. This dialogue is not surprising because, in the last decade, there has been an increased awareness about the long wait-times in Ontario's health care system. As described in section 4.1, the consultative process between the interest groups and HPRAC was initiated by the Minister of Health's request for HPRAC to identify mechanisms that would facilitate IPC. However, the specific request by the Minister to evaluate the "standards of practice and professional practice guidelines" (HPRAC, 2008a, p. 45) caused the discourse to change; any further consultation between the regulatory colleges, professional associations, HPRAC, and the Minister of Health emphasized the "enhancement of scopes of practice" to allow certain health care professionals to perform additional controlled acts¹² instead of identifying mechanisms to facilitate and support IPC. Previous materials have not established the relationship between IPC and the enhancement of scopes of practices but overlapping scopes of practices had been cited as barriers for IPC (section 1.1). The Ontario College of Family Physicians (OCFP) repeatedly used the phrase "[IPC] can be enabled; it cannot be legislated" in many of its documents, including their submissions to HRPAC, to emphasize their opinion that the facilitation of IPC requires systematic mechanisms that cannot be achieved through

¹² Controlled acts are medical acts that can only be performed by authorized healthcare professions. In some cases, these acts may be delegated to others (i.e. a physician will allow a physiotherapist to administer an inhaler during a pulmonary function test).

legislative changes to the scopes of practice. Similarly, the Ontario Dental Association [ODA] (2008) stated:

IPC requires a broad range of regulated and, in some instances, non-regulated health care providers to work in teams ... Understanding the value of each member of the team is important. It is not necessary to promote changing scopes to maximize the way that individuals can contribute to the care of the patient. (p. 6-7)

Other submissions from interest groups, with the exceptions of those representing the medical and dental professions, did not comment on the relationship between scopes of practice and IPC.

A second change during the policy process occurred after the release of the draft for Bill 179. The discussion surrounding the enhancement of scopes of practice remained strong but the unexpected inclusion of a “supervisor provision” – to provide the Minister the authority to control the administrative functions of the regulatory colleges, at will – caused many interest groups to address this aspect of the bill within their submissions to the Committee. As such, the submissions contained many different focal points that resulted in a less cohesive message from most health professional organizations. In particular, the four main health professions (as listed in Table 4-1) were strongly opposed to the supervisor provision.

The purpose of the following sections will be to identify and describe the content of the discourse that occurred in regards to: the identification of mechanisms to facilitate and support IPC; enhancement of scopes of practices as a measure to facilitate and support IPC (for both the individual professions and the whole regulatory framework); and inclusion of the “supervisor provision”. This section will assist us in analyzing the interactions that occurred between policy actors, the HPRAC, and the Committee during the policy process that led to Bill 179.

4.3.1 Mechanisms to Facilitate and Support IPC: The General Consensus

The HPRAC (2008) discussion guide invited interest groups to participate in the consultative process intended to address the Minister of Health's request. The guide offered 43 questions to be considered in the development of the interest groups' submissions. While the guide stated that these questions were not a requirement, very few submissions deviated from those questions. As such, the majority of submissions closely reflected the questions of the consultative guide and undeniably determined the general content of the discourse. Table 4-3 identifies the topics emphasized in the consultation process and the general message provided by the interest groups' submissions.

Submissions to HPRAC demonstrate a general consensus among interest groups on the questions presented in the consultation guide. First, the majority of submissions agreed that IPC may alleviate the pressures on health human resources. Interest groups cited issues related to a decrease in physician capacity, a different generation of physicians who work fewer hours, and an aging population require "...an evolution of the health care system." (College of Physician and Surgeons of Ontario [CPSO], 2008, p. 2) Additionally, there was general agreement on the proposed elements of HPRAC's definition for IPC but interest groups identified that further consultation among health care professions was required to refine this definition. The need for further consultation indicates continued uncertainty around the meaning and requirements of collaborative care among health care professionals.

Topic	Submission
Defining IPC	<ul style="list-style-type: none"> - IPC is imperative to resolve the health human resources pressures - It is imperative that IPC is implemented in Ontario's health care system - Health Force Ontario definition: the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings - There are many ways to define collaboration and further consultation should be conducted to refine this term.
Eliminating barriers	<ul style="list-style-type: none"> - The RHPA is not considered a barrier because it was designed to build on the regulatory framework guiding health care providers. However, there is a desire for a quicker process to implement amendments. - Changes to the RHPA by the <i>Health Systems Improvements Act, 2006</i>, already do much to promote and support IPC. - A review of auxiliary acts is needed to identify how they may encourage IPC. Particularly <i>the Public Hospitals Act, the Healing Arts Radiation and Protection Act, the Nursing Act, the Laboratory and Specimen Collection Centre Licensing Act, and the Health Insurance Act.</i>
Developing enablers for collaboration	<ul style="list-style-type: none"> - Professional development programs would help team members work collaboratively and overcome professional cultural issues. - There should be more resources available to develop IPE curriculums within academic institutions and skill development at the practice level. - Ensure long-term funding/compensation for IPC models. - Physicians insist that collaboration should be encouraged instead of legislated.
Individual liability for IPC	<ul style="list-style-type: none"> - Professional liability coverage is not mandated because it is usually provided by the employer, unless they are contract workers. - Many do not see how mandatory liability coverage will eliminate barriers to IPC. However, there is agreement that personal liability policy would be a good idea (amounts state \$1-2 million).
Structural mechanisms	<ul style="list-style-type: none"> - Responses are mixed about an interprofessional quality assurance model; some believe it would assist in establishing best practice for professionals while others do not believe it will provide any benefit. - An interprofessional complaints process may be costly and replace the role of the college's own complaint process. Colleges are confident that a process can be developed between colleges to use existing processes to deal with such inquiries. - There is a lack of professional guidelines and tools among colleges; would be supported of a selected interprofessional standard relevant across Colleges. - The Federation of Health Regulatory Colleges of Ontario could take on the responsibility to develop common standards, tools, and processes for IPC. - Colleges feel existing mechanisms are sufficient to ensure accountability, and to facilitate and support collaboration among the Colleges; do not require the addition of an independent oversight body

Table 4-3: Summary of the submissions to HPRAC on mechanisms to facilitate and support IPC among regulatory colleges.

Second, the RHPA was not considered a barrier for IPC but there was a desire among regulatory colleges to create a faster process to implement amendments. Also, further amendments to the RHPA were not necessary because of the anticipated implementation of *Bill 171, The Health System Improvement Act*, which also intended to encourage IPC¹³. However, submissions did encourage the review of the legislation and auxiliary acts specific to individual professions that outline their scopes of practice, an idea that was similar to part of the Minister's request. Once again, the majority of arguments stated that changes to scopes of practice appear to advance the profession, but it is not clear how they would facilitate or support IPC.

Third, two main issues were identified in regards to the development of enablers that would support IPC: education and financing. Many submissions identified the need to implement and support IPE curriculums within academic institutions in an effort to develop the students' skills for collaborative practice, prior to their application for registration with the regulatory college. Additionally, some submissions focused on education post-registration; there was a great interest to implement professional development programs for health care professionals currently delivering services. Those submissions that mentioned financing IPC models all agreed that long-term and alternative payment models were needed to support collaborative practice.

Fourth, the majority of responses from interest groups were uncertain about the topic of liability insurance. Submissions identified that individual liability requirements were not consistent across regulatory colleges, partly because the situation differed from one health profession to another, depending on their health care setting (i.e. hospital versus private

¹³ Key features of Bill 171 include provisions to increase transparency and accountability of regulatory colleges and enhancing the scopes of practice of certain professions.

clinic). In most cases, regulatory colleges do not require their members to obtain individual liability insurance because they are usually provided by the employer. Thus, there was uncertainty about the benefits of mandating individual liability to facilitate IPC among health professions. But most responses agreed that \$1-2 million of individual liability insurance would be advantageous for team-based care facilities.

Finally, there was consensus on the subject of structural mechanisms for IPC. In this case, the consultative guide identified specific processes and tools to assist in the facilitation and support of IPC, including: quality assurance models; an interprofessional complaints process; and guidelines and tools to support IPC. Most submissions identified the acceptance of accountability measures for their professions but there were uncertainties in regards to the additional benefits yielded by IPC-specific models and processes for health professions and the public. These submissions identified that pre-existing processes within the regulatory colleges could be utilized on a case-by-case basis. In other words, the regulatory colleges could be able to combine their processes and resources to deal with complaints processes as the occasion arose; most submissions identify the Federation of Health Regulatory College of Ontario as a potential organization to ensure consistency within the guidelines, tools, and policies for IPC across regulatory colleges.

It is important to note that there was a general consensus among the majority of interest groups on the aforementioned mechanisms to facilitate and support IPC (Table 4.3). However, the medical profession also focused on increasing physician capacity, as well as implementing electronic health records (EHRs) and remuneration models to facilitate and support IPC. It is not surprising that the medical profession would seek to advocate for more physicians, or the systematic mechanisms that would aid their own practice. But it is

surprising that the submissions from other interest groups did not emphasize the need for EHRs¹⁴ because research suggests that the use of EHRs is critical for advanced interprofessional teams (Virani, 2012).

The focus on increasing physician capacity as a measure to ensure access to services was prominent within the medical profession. According to the College of Family Physicians of Canada [CFPC] (2007), “[e]vidence strongly supports better health outcomes for those in communities with better access to family physicians and associated primary health care professionals”¹⁵. (p. 2) The CFPC did not offer how or why family physicians are able to achieve these health outcomes but the OMA argued that the physicians’ role as a frontline health care provider provide them with a “... unique perspective on what types of services are required to meet the needs of patients.” (OMA, 2009c, par. 5) Thus, in their view, physicians, as gatekeepers, are better able to assist the patient in accessing necessary services.

The CFPC recommended that increasing access to physicians could be achieved by the enhancement of medical education programs to support residents intending to practice family medicine. The Royal College of Physicians and Surgeons of Canada [RCPSC], the College of Physicians and Surgeons of Ontario [CPSO], the OCFP, and OMA shared similar views but within a broader perspective, suggesting the need to support residency programs in specialty care areas. For example, the OMA focused on the need to develop physician capacity for maternity care in rural and remote communities.

¹⁴ While this element was not captured in the submissions, it was identified in a workshop hosted by the HPRAC. It received one sentence in the Interim report (HPRAC, 2008b) to the Minister of Health.

¹⁵ The phrase “associated primary care professionals” places greater emphasis on the benefits of family physicians since they do not specify which professions are associated with family medicine.

Additionally, the CPSO, OCFP, and OMA strongly advocated for two other systemic issues that, in their opinion, required the province's attention. First, there was significant support for a provincial infrastructure for electronic health records to decrease redundancies, as demonstrated by the following excerpts:

IPC is facilitated when health care providers have access to the necessary information about patients [and] are able to communicate with one another. Electronic solutions, including the Drug Information System, and ultimately an electronic health record, will be the foundation of IPC. The CPSO urges the Ministry to make the development of an electronic health record a priority in its IPC mandate. (CPSO, 2009, p. 2)

While enhancing efficiencies are the underlying goal, access to electronic medical records is important or there will be duplication in lab orders. Additionally, with more professionals independently ordering tests, duplication is a concern leading to fragmentation and additional costs. (OCFP, 2008, p. 10)

“Doctors who use Electronic Medical Records report patient safety, continuity of care and quality of care have improved,” said Dr. Strasberg. “Ensuring that EMRs are available in every doctor's office is an important step towards improving and strengthening Ontario's health care system.” (OMA, 2009a, par. 6)

Second, documents from the medical profession often cited insufficient funding and payment arrangements as a barrier to IPC; the current fee-for-service model does not facilitate IPC arrangements. According to the CMA (2007):

Remuneration models should be established in a manner that encourages providers to participate effectively in the delivery of care and team effectiveness. Reimbursement models must be configured to remunerate the communicator, coordinator, manager, and other roles and responsibilities of providers necessary for the success of collaborative care practice. (p. 10)

As such, the CPSO, OCFP, and OMA recommend the government investigate alternative payment models, such as the Family Health Team (FHT) model, to ensure patients are able to access their collaborative services. However, the OMA appeared frustrated when the government began to support the implementation of nurse practitioner-led clinics over FHTs in 2009, stating: “It is puzzling why the government would press ahead with an unproven

and untested model, such as independent led nurse practitioner clinics, rather than effective and efficient collaborative care models such as FHTs.” (OMA, 2009b, par.1) The OMA argues that nurse practitioner-led clinics remove the physician in delivery quality and safe patient care whereas FHTs allow the contribution of multiple health care professions.

Concluding Remarks

In sum, there was general consensus among interest groups about the mechanisms needed to facilitate and support IPC. The interest groups representing the medical profession emphasized different items within their submission that neither contradicted, nor supported, the submissions of other interest groups, but emphasized a gap in the literature. However, the content of the discourse did not transfer beyond this specific consultation process or the resulting report; there was no explanation as to why this particular discussion stopped. In general, the consultative process appeared fragmented. Interest groups provided their submissions to HPRAC, which aggregated the information into a report for the Minister of Health, but there was not feedback from HPRAC unless it requested further clarification.

4.3.2 A Fight for Greater Responsibility: Enhancing Scopes of Practice

As previously mentioned, the Minister of Health’s request to specifically review the scopes of practice of health care professionals, particularly for nurse practitioners (NPs), as well as prescribing for non-physician professionals, shifted the policy focus onto individual professional practices instead of mechanisms that would facilitate and support IPC. As a result, the second HPRAC consultative practice focused on the review of the scopes of

practice of the following ten non-physicians professions who are authorized to prescribe and/or use drugs in the course of their practice¹⁶:

- Chiropody
- Dental Hygiene
- Dentistry
- Naturopathy
- Midwifery
- Pharmacy
- Physiotherapy
- Nurse Practitioners
- Medical Radiation Technology
- Diagnostic Medical Sonography

Subsequent submissions from interest groups to HPRAC detailed potential amendments to auxiliary acts that, in their opinion, would enhance their profession's scopes of practice and, inevitably, support IPC in the delivery of health services. As expected, these submissions outlined the need to allow the above professions authorization to perform additional controlled acts, in order to maximize their skills, mainly for prescribing and dispensing of drugs and substances by non-physicians. There was also significant interest in allowing professions to communicate a diagnosis to the patient and perform and/or request laboratory testing. Although the Minister of Health did request the review of scope of practice of NPs, as well as non-physician prescribing, there was no mention of how or why the above professions were selected in the consultative process. The following sections will evaluate the themes that emerged in the discourse related to the enhancement of scopes of practice for each of the above listed professions.

4.3.2.1 The Lightweights: Chiropody, Dental Hygiene, Dentistry, Naturopathy, and Midwifery

The interest groups representing the professions of chiropody, dental hygiene, dentistry, and naturopathy had smaller roles in the consultative processes for Bill 179.

¹⁶ Other professions may have had their scopes of practice reviewed in preparation of Bill 179. However, the interactions that occurred within the consultative process focused on these listed professions.

Submissions were received from these professions to enhance their respective scope of practice but other interest groups did not appear to provide a response, or the number of responses was limited; few documents addressing these submissions were located in the data collection. This lack of documentation suggests that these proposed amendments did not conflict with the scopes of practice of other professions and, as such, did not receive attention from other interest groups. As identified in section 3.4, it is also possible that the responses to these submissions were no longer made available online.

Amendments for the scope of practice of chiropractors received the least amount of attention in the consultative process. In fact, data collection was unable to locate the responses to the submission for the enhancement of the scope of practice for chiropractors. According to Rosendum & DuMoulin (2010), their submission requested the addition of the authorized act to administer¹⁷, by inhalation, a substance designated within their regulations. Likewise, the proposed amendments to the scopes of practice of naturopaths received no responses from other interest groups. It was an interesting case because the *Naturopathy Act, 2007* had not yet been implemented but amendments to their scope of practice were still recommended. In their joint submission to HPRAC, the Board of Directors of Drugless Therapy – Naturopathy (BDDT-N) and Ontario Association of Naturopathic Doctors (OAND) recommended that natural substances (i.e. vitamins) be included in the list of drugs that naturopaths are able to prescribe, dispense, compound, or sell. While this recommendation appeared sound, it remains unclear why the *Naturopathy Act* did not already include the ability to prescribe natural substances that were common to the profession. Further research into this area determined that some of these natural substances

¹⁷ Administration refers to the direct placement of a drug by into the patient's body by immediate ingestion, application, inhalation, insertion or injection, for diagnostic or therapeutic purposes.

were re-classified as controlled substances because of their potential to cause serious harm if taken incorrectly. This raises the limitations of the lengthy process required to amend the list of controlled substances authorized to certain health professions. This message was echoed at the Committee hearing by the OAND and BDDT-N, which clarified that they are “...only asking for access to substances that would maintain the existing scope of practice, so that would be those kinds of substances that [naturopathic doctors] have always prescribed for patients that have been moved to restricted lists.” (Ontario, 2009a, p. SP-745)

Furthermore, the OAND and BDDT-N recommend changes to the controlled act of “communicating a naturopathic diagnosis” (Ontario, 2009a, p. SP-740). The submissions requested that the term “naturopathic” be dropped from the wording of this controlled act to prevent confusion that this diagnosis is any different from a medical diagnosis. Such a change would ensure that patients perceived the same level of significance in the diagnosis, whether it was from a naturopath or physician. In other words, the status of a naturopath would be equal to the status of physicians, in regards to naturopathy. Additionally, the OAND argued that the confusion between the two terms would create significant barriers to collaboration but they do not demonstrate how or why this barrier could exist. Other recommendations included the ability to complete in-clinic lab testing and send testing requests to Ontario laboratories. The recommendations offered by the OAND and BDDT-N were strengthened by the participation of the Canadian College of Naturopathic Medicine at the Committee hearing, which outlined the competencies of their students to provide the services outlined in the above recommendations.

Much like the professions of chiropody and naturopathic doctors, there was little response from other interest groups to the submissions for the enhancement of the scopes of

practice of dental hygienists and dentists. It is likely that this discourse was limited because of their unique scopes of practice but, as we will see, there was considerable tension and disagreement between dental hygienists and dentists.

In the case of dental hygienists, the scope of practice already included the controlled act of administering drugs but interest groups recommended the additional authorization for prescribing, dispensing¹⁸, compounding¹⁹, or selling²⁰ for the purpose of pain management and the sale of smoking cessation therapies and antibiotics. In particular, the College of Dental Hygienists of Ontario (CDHO) appealed for the improvement of patient safety and comfort at the Committee hearing by urging for more compassionate health services: “In today’s world, with modern health care and modern drugs, there is no reason why anyone should have to suffer pain when they get their teeth cleaned.” (Ontario, 2009a, p. SP-748) This argument was supported with examples of other provinces and countries in which dental hygienists successfully perform the recommended controlled acts. Furthermore, their submission outlined a comprehensive plan to develop a curriculum to train dental hygienists in these controlled acts and identified their collaboration with university-based programs in dentistry and dental hygiene to develop a certificate program in Ontario.

At the Committee hearing, the ODA was hesitant in its support of CDHO’s recommendation. The ODA believed it was necessary for dental hygiene students to have more education and training in “...anatomy, biochemistry and physiology as well as a more in-depth understanding of pharmacotherapeutics before being permitted to prescribe and use additional drugs.” (Ontario, 2009c, p. SP – 791) The ODA response does not clearly indicate

¹⁸ Dispensing refers to the selection, preparation and transfer of a drug to a patient for administration.

¹⁹ Compounding refers to the act of combining two or more elements to create a distinct pharmaceutical product.

²⁰ Healthcare professionals must be authorized to exchange a dispensed drug for money or other consideration.

if the existing curriculum is insufficient or if the proposed changes to the curriculum are still insufficient. Regardless, they recommended the participation of dentists on the committee to develop the controlled acts for dental hygienists. Their participation would provide dental hygienists with expertise in conducting the controlled acts, but it would also maintain dentists' dominance in this area. However, the Royal College of Dental Surgeon of Ontario (RCDSO) did not comment on these recommendations. As the regulatory college for dentists, their lack of participation suggests the recommendations outlined by the CDHO do not have significant impact on their member's practice.

Recommendations for the enhancement of the scope of practice of dentists included the addition of the controlled acts for compounding and selling a drug within their regulation. The controlled acts of prescribing, administration, and dispensing drugs were already a component of the dentists' scope of practice. While no explanation was provided by the RCDSO, ODA, or the Government of Ontario for these recommendations, Rosendum & DuMoulin (2010) explain these changes were made to close the gap in the controlled act for drugs of dentists. But the ODA and RCDSO did not further discuss the enhancement of the dentists' scope of practice at the Committee hearing but focused instead on the supervisor provision (discussed in section 4.3.3).

The recommendations provided by the College of Midwives of Ontario (CMO) and the Association of Ontario Midwives (AOM) offered similar amendments to enhance the scopes of practice for midwifery, but generated more responses from other interest groups. First, both the CMO and AOM identified the need to update the list of drugs designated in their regulations, which were drafted 15 years ago, due to significant advances in the profession's skills and medication therapy that were not yet reflected in the list. This example drew

attention to the limitations of the “lengthy and restrictive” drug-approval process and emphasized the need to improve this process to ensure patient safety. “The process has really dragged on, and five years later we’re still consulting in order to get a simple prescription for something that is routine.” (Ontario, 2009a, p. SP-755) Similarly to the profession of naturopathy, midwives also lost the ability to provide necessary medication when that drug was no longer accessible to them. “...[I]t took one year to get special permission for midwives to get access to a different drug of the same type to use at home births and in other emergency situations. This is critical.” (Ontario, 2009a, p. SP-755) Finally, the discussion hints at establishing a pan-Canadian standard for the regulation of health professionals; the CMO identified that a number of areas in their scope of practice required amendments to align Ontario midwives with the practices of midwives in other provinces.

A total of 26 responses were received by HPRAC of which 14 were from practicing midwives. In general, the majority of the 12 responses from others supported the changes presented by the CMO and AOM. There was stronger criticism from the interest groups representing the medical profession, who were concerned that midwives did not possess the education, training, or continued professional development to allow these enhancements. The medical profession supported expanding the list of drugs to include commonly used antibiotics, and other types of medication, but there was disagreement that midwives should perform certain acts currently performed by obstetricians. They argued that further enhancements would fragment primary care services for women and newborns – although it is unclear how this could occur. In particular, the medical profession was concerned that midwives were being used as “physician replacements” in urban areas. The medical profession suggested that midwives working in remote and rural areas could perform the

services in question, in the absence of an available obstetrician or physician. However, they emphasized that there was no need to authorize midwives to perform those services in areas where obstetricians are readily available. At the Committee hearing, however, representatives of the medical profession supported the participation of a member of the medical profession to assist the midwives in developing an enhanced scope of practice and curriculum to support the required knowledge and skills. Similar to the interaction between dentists and dental hygienists, it would appear the medical profession is attempting to continue its dominance over its scope of practice.

In sum, the proposed amendments to the professions of chiropractic, naturopathy, dental hygiene, dentists, and midwifery were very clear throughout the consultative process and remained on-point to advocate the enhancement of their own profession's scope of practice; they did not respond to the submissions of other interest groups within their presentation at the Committee hearing. In addition, their submissions did not gain significant attention during the consultative process or the Committee hearing, likely because their scopes of practice did not overlap with other professions. But as evident in the interaction between the dental hygienists and dentists, as well as midwives and physicians, scopes of practice that overlapped prompted the dental and medical professions to question their ability to perform those controlled acts, based on their existing competencies and training. In both cases, the dental and medical professions remained "political" in their responses by not, necessarily, denouncing the recommended enhancements. Instead, the dental and medical professions recommended further consultation with one of their members to assist in the development of the scopes of practice, and offer advice to develop a curriculum and professional development plan. As a result, the dental and medical professions could maintain dominance

over their scopes of practice by influencing the development of the practices of the other professions.

4.3.2.2 From One Side of the Counter to the Other: Pharmacy

The dominant theme emerging from the pharmaceutical interest groups is the evolution of the profession from the traditional role of “count and pour, lick and stick” (Ontario College of Pharmacists [OCP], 2008, p. i). According to the Ontario College of Pharmacists (OCP, 2008), “[m]any pharmacists promote health and wellness in their practice settings...” and the *Pharmacy Act, 1991* requires amendments to “...more accurately reflect pharmacist practice today.” (p. ii) Additionally, the OCP argued their profession now involves a “cognitive role” in the management of medication therapy; pharmacists are increasingly reviewing the patient’s medication and relevant history to ensure patient compliance and effective medication therapy (OCP, 2008).

The OCP and Ontario Pharmacists’ Association (OPA) provided recommendations that complemented each other and supported amendments to allow pharmacists greater responsibility in dispensing and managing medication therapy. However, many of their enhancements overlapped with the scope of practice of physicians, such as: authorizing an extension on prescriptions (continue refills for continuity of care); prescribing drugs and substances regulation for minor ailments in cases where reimbursement under drug plans is required; ordering and interpreting laboratory tests to adjust dosage of medication in response to monitoring; and administering drugs through injection and inhalation, for patient education. Additionally, the recommendation included formalizing a practice that was commonly associated with pharmacists: adapting existing prescriptions to facilitate patient compliance (i.e. changing dosage form or dosage regimen due to patient’s preferences, third-

party drug benefit plans, and commercial availability) (OCP, 2008; Rosendum & DuMoulin, 2010).

The submissions from the OCP and OPA received significant response from pharmacists and other interest groups; 76 letters were received by HPRAC from individual pharmacists and physicians supporting the recommendations. Eleven other prominent groups wrote to HPRAC in support of these recommendations, including the Canadian Association of Chain Drug Stores, Canadian Society of Hospital Pharmacists, Dietitians of Canada, Shoppers Drug Mart, and Pharmasave Ontario. The recommendations offered by OCP and OPA are largely indicative of the possible implementation of a program in which the pharmacist is the patient's first point of contact for minor ailments and simple tasks (i.e. prescription renewal). The OPA submission provided a cost-saving analysis that demonstrated the potential benefits of this model of health care delivery by referring to the successful implementation of this model in the United Kingdom.

The recommendations were also supported by the large retail chains, Shoppers Drug Mart and Pharmasave. Their participation in the consultative process and at the Committee hearing is not surprising as most pharmacists provide services out of retail stores; any changes to their scope of practice may impact the profits collected by these chains. Shoppers Drug Mart provided compelling examples of pharmacists in their stores across Canada who performed services related to the proposed amendments. They argued that patients have experienced greater access to health services because the enhancements to the pharmacist's scope of practice in British Columbia, Alberta, and New Brunswick have allowed patients with minor cases to seek advice from pharmacists. They argued that these enhancements have shifted some of the burden on the health care system from emergency rooms and

medical offices to retail stores. In addition, pharmacists working in their 24-hour stores have assisted nurses working in the Telehealth program by responding to, on average, 20 Telehealth calls per night, addressing questions related to medication issues.

At the Committee hearing, presentations from pharmaceutical interest groups focused on promoting their proposed amendments. The OPA expressed cautious support for the enhancement of scopes of practice of other professions as it related to the dispensing, compounding, and selling of drugs, without the presence of a pharmacist. The *Drug Pharmacies Regulation Act, 1990* requires the presence of a pharmacist when compounding and dispensing drugs. However, amendments to this act would remove this provision to allow non-pharmacists to enhance their own scope of practice in regards to drugs and substances. The OPA does not identify the potential consequences of this enhancement, but recommended that "... the standards for these controlled acts should be closely aligned with those of pharmacy." (OPA, n.d.) Once again, there was opposition to the amendments of the scope of practice that overlapped with other professions. However, the pharmaceutical interest groups appeared less concerned about sharing scopes of practice with other professions, in comparison to the dental and medical professions. It is not clear why only the OPA expressed concerns about these amendments (instead of the OCP) but, then again, the model of medication therapy was not clearly explained. The proposed amendments do not appear to affect the majority (76.4%) of pharmacists working in community pharmacies (Canadian Institute for Health Information [CIHI], 2012) who gain most of their business from patients who have already received a prescription or require an over-the-counter medication. Pharmacists working in hospitals and other health care facilities would still have a role regardless of which health care practitioners sends the prescription.

The proposed amendments in Bill 179 included a provision to allow for remote dispensing, an issue of interest for PharmaTrust and the Independent Pharmacists of Ontario (IPO) at the Committee hearing. PharmaTrust advocated for the use of innovative technologies to extend pharmacy services throughout the province, including remote areas. But it is important to note that PharmaTrust is the developer of the MedCentre, an automated pharmacy dispensing system and amendment to the related Acts to allow remote dispensing would significantly assist this company in selling its product.

PharmaTrust did not clearly articulate their proposed amendments; at times, their presentation appeared incoherent or fragmented and it did not clearly specify the nature of their proposed amendments for Bill 179:

However, fundamentally, the safety of any of these systems, be it the telephone, a remote dispensing station, robotics, which exist in pharmacies and hospitals across this province—the existing systems rest upon one thing: the professional judgment of a pharmacist. We ask that Bill 179 be modified so that it too rests upon that professional judgment of the pharmacist, and that the regulations that fall from Bill 179 not be unduly limited so that the benefits of these technologies are, in fact, made available and the spirit and intent of the legislation is actually brought to life in the industry and in the community for the benefit of Ontarians and pharmacists.

In pursuit of such, we propose two definitional changes: One is to incorporate a definition of remote dispensing, and another to incorporate a definition of a remote dispensing location—“remote dispensing” meaning dispensing at a remote dispensing location under the authority of a pharmacist or other authorized person through technological means; and “remote dispensing location” meaning a place where drugs may be dispensed remotely, pursuant to the authority of a pharmacist or another authorized person and subject to the approval of the college of pharmacy. (Ontario, 2009c, p. SP-794)

In contrast, the IPO expressed concern about the use of remote dispensing and argued that the presence of a pharmacist is a safeguard to ensure patient care and safety (Ontario, 2009a). According to the IPO, this amendment was introduced with little consultation and no report identified a shortage of physicians that would warrant such an initiative. “[W]e are

concerned that by promoting machines instead of health care professionals within communities, we are in fact fragmenting and diluting the care that is provided across the province.” (Ontario, 2009a, p. SP-743)

Of course, the enhancement of the scope of practice for pharmacy was largely contested by the medical profession as these amendments threatened to detract from the physician’s role. Since these amendments were one of two main issues for the medical profession, the interactions that emerged as a result of this objection will be discussed later in section 4.3.2.6.

4.3.2.3 More Than Just Bones and Muscles: Physiotherapy

The submission to HPRAC on the scope of practice for physiotherapy was jointly developed by the College of Physiotherapists of Ontario (CPO) and the Ontario Physiotherapy Association (OPhA)²¹. Twenty-six responses were received by HPRAC, the majority of which (16) supported these recommendations were derived from other interest groups and regulatory colleges with similar backgrounds, such as the Canadian Memorial Chiropractic College, Canadian Physiotherapy Association, the College of Occupational Therapists of Ontario, Ontario Chiropractic Association, Respiratory Therapy Society of Ontario, and others. Another eight responses were received from practicing physiotherapists.

Similar to the pharmacy submission, the CPO and OPhA identify the need to recognize the development of the profession, beyond their traditional practice. Within their recommendations, the CPO and OPhA propose the enhancement of their scope of practice to include their role in neuromuscular and cardiorespiratory disorders or diseases, an added profile to their traditional focus on disorders/diseases of the musculoskeletal system (i.e.

²¹ The acronym for the Ontario Physiotherapy Association and Ontario Pharmacists’ Association is the same (OPA). For the purpose of this thesis, I will refer to the physiotherapy group as the OPhA.

physical dys/function, pain, and rehabilitation). Proposed amendments include: the ability to communicate a diagnosis; perform controlled acts under the authorization of other professions; and the application of MRI and ultrasound for the purpose of assessing or diagnosing a physical dysfunction, disease or disorder. Related to the last amendment, the submission also requested the removal of limitations to order x-rays, laboratory investigation, and the ability to offer a referral (i.e. requiring a physician to order these tests or refer a patient).

At the Committee hearings, the CPO and OPhA maintained the focus of their recommendations on the enhancement of their scope of practice. Both groups identified that the existing process for medical directives involve constant back-and-forth between physiotherapists and other health professions. For example, physiotherapists must first be allowed to order the substance to be administered, and then the health care practitioner must order the physiotherapist to administer the substance. As such, the CPO and OPhA highlight the opportunity to reduce the number of steps in the process. “The [CPO] believes this requirement will continue to impose significant practical barriers that create inefficiencies in the provision of quality care.” (Ontario, 2009a, p. SP-761) At the Committee hearing, the CPO and OPhA did not respond to those amendments of other interest groups.

In general, responses from other interest groups stated their support for the amendments but the medical profession did raise concerns about these amendments, questioning, once again, if the profession had the necessary knowledge and skills to perform the services, particularly in assessing and diagnosing musculoskeletal disorder/diseases using ultrasound and diagnostic imaging. However, it was interesting that no written responses were received from the diagnostic medical sonography and medical radiation

therapy interest groups. The proposed amendments in regards to applying an MRI or x-ray appear to overlap with the scopes of practice for these professions and, based on the previous trends, it was expected that a response would be submitted from these two professions. There is no clear explanation as to why written responses were not provided from these interest groups when, as we will see in section 4.3.2.4, there was significant concern from the diagnostic medical sonography and medical radiation therapy interest groups about enhancing the scope of practice of NPs in the same area. At the committee hearing, the diagnostic medical sonographers and medical radiation therapy interest groups raised concerns about these amendments. However, the presentations referred to these amendments more as a passing note than a legitimate concern of these professions.

4.3.2.4 Doctor substitutes?: Nurse Practitioners (Registered Nurses in the Extended Class)

There was significant discussion surrounding the review of the nurse practitioner's (NP) scope of practice, as a result of the specific Minister's request (section 4.3). However, it was surprisingly difficult to locate responses from interest groups related to submissions on this review²². The HPRAC report on the review of scopes of practice of NP's stated that 125 responses were received and posted on the HPRAC website but it could not be located. However, additional submissions from College of Nurses of Ontario [CNO], the Registered Nurses' Association of Ontario (RNAO), and the Nurse Practitioners' Association of Ontario (NPAO) were located on the health professional organizations' websites.

The recommendations provided by these interest groups centred on one issue: removing restrictions on access to the controlled act of prescribing drugs and substances. At the time, NPs were allowed to prescribe from a list of drugs. However, the rate at which

²² This might be explained by the fact that the review was conducted in 2006, independently by the CNO.

newer medications entered the market far surpassed the rate at which the list was updated, which could result in sub-optimal care for the patient. The transcripts from the Committee hearings identified that those interest groups were cautious about giving NPs full access to this controlled act; they were concerned it would compromise patient safety even though the CNO, RNAO, and NPAO provided clear and sound rationale to address their concerns.

First, the CNO argued the fact that NPs had even just partial access to the controlled act demonstrated their competence to prescribe drugs. NPs are currently involved in the integrated process for prescribing, which includes the completion of a health assessment, patient history, analysis of clinical results, and the documentation of the medical record. As such, the NP curriculum covers the entire process involved with prescribing. Second, in terms of patient safety, the CNO stated that there is no connection between a list of drugs and safe prescribing but, regardless, "... NP only prescribes those drugs that she or he is competent to prescribe and that are relevant to the patient population with whom she or he works." (Ontario, 2009b, p. SP-783) The CNO, RNAO, and NPAO state that the list of drugs (instead of categories) are rigid and prevent NPs to provide the best available medication therapy to their patients. Third, the NPAO stated that this amendment would help "bring Ontario up to meet the bar" (Ontario, 2009a, p. SP-747) as seven other provinces and territories now authorize open prescribing for NPs.

The same three examples are used in the materials of the CNO, RNAO, and NPAO in their materials and presentations to emphasize the need for open prescribing:

Twinrix is a combination vaccine that offers dual protection for both hepatitis A and hepatitis B. According to the drug list, a nurse practitioner can prescribe the hepatitis A vaccine and/or the hepatitis B vaccine, but not the combined agent because this drug is not on the list. (Ontario, 2009b, p. SP-783)

One of the [NPs] in Thunder Bay recently told me that she needed to prescribe Ventolin to a [homeless] patient. He wasn't in severe distress, but he needed

puffers to keep it that way. The list only allows her to renew the Ventolin – that is, it must first be prescribed by a physician – and then the list permits her to order the repeats. The patient is homeless. He does not have a physician. Although this NP is perfectly capable of prescribing Ventolin, her best available option that day was to send him to the emergency department to get that first puffer. And by the way, the ER in Thunder Bay saw 125,000 people last year – one of the busiest in the country. That was her critical window of opportunity to provide that patient with the medication he needed. (Ontario, 2009b, p. SP-783)

Because of the list approach that nurse practitioners are currently restricted to, we don't know if we're going to be able to prescribe the vaccine for the H1N1 flu. It will all depend on the name that is given to that particular vaccine. If it's called "influenza vaccine," we're able to prescribe that. If it's called something else, as simple as H1N1, it will not be on our list and will not be able to prescribe, but nurse practitioners in other provinces will. (Ontario, 2009a, p. SP-747)

By using plain language and examples to which people can relate, the CNO, RNAO, and NPAO arguments appear concise and compelling.

The RNAO also briefly identified the limitations related to diagnostic and laboratory testing, arguing the enhancement of the scope of practice in this area "... would not only increase the overall efficiency of nurse practitioners assessment and treatment but would also reduce costs to the system as a whole." (Ontario, 2009c, p. SP-790) Not surprisingly, this recommendation drew strong opposition from the medical radiation technology and diagnostic ultrasound professions (discussed section 4.3.2.5).

While there are many issues raised in these submissions, the message among the interest groups representing the NPs was consistent throughout the consultative processes and the Committee hearing. The proposed amendments clearly affected the medical professions because patients would no longer be required to access the services of a physician for common prescriptions. As such, it is not surprising that the interest groups representing the medical profession had strong objections to the amendments. Arguably, the

CNO proposal received the most attention from the interest groups representing the medical profession, which will be discussed later in this chapter (section 4.3.2.6).

4.3.2.5 Medical Radiation Technologists and Diagnostic Ultrasound Sonographers

The recommendations provided jointly by the College of Medical Radiation Technologists of Ontario (CMRTO) and the Ontario Association of Medical Radiation Technologists (OAMRT) on the scope of practice for medical radiation technologists (MRTs) related to the requirement of medical directives to perform the controlled acts of diagnostic sonography and radiation therapy. The CMRTO and OAMRT argued that the MRT curriculum competently prepares its members to perform these acts and should be included in the *Medical Radiation Technology Act, 1991* to reduce the inefficiency of having to go back and forth with the authorizing health care professional of the medical directive; this is a similar argument proposed by the physiotherapists and NPs.

In general, these recommendations received little response from other interest groups. Only one individual MRT and three interest groups (the Canadian Association of Medical Radiation Technologists, Ontario Association of Radiology Managers, and Ontario Hospital Association) provided a letter of support to HPRAC on this joint submission. The OMA, in general, also supported the changes to the submission but requested clarification on some of the recommendations. The CMRTO and OAMRT's presentations at the Committee hearing reiterated these recommendations and provided a thorough explanation of how the curriculum supports the MRT's responsibilities in regards to these controlled acts.

The prominent contribution of these interest groups within the HPRAC consultative process and Committee hearings were their reservations about the recommended amendments to enhance the scopes of practice of NPs in relation to diagnostic sonography

and radiation therapy. Interestingly, the professions of physiotherapy and NPs requested the controlled act of applying MRI and ultrasound for the purpose of assessment and diagnosis. While the following the responses clearly evaluate and discuss the implications of this enhancement for NPs, there is little mention of the enhancements in scope of practice for physiotherapists. It is not clear why these professions chose to focus on one of these reviews since the proposed amendments appear to be very similar. There may be a difference between the practice of physiotherapy and NPs that was not apparent in the data.

A written response provided by the OAMRT on the CNO review of the scope of practice of NPs stated "...that there is ample evidence that [NPs] lack the necessary competencies regarding radiation protection, radiation biology, and "utilization" issues..." (OAMRT, 2007, p. 6) because of their improper use of the terminology. However, the OAMRT attributes this problem to most non-radiologists and oncologists, claiming that these professions "... are poorly educated on radiation safety, radiation exposure (radiobiology!!)... RN and RN(EC) [NPs]: must not be allowed to order CTs. It's bad enough most Physicians [sic] are allowed to order CTs!!! (because they don't know what they are ordering)." (OAMRT, 2007, p.8) It is important to note that this part of the OAMRT submission appears fairly unprofessional because of the poor sentence structure but an additional 41 letters were located on the HPRAC website, with over 150 signatures from members of the OSDMS, which outline similar concerns and objections about the CNO submission.

The OAMRT used a softer tone in their presentation at the Committee hearing and expanded their recommendations to include the review of the physiotherapist scope of practice. They stated:

Although we have no issue in terms of [NPs] and physiotherapists being able to order diagnostic imaging tests, we think it's a bit premature at this time, given the condition of the Healing Arts Radiation Protection Act and the education and training of [NPs] and physiotherapists related to diagnostic imaging exams, in terms of utilization and the radiation protection aspects." (Ontario, 2009a, p. SP-749)

In addition their concern about patient safety, the OAMRT feared that without the proper education and training, these professions may order diagnostic tests inappropriately (i.e. the patient does not require the test or the wrong test was requested) and more frequently, which could overburden their members.

The Canadian Society of Diagnostic Medical Sonographers (CSDMS) presentation echoed the OARMT arguments; they are not opposed to the recommendations but "...want the appropriate training, education and certification to be included in the competency profiles for [NPs]." (Ontario, 2009b, p. SP-768) The Ontario Society of Diagnostic Medical Sonographers (OSDMS) furthered the discussion on NP competency by offering a potential scenario: "... what happens if the [NP] believes that they have the appropriate knowledge, skills and judgement but in fact they have been misguided in this respect?" (Ontario, 2009c, p. SP-802) As such, the OSDMS recommend that the NP curriculum incorporate the national competency profile for entry-level persons practising sonography into their training.

The OSDMS raised the same concern as the OAMRT on the inconsistent use of terminology within the 2006 CNO submission. More discerning, the OSDMS identifies their willingness to collaborate with the CNO on this issue, "...however, we were never asked before the submission that was made to HPRAC, nor were we identified as stakeholders." (Ontario, 2009c, p. SP-802) "Our concern was, if the [NPs] are the ones doing the mentoring, without any consultation with sonographers, perhaps that's not going to allow for an appropriate education for them." (Ontario, 2009c, p. SP-803)

Much like the previous interactions between groups with similar scopes of practice, the interest groups representing the professions of diagnostic ultrasound sonographers and MRTs raised significant concern about the NPs ability to perform the requested controlled acts. They are not opposed to the enhancement of this controlled act for NPs if the NP curriculum incorporates the national competency profile of diagnostic ultrasound sonographers and MRTs. Additionally, they are willing to collaborate with NPs to ensure their members are equipped with the skills and knowledge to order and perform diagnostic testing. This offer for collaboration would legitimize the diagnostic ultrasound sonographers' and MRTs' expertise in this area of the health care system. Also, it would allow them to maintain their dominance over these scopes of practice by restricting certain professions from performing the related practices.

Interestingly, data analysis of the materials derived from these interest groups was particularly challenging. In other cases where multiple professions had overlapping scopes of practice, both the regulatory colleges and professional associations concentrated their efforts to explain why other professions should not possess the same scope of practice. Unlike some of the other professions, the MRT and diagnostic ultrasound sonographer interest groups did not appear as organized or consistent in their responses. In particular, as previously mentioned, the OAMRT response to the CNO review of the NPs' scope of practice was poorly written, which may have undermined their response. This may be attributed to the fact that these interest groups have a shorter history than some of the other interest groups.

4.3.2.6 *Ruling with a weaker-than-iron fist: The Medical Profession*

As highlighted in most sections of this chapter, the interest groups representing the medical profession outlined many objections for the enhancement of the scopes of practice of various health professions. But these interest groups were also one of the few that raised concerns about the general process implemented for this review; these concerns (Figure 4-2) were clearly listed by the CPSO (2008).

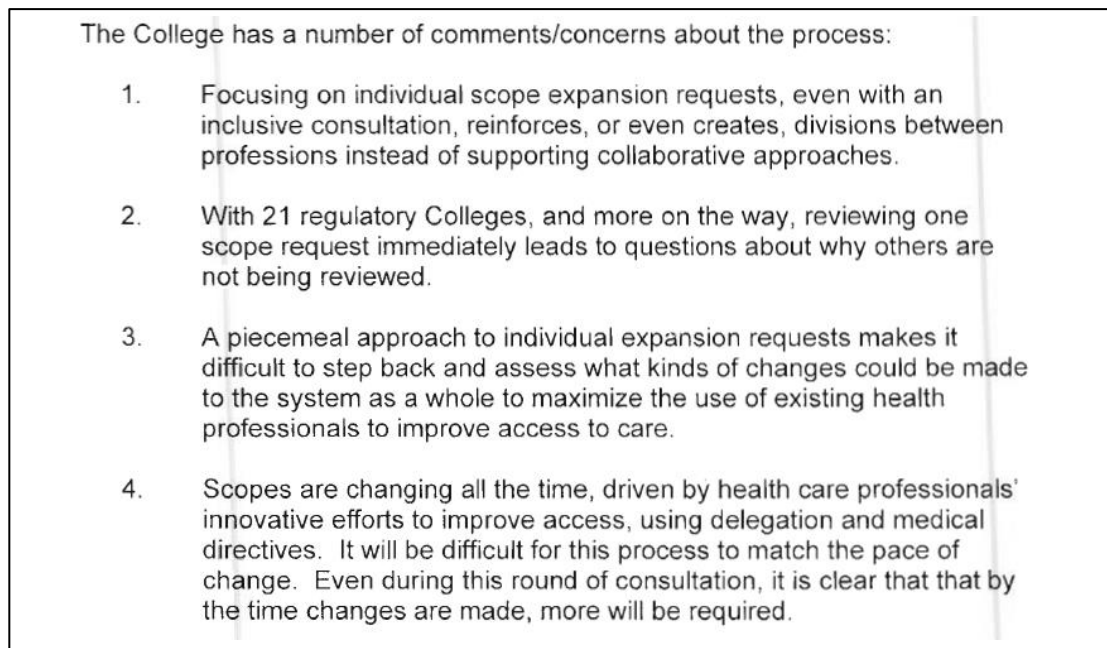


Figure 4-2: The CPSO's general comments and concerns about the consultative process for the review of scopes of practice.

The OMA provided further clarification within their submission to HPRAC on the issue of potential divisions between professions that may occur as a result of this review:

It is the OMA's understanding that the HPRAC review project has, as its goal, improving quality patient care in a collaborative environment. However, it appears that some professions' proposed changes may inadvertently cause further fractionation instead of integrating care. Certain medical conditions demand physician attention; management of these complex cases should not be delayed or undermined because of practitioners' unwillingness to share care or make referrals. This will create more silos of care rather than fostering collaborative care. (OMA, 2008, p. 2)

Additionally, there were concerns that HPRAC did not give enough time for interest groups to submit a complete response on the Minister's request. The ODA and CNO also raised these concerns in their written submissions to HPRAC.

A recurring statement that emerged in the review of various professional scopes of practice was the medical profession's concern that other professions do not currently possess the knowledge and skills required to perform various acts; there was significant emphasis placed on ensuring that the professions' curriculums and professional development programs met the requirements of the practice, before scopes of practice were enhanced. However, responses frequently began with a statement of support for the practitioners in question, applauding their role in the delivery of health services. Responses from the medical profession interest groups focused on the review of the proposals from the professions of dietetics, MRT, physiotherapy, pharmacy, and NPs.

The CPSO has a surprisingly short response (a little over 5 pages) for the review of the previously mentioned scopes of practice while other responses ranged from 10 to 20 pages, and sometimes longer. The CPSO only addressed the proposals from the pharmacists and midwives, stating that “[w]hile the CPSO is concerned about the proposals made by the Colleges of Dietitians and Physiotherapists, it requires further information to provide detailed comments.” (CPSO, 2008, p.2) It is important to note that the MRTs were identified in the title of their response, suggesting that the CPSO had a perspective on those recommendations but there was no further mention of MRTs in response. It appears that no subsequent response was submitted to review the scopes of practice of dietitians, physiotherapists, and MRTs. The debate among the medical profession on the review of scopes of practice of dietitians and MRTs was mute even though these professions

recommended amendments that would overlap the scopes of practice of the medical profession.

There was disagreement among the interest groups of the medical profession in regards to the review of the pharmacists' scope of practice. The CPSO stated that, in general, it supported the pharmacists' recommendations and refers to a previous initiative²³ between pharmacists and physicians, where efforts were made to create a foundation that would extend prescribing to pharmacists in cases of patients with stable chronic conditions. Thus, efforts to enhance collaboration between these two professions had already been initiated at the regulatory college level. However, the CPSO had concerns about the role of pharmacists in educating patients, reporting, and record keeping information, stating "[we] would need considerably more information about how all of these aspects of patient care would be managed before we could provide a considered response." (CPSO, 2008, p. 3)

Unlike the CPSO, the OMA had significant doubts about the pharmacist's ability to perform the functions outlined in their recommendations and suggested that the underlying premise of these recommendations was to replace physicians. According to the OMA, the OCP's submission would take away the physician's integral role of screening and counselling patients that can lead to the identification of other medical problems. Furthermore, the OMA argued that allowing pharmacists to order lab tests had the potential to duplicate services and increased costs because there was no system in place to record the patients' medical record. Finally, the OMA argued that the authorization for further extensions on prescriptions, or adjusting the dosage of medication, should be done in consultation with the provider. "The physician has an ongoing responsibility to the patient to prescribe appropriate dosages, follow up on treatment, and if needed, alter medication. To

²³ The Pharmacists Authorization of Prescription Extensions (PAPE) agreement

fulfill these professional obligations, the prescriber must be able to assess whether the decision made by the pharmacist is appropriate given the patient's condition.” (OMA, 2008, p. 11-12) As previously mentioned, the concern about whether or not the health profession possessed the necessary knowledge and training to perform the recommended acts was raised on many occasions by the medical profession. The OMA disagreed with the CPSO that pharmacists have the knowledge and skills to adjust medications or to assess and diagnose patients for minor ailments; they argue that pharmacists are not trained to conduct the necessary patient assessment and screening required to make the necessary alterations to medications. In general, the OMA maintained these recommendations during their presentation at the Committee hearing and furthered the discussion by suggesting the need of an integrated EHR system before allowing different health professions that authorization to prescribe drugs and substances, or order diagnostic tests.

There was a fair amount of criticism from the medical profession that midwives lacked the knowledge and training required to perform the controlled acts listed in their recommendations (section 4.3.2.1). Not surprisingly, the medical profession interest groups were concerned that some of these controlled acts, currently performed by obstetricians, would result in a parallel primary care, rather than a collaborative practice. However, they appeared to demonstrate a double standard because they supported the idea of midwives practicing those controlled acts in rural areas, when there was no available physician or obstetrician, but not in urban areas. The medical profession appeared to expect that this arrangement would be achieved through medical directives, but the example provided by the AOM indicated that physicians did not want to be burdened by this process. The AOM president shared her experience as a midwife and a common interaction she has with

physicians in regards to prescribing drugs: “I can’t tell you how many times doctors have said to me, “Why can’t you guys do that? I don’t understand why you guys can’t do that. You guys really need to be able to do that.”” (Ontario, 2009a, p. SP-755)

The discussion among the medical profession interest groups on the review of the physiotherapist’s scope of practice remained consistent throughout the HPRAC consultative processes and the Committee hearing. Concerns were raised, once again, about the profession’s knowledge and ability to perform the acts, as well as the possible implications of removing physicians from the consultations that occurred with medical directives. In particular, the CPSO and OMA stated that the recommendations provided by the profession of physiotherapy were too broad, particularly for the acts to diagnose and communicate a diagnosis, and ordering various diagnostic tests. “Incorrect diagnoses may lead to complications and conditions that are avoidable with appropriate medical assessment. The OMA suggests that consideration be given to allowing physiotherapists to communicate a diagnosis within appropriate profession-specific parameters.” (OMA, 2008, p. 4)

Additionally, allowing “open” diagnostic testing would create a higher demand on a resource already in high demand, and physiotherapists do not have the educational training to interpret results. The responses from interest groups representing the medical profession do not clearly demonstrate how or why these amendments could cause these issues. However, this is another case where overlapping scopes of practice prompted the medical profession to raise concerns about the proposed amendments.

The discussion among the medical profession on the review of the scope of practice for NPs is no different. As previously stated, data collection was unable to locate the responses from other interest groups on this review. The majority of the data collected for this

particular analysis was derived from the transcripts of the Committee hearings. The term “physician substitutes” was repeated frequently among the interest groups representing the medical profession. The OMA provided a clear statement on the existing collaborative interaction between physicians and nurses: “Physicians have practised in some type of collaborative styles with nurses for decades. One only has to look at our provinces’ shared-care pilot projects with [NPs] based in fee-for-service office settings to see that good things can happen when health care providers complement one another, not replace one or the other.” (Ontario, 2009b, p. SP-769) Here, the OMA argued that collaborative practice has been well established between physicians and nurses, as such, there was no need to further enhance this relationship. Again, the medical profession raised concerns about the NPs’ knowledge and training to perform the controlled acts that were recommended by the NPs, particularly their ability to correctly diagnosis; this was supported by the OCFP at the Committee hearing. In particular, the OMA expressed concerns that NPs may decide to treat patients without consulting physicians. The OMA argued that physician consultations are able to identify underlying medical problems that can be easily overlooked by the NP, inevitably resulting in severe medical consequences for the patients.

In sum, the medical profession outlined strong opposition to amendments of the scopes of practice of these health professions. The same argument was repeated in their review of the recommendations: whether the health professions in question possessed the knowledge and skills required to perform the proposed controlled acts. Responses were much more thorough when the proposed scope of practice overlapped the scope of practice of the medical profession. In this case, the medical profession cautioned the use of other health professions as physician substitutes. Quite often, responses cited the additional benefits of

requiring professions to consult with physicians in order to obtain medical directives. These findings suggest that the medical profession's primary interest within the development of Bill 179 was to maintain dominance of their own scope of practice.

4.3.3 Out of Left Field: The Supervisor and Audit Provision

The most agreed upon issue of Bill 179, for the policy actors, was the sudden inclusion of the supervisor and audit provisions without any previous consultations and unanticipated by the policy actors. Thus, discussion about these provisions among policy actors was identified only during the Committee hearings. The following excerpts were drawn from Bill 179 to provide the details of these provisions (Bill 179, S.O. 2009, c.26):

College supervisor

5.0.1 (1) The Lieutenant Governor in Council may appoint a person as a College supervisor, on the recommendation of the Minister, where the Minister considers it appropriate or necessary and where, in the Minister's opinion, a Council has not complied with a requirement under subsection 5 (1).

Notice

(3) At least 30 days before recommending to the Lieutenant Governor in Council that a College supervisor be appointed, the Minister shall give the College a notice of his or her intention to make the recommendation and in the notice advise the College that it may make written submissions to the Minister.

Review of submissions

(4) The Minister shall review any submissions made by the College and if the Minister makes a recommendation to the Lieutenant Governor in Council to appoint a College supervisor, the Minister shall provide the College's submissions, if any, to the Lieutenant Governor in Council.

A submission jointly developed by the CPSO, OCP, CNO, and RCDSO requested that the supervisor and audit provisions be removed from Bill 179. There was concern that these provisions would give the Minister broad discretion to take over self-regulation, virtually at

will. “The Minister has sufficient authority under the current s5 of the RHPA²⁴ to ensure accountability. The Colleges are also subject to numerous oversight mechanisms that further ensure accountability.” (CPSO, OCP, CNO & RCDSO, 2009, p. 1) Furthermore, the CPSO argued that these provisions demonstrated a lack of trust in self-regulation even though there were numerous oversight mechanisms in place to ensure the accountability of the regulatory framework. This provision would undermine the concept of self-regulation and depreciate the value of health professions. Additionally, the FHRCO identified that the proposed measures did not have any constraints; there was no protection to ensure confidentiality or prevent the disclosure of privileged information that may harm patients, health professions, or both. There was also no discussion on who pays for the supervisor’s or auditor’s work, remuneration, or preservation of the college’s assets.

At the Committee hearings, these groups recommended the removal of these provisions and identified the measures in place (then) to ensure the accountability of regulatory colleges. These interest groups argued that while they welcomed accountability, it must be done in a meaningful and fair way. The following excerpts from the Committee hearing transcripts emphasize the confusion surrounding the origin of these provisions and concerns of their consequences:

CPSO: Mrs. Elizabeth Witmer: Thank you very much for your presentation. I know that the issue of a supervisor has been of concern to yourselves and other colleges as well. I’d just like to ask you briefly: What would be the implications to public safety if a supervisor was appointed to take all of or part of the college’s mandate?

Dr. Rayudu Koka: Maybe Rocco could answer that.

Dr. Rocco Gerace: The concern is whether or not there will be the ability to appreciate the practice of medicine. As you know, the profession has long taken that responsibility, understanding what doctors do and being able to adjudicate in areas of

²⁴ Section 5 of the RHPA provides the MOHLTC the authority to require health colleges to provide reports, make, amend or revoke a regulation, and use any means necessary (within the opinion of the Minister) to carry out the intent of the RHPA, the health profession Acts or the *Drug and Pharmacies Regulation Act*.

misconduct and in-competence. We're not sure that an independent individual would have that ability. (Ontario, 2009b, p. SP-773)

RCDSO: Mme France Gélinas: I certainly agree with the comments that my colleague just made, and you are not the first representative to talk about the provision of a supervisor. Do you have any idea where it came from and what it's trying to do?

Mr. Irwin Fefergrad: I don't. In fact, I asked that question at briefings, and I'm no clearer as to where it comes from. My assumption is that it comes from a very good place: government trying to do the best it can to address a problem. I'm not sure what the problem is, but I know the solution can't be appropriate to whatever the problem is. The self-regulation we have in this province is envied across the world. This kind of provision is not a healthy message to give. (Ontario, 2009b, p. SP-782)

ODA: The bill provides no insight as to what would trigger the use of this clause. Equally important, there is no indication as to what would trigger the removal of the supervisor. In the event that a college council and/or staff, including the registrar, saw the appointment of a supervisor as a vote of non-confidence, causing them to resign, there are no clear provisions for a transition to the election or appointment of a new college council. (Ontario, 2009c, p. SP-790)

CDO: If the objective of the supervisory provisions is to instill public trust, I think we have to be a lot more thoughtful about how we do this. Maybe what needs to be addressed is how to get better accountability with fewer or more effective accountability instruments, including the indicators and the actual processes, because if we want the public to trust what we have, what we're developing is a lot more transparency based on some-thing that gives them the message of effectiveness or not. Another way to improve is simply to make more and better use of the section 5 powers that are currently in place. (Ontario, 2009c, p. SP-807)

Two groups identified their support for these provisions. The Ontario Association of Optometrists backed the idea of increasing the Minister's powers in ensuring compliance with the RHPA and associated legislation. Within their presentation, they cite the actions of members of the College of Opticians of Ontario who perform one aspect of a comprehensive eye examination to bypass the legislative requirements for a prescription, in order to dispense eyewear. The Lyme Action group provides a case of a doctor, trained and accredited by the International Lyme and Associated Diseases Society, being investigated by the CPSO without "a single patient complaint against him, yet the disciplinary proceedings

are moving forward.” Thus, “[given] the shortcomings described in the application of existing college disciplinary procedures, we believe that additional oversight of the CPSO is warranted.” (Ontario, 2009c, p. SP-796)

4.4 Conclusion

This chapter provided a descriptive analysis of the agenda setting and policy development stage of the policy process. This analysis identified the policy actors, activities, and the interactions between policy actors. It is important to note that the limitation of this thesis – the sole use of publicly available materials – created challenges in developing an accurate description and analysis of the interactions that occurred among interest groups because not all of the information was made available to the public. The policy actors were numerous, ranging from private citizens and individual health care practitioners to interest groups, such as the regulatory colleges and professionals.

It was believed that policy actors would be more active in the initiation of interactions and deliberations with each other, and policy-makers, to identify policy issues and develop proposals. Instead, this analysis demonstrated that the interactions among interest groups were, in fact, initiated by HPRAC to advise the MOHLTC’s on the policy agenda; interest groups consulted with their members to develop their official recommendations to address the Minister’s request. However, the manner in which the Minister’s request was presented influenced the nature and direction of the discourse. As demonstrated, the discussion began by identifying mechanisms to facilitate and support IPC but quickly shifted to the review individual scopes of practice of certain professions. Interest groups representing the same health profession would often collaborate to complete their submissions and developed complementary responses. But interest groups representing different health professions

tended to collaborate with each other if they had a common interest, such as eliminating the supervisor and audit provisions.

The following chapter will provide further analysis of these interactions that emerged in the agenda setting and policy stages of Bill 179 to determine how they influenced the relationship between the regulatory colleges, professional associations, and the state.

5 Analysis and Discussion

Chapter 5 builds on the descriptive analysis provided in the previous chapter to analyze the discursive interactions that occurred in the agenda setting and policy development stages of the policy process that led to Bill 179. In Chapter 3, we identified that language is more than just a means of communication; we make and build things in our world by speaking words that accomplish actions and enact identities. According to Gee (2011), "...we always (often simultaneously) construct or build seven things or seven areas of "reality"." (p. 17). This chapter draws on the seven building tasks of language, as described by Gee (2011), to analyze the interactions among policy actors.

5.1 Building Significance

Language can be used to make certain things significant and establish their meaning. In this case, the language used in this discourse relayed the importance, and need, of IPC; this concept is framed as an alternative to address the wait time issues, increase access to care, and meet the complex needs of patients with chronic illnesses. Many policy actors support IPC because it is believed to improve both the delivery of health services and the work environment of health care providers (section 1.1); recall that the majority of policy actors, in this case, represented a health profession. There is also a sense of urgency that IPC is imperative and necessary for the future of Ontario's health care system. Second, the enhancement of scopes of practice was identified as a priority by the Minister of Health and HPRAC to facilitate IPC among regulatory colleges, thereby allowing health care practitioners to maximize their abilities and improve access to health services. This idea was supported by most interest groups; submissions to HPRAC provided the profession's perspective on the questions outlined by the consultation discussion guide and, with the

exception of the medical and dental professions, did not raise concerns about the consultative process or the questions posed by the Minister's request. The emphasis on enhancing scopes of practice also placed greater significance on reducing inefficiencies; many submissions advocated for the authorization of controlled acts into that were originally performed under medical directives, which would remove the need to consult with other health professions.

5.2 Building Activities

Language can be used to engage in, and build, certain activities. As seen in the previous chapter, three main activities emerged (Figure 4-1) within the interactions surrounding the development of Bill 179: the two consultative processes initiated by HPRAC at the Minister's request and the hearing on Bill 179 initiated by the Committee at the request of the Legislative Assembly of Ontario. It is not surprising that the MOHLTC and the Government of Ontario would seek the advice of experts in developing policies related to the regulation of health professions. In fact, many would question the validity of Bill 179 if health care professions were not consulted on the issue of enhancing their professional scopes of practice.

The majority of policy actors engaging in these activities were interest groups representing different health care professionals, including regulatory colleges and professional associations. Since amendments to the RHPA would directly affect the practice of health care practitioners, it was expected that these interest groups would participate in the consultative processes. To engage in the activities, policy actors developed submissions using language that was fairly similar to those of their peers; submissions reflected knowledge and technical skills unique to the profession but the use of plain language

allowed the lay-person to understand their arguments. This balance in the plain and technical language is important to ensure that any policy-maker – regardless of their level of expertise vis-à-vis the regulation of health professions – is able to understand the issues presented by those submissions.

It was surprising that the policy actors did not indicate if they built their own activities to identify their ideas, interests, and strategic plans to address the issues within their practice; this is a practice that would be expected by most regulatory colleges and professional associations. Many of the regulatory colleges and professional associations usually conduct annual meetings where these items are discussed but only the OMA provided a record of their annual meetings and the topic of discussion. Other interest groups provided information to their members through newsletters (Appendix A) but this activity does not create meaningful dialogue between members. The newsletters provided brief explanations for the benefits of IPC and how it can improve health services. But these items are more like notices; they do not provide members to opportunity to deliberate about IPC.

In sum, it is difficult to determine if, or how, language was used to build activities surrounding IPC among interest groups. Outside of the consultative processes and Committee hearings, there appear to be few activities that would enable policy actors to exchange ideas about IPC. It is very likely that such activities occurred at conference or forum proceedings but the materials collected for this thesis do not identify where and how the activities occurred, or how IPC was identified as a potential tool to improve health services.

5.3 Building Identities

The manner in which language is used can ascertain recognition for a certain identity or role, such as the advisory role of HPRAC, which is clearly outlined in the RHPA and its reports to the Minister of Health. But there is also an inexplicit role identified within the previous chapter: HPRAC acts as a gatekeeper to Ontario's health care practitioners by restricting their participation in the exchange of ideas between interest groups and policy-makers. HPRAC emphasized this role by maintaining authority over how policy actors are able to participate in the consultative process. HPRAC used very restrictive language when providing the criteria for the submission of responses, all the while maintaining a positive tone to encourage participation (Figure 5-1). HPRAC relies on the submissions and participation of the various policy actors interested in the regulation of health care practitioners in order to fulfill its advisory role to the MOHLTC. Thus, using words such as "welcome" and "appreciate" within the criteria of the consultation guide creates a sense of collegiality between HPRAC and the policy actors when, in fact, HPRAC is maintaining its authority over the consultative process and controlling the type of information it collects from policy actors.

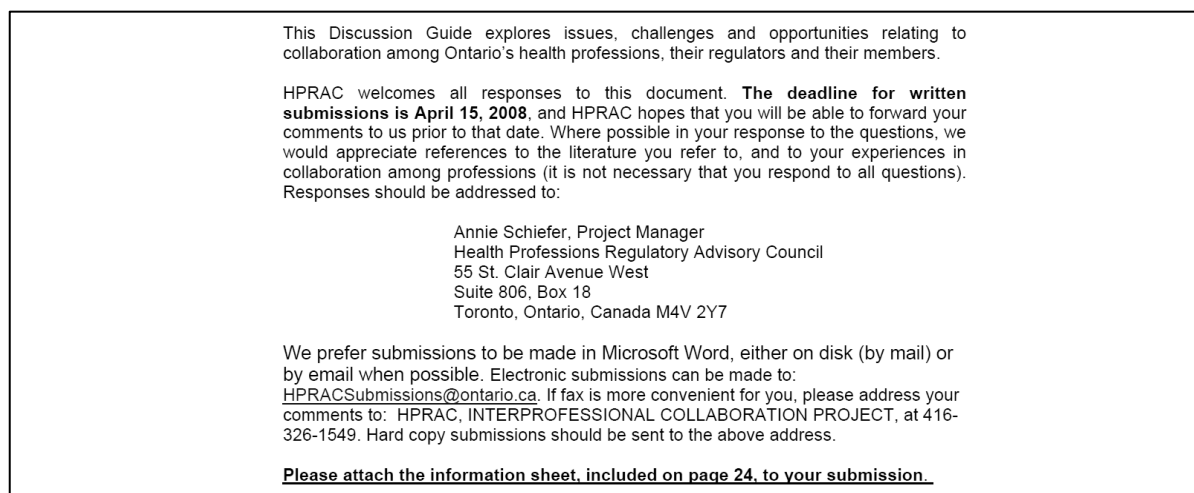


Figure 5-1: Excerpt from the HPRAC Consultation Guide

The advisory role of the Committee to the Legislative Assembly of Ontario was also well identified, in this instance, by the Official Report of Debates from the Committee hearings. The Committee maintained a greater level of authority over the policy actors within their hearings. Due to the limited number of hearings, and strict time for the presentation, the chair would have to be very stern with participants to ensure that the process moved forward. On many occasions, presenters were interrupted and unable to fully formulate their ideas. Moreover, there were instances where Committee members had insufficient time to pose questions in order to clarify the policy issue. In many instances, there appeared to be a struggle between the presenters and the Committee members in relaying (or gaining) the information required to make an informed decision about the policy issues raised by the presenters. This discourse was, in many ways, one-directional – from the presenters to Committee members – and fragmented because of the hurried pace of the hearing.

The role of health care practitioners as content matter experts was very prominent throughout the consultative processes. Policy-makers have long established their reliance on the expertise of health care practitioners to inform health policies and conducting consultations with health care practitioners reinforces this aspect of their identity. In providing personal examples of the issues present in the regulation of health care providers to demonstrate their expertise and knowledge of the health care system, health care practitioners also established their identity as “protectors” of the patient by using terms such as such as “patient safety”, “appropriate training”, and “protecting Ontario’s health”. This language strengthened the importance, and even urgency, of their recommendations and the need for political action.

The role of the medical profession as the “leader” or “decision-maker” of the health care system is underrepresented in these interactions. The medical (and dental) profession maintained their argument that the enhancement of scopes of practice was not an appropriate mechanism to facilitate IPC but the discourse moved forward to the issue of enhancing scopes of practice regardless of their opinion. There was no indication in the collected material that HPRAC or the Committee seriously considered these recommendations. Instead, it appeared that the leadership role was transferred to those professions that complemented the original request of the Minister of Health and continued their pursuit the enhancement of their scopes of practice.

In sum, the development of these identities demonstrate a hierarchy between the MOHLTC and health care practitioners, where HPRAC and the Committee act as facilitators (or gatekeepers) in the exchange of ideas between these two groups. However, HPRAC and the Committee also enforce constraints on the participation of policy actors within the consultative processes. Additionally, the identities of participating health care professions are equalized through the enforcement of those constraints; the medical profession appeared to have less dominance over the regulation of health care professions.

5.4 Building Relationships

Language can signal our existing relationships, the ones we want to have, or are trying to have. Since this thesis analyzed the interactions within a specified time frame, it is difficult to establish if new relationships emerged. The purpose of the consultative process for Bill 179 was to develop collaboration among regulatory colleges in order to facilitate IPC (Ontario, 2009b) but, in reality, there was greater interest in promoting a profession’s individual ideas and interests in regards to their practice; the consultative processes resulted

in a mosaic of multiple and diverse “segments” of dialogue on the best methods to enhance the scopes of practice of individual health care professions. Data analysis indicated that some interest groups had previously established relationships and agreed that the relationships should be strengthened by collaborating on issues related to IPC at the regulatory level.

The interactions that emerged in the consultative processes and in the Committee hearings identified that the interest groups representing the same profession (i.e. the regulatory colleges and professional associations) had strong, existing relationships that stemmed from their common interest in protecting the practice of their profession. In some cases, these interest groups developed joint submissions to HPRAC or the Committee. These relationships did not appear to change throughout the course of the consultative processes. In situations where interests were similar, such as the inclusion of the supervisor and audit provisions, which threatened the principles of self-regulation, interest groups representing various health care professions would collaborate with each other to strengthen their recommendations. However, they also addressed their concerns individually at the Committee hearing.

On the other hand, there existed a unique relationship between the policy and non-policy actors. HPRAC and the Committee rely on the expertise of the policy actors to ensure the legitimacy of their actions and the validity of their policies, whereas the policy actors depend upon HPRAC and the Committee to communicate their needs to the Government of Ontario; this relationship demonstrates characteristics of interdependence. However, the discourse that was maintained within the consultative processes did not embody an interactive process. There was a one-way dialogue between HPRAC and the interest groups. Although HPRAC would invite the interest group to participate in the consultation, HPRAC

appeared to focus solely on completing its task to Minister by collecting responses and synthesizing the information in a manner that would best meet the needs of the Minister. Additionally, the Committee hearings appeared hurried and insufficient to provide policy-makers and interest groups an appropriate venue to discuss the implications of Bill 179. There was little communication from HPRAC and the Committee to the policy actors, unless they required further clarification from policy actors on the recommendations and responses, or reports were published and made available to general public. In other words, HPRAC and the Committee focused on completing their tasks for the Minister or Legislative Assembly of Ontario, respectively. These consultative processes legitimize Bill 179 but do not facilitate collaboration between health professions and the state.

An important issue identified by this thesis was the confusion about the rationale for conducting the consultative processes. In other words, why was there a need to review scopes of practice to facilitate IPC? This would suggest that the MOHLTC had its own agenda to enhance scopes of practice and could not be swayed by the interactions of the policy actors and recommendations that they provided. Additionally, the sudden inclusion of the supervisor and audit provision in Bill 179 demonstrated the states continued dominance over the context and control of medical care.

5.5 Building Politics (the distribution of social goods)

Language can be used to convey a perspective on the nature of the distribution of social goods; the method in which something is phrased can have implications for social goods. In other words, language can communicate responsibility, identify bad or good motives, or imply that something is adequate, good, or excellent.

The entire premise of the consultative processes and Committee hearing centered on relaying the perspectives of policy actors on the distribution of social goods; policy actors would present submissions that identified “the way things are” and “the way things ought to be” for the distribution of health services. The majority of participants relayed their belief that the delivery of health services (as well as the processes to amend professional acts) is slow and inefficient. The examples provided within the submissions and presentations identified processes that required health care practitioners to consult with a physician on certain controlled acts (i.e. ordering tests and renewing prescriptions) and argued that these consultations did not yield different treatment outcomes; many examples indicated that physicians quickly signed off on requests or complained about the need to get their signatures. The non-physician professions identified that services needed to be more streamlined in order to improve access to services; health care practitioners should be able to perform a greater range of controlled acts to meet the needs of Ontarians.

Not surprisingly, the language used by policy actors relayed the need for government leadership to enable changes at the regulatory level that will improve Ontario’s health care system (through the promotion of IPC). Interest groups that supported the enhancement of the scopes of practice suggested that this goal could only be achieved through amendments to the RHPA and auxiliary acts. This same language enforced the responsibility of the MOHLTC “...to ensure safe, effective health services for the citizens of this province.” (Ontario, 2009a, p. SP-763)

In contrast, the medical profession held a different position on the enhancement of scopes of practice as a mechanism to promote IPC at the regulatory level. They suggested there was a greater need to ensure the establishment of systematic mechanisms (i.e. EHRs

and alternative funding models) to facilitate IPC at the clinical level. However, the frequent opposition to the enhancement of scopes of practice suggested the medical profession had a greater interest in protecting its “turf” over the public’s interest. Although less prominent, the MOHLTC’s push to enhance the scope of practice of NPs and implement a greater number of NP-led clinics also suggested a questionable motive. Physicians are remunerated for their services through a fee schedule that yields a higher cost than the salary of NPs (NPAO, 2011), thus providing the MOHLTC a financial incentive to “substitute” physicians with other health care professionals.

In sum, policy actors agreed that there was an urgent need to improve the delivery of health services, a sentiment that appears to be supported by the MOHLTC. The language used by Ministerial requests and the submissions indicate a genuine motive on the part of all participants to improve Ontario’s health care system to ensure that it meets the needs of the population. But determining whether those motives are, in fact, genuine is difficult to establish because policy actors appear to concentrate more on maintaining or enhancing the scopes of practices of their professions while the MOHLTC does not outline its intents in regards to the review of scopes of practice.

5.6 Building Connections

According to Gee (2011), language can render things connected or relevant to other things. Within the descriptive analysis, many concepts and ideas were identified that were connected to, and perceived to be relevant to, the facilitation and promotion of IPC. First, the relevance for IPC was introduced when it was identified by the MOHLTC as a mechanism to increase access to services. These interactions propelled IPC to the top of the political agenda and then used as a rationale to enhance scopes of practice, thereby, improving access

to health services. The language used to describe the deficiencies of the health care system suggests a sense of urgency, or need, to quickly implement this model of care. Since research on IPC has demonstrated benefits to both the patients and health care practitioners, both the users and providers of health services have an incentive to support its implementation.

The dental and medical professions strongly opposed the enhancements of scopes of practice when they would overlap with their own practice. Both the dental and medical professions articulated the significant contributions of these other professions and maintained a “professional tone” in their materials, but they continually insisted that these professions did not possess sufficient knowledge and/or training to perform the skills required of the controlled act. This prominent message raises an important connection between the regulation of health professions and their educational curriculums, or professional development programs. It is expected that health care practitioners are trained to perform the practices outlined by their auxiliary acts, but the medical profession does not identify at what point the other professions should learn and train to perform the additional acts, outside of their scope of practice. It is possible that educational curriculums prepare students to perform these additional acts in preparation for future enhancements that are commonly performed in clinical settings (i.e. interpreting diagnostic results usually done by a physician, for instance) or students gain these skills in clinical placements and through professional development programs. But this situation creates a chicken-or-the-egg scenario; should scopes of practice be enhanced before health care practitioners are trained to perform them, or is there an expectation that the required knowledge and skills should be included in the educational curriculum (or professional development program) before practitioners are

allowed to perform them? Within the policy actors' interactions in the policy process that led to the creation of Bill 179, it is apparent that the medical profession would prefer the latter but it seems relatively difficult for program evaluators to predict the direction in which scopes of practice will be enhanced.

In sum, the interactions yielded unclear connections throughout the consultative processes in relation to the current realities of the health care system. It is possible that this lack of clarity could have been rectified with access to information from health care practitioners themselves but this was beyond the scope of this thesis. Notwithstanding the possible limitations vis-à-vis data collection, one can conclude that the MOHLTC used IPC as a “window of opportunity” (Kingdon, 2012) to enhance scopes of practice, not to foster an environment of team-based care. Instead, the Ministry sought increase access to services, which is a significant concern in the province and the basis for Ontario's Wait Time Strategy initiated by the MOHLTC (Ontario, 2010). Similarly, it could be argued that the contradictory statements made by the medical profession on the value of other health care practitioners (their role in health care is important but we cannot trust them to perform enhanced practices) is used as a delaying tactic for the implementation of these recommendations by requesting further review of the proposed amendments by a committee consisting of a member of the medical profession. Undeniably, a role on the review committee would allow the medical profession to maintain its dominance over the profession in question.

5.7 Building Sign Systems and Knowledge

Language can be used to make certain “sign systems”, and forms of knowledge and beliefs, relevant or privileged. A sign system can include different languages, different

varieties of any one language (i.e. professional or technical language), and communicative systems that are not language (i.e. images). Analysis of the collected material demonstrated a privileged discourse whereby participation was restricted largely to health care practitioners (or those with expert knowledge about the health care system) and policy-makers.

The discourse evaluated in this case required a sign system and knowledge unique to health care practitioners and experts. They used language related to their experience in *delivering* health services but no language was used to relate the perspective of *receiving* care; that is, the perspective of the patient. The consultative processes required knowledge about the realities and issues of the health care system, as well as “what ought to be”. Within this sign system, there were also different varieties of language used by health care practitioners because each profession had developed their own language based on their individual practice and experience. This is clearly demonstrated by the MRT profession who criticize the NPs for their improper use of terminology as it relates to diagnostic imaging and testing. However, interest groups were required to develop submissions that balanced their sign system and knowledge to clearly articulate their recommendations to the policy-makers who do not necessarily possess the same level of knowledge or understand these sign systems.

Another sign system was also evident in relation to the regulatory; this discourse is privileged to participants who understand and use language related to the regulatory framework for Ontario’s health care practitioners. As such, without a good understanding of these sign systems, there may have been significant communication barriers for the general public, or patients, to participate in the consultative processes and the Committee hearing. This enforces the health care practitioner’s identity as experts to the policy-makers,

including the measures required to ensure health policies reflect the needs of the patient, health care practitioners, and the health care system. In sum, the activities facilitated the discourse and interactions between policy actors to discuss the policy issues presented by IPC and Bill 179 but privileged key policy actors with the knowledge and expertise of the health care system.

5.8 Conclusion

This chapter used the seven building tasks of language (Gee, 2011) to assess the interactions of policy actors in the policy process that led to Bill 179. The analysis of the discursive interactions confirmed Coburn's (1993) argument that health professional organizations have dual roles in the health policy process: to protect the interests of its members and the public. There was considerable tension between the interest groups and the Government of Ontario; health professions continue to struggle to maintain the self-regulation of their members, but this time with the Government of Ontario, not the dominant health professions.

6 Conclusion

This thesis aimed to build upon the literature on the role of ideas and interests in the policy process and how proposals or alternatives are promoted to address policy issues through discourse. This thesis adopted a theoretical framework that focused on the interactive processes of the discourse among policy actors, within an institutional context. Thus, data analysis emphasized the emerging recognition and importance of argumentation and deliberation within the policy process. Additional objectives of this thesis were to assess the relationship between health professional organizations (i.e. regulatory colleges and professional associations) and the Government of Ontario, as well as demonstrate the application of DI as a framework to analyze the importance of discourse in the health policy process. This thesis makes four contributions as a result of these objectives.

First, this thesis provides a theoretical contribution through its application of DI in health policy research, more specifically, the case of IPC and the regulation of health professions in Ontario. This framework allowed me to evaluate the relationships between policy and state actors, by focusing on their interactions and discourse that make up the policy context, and identified the importance of the interactions and discourse in exchanging ideas and interests to facilitate institutional change. In section 2.1, it was argued that ideas cannot sustain themselves because they are dependent on the interactions among policy actors, who must find value in the idea in order to give it power (Béland & Cox, 2011; Fischer, 2003; Schmidt, 2008); this argument was supported by the results of this thesis. The enhancement of scopes of practice was the prominent idea in the policy process that led to Bill 179. This idea was presented as a solution by the MOHLTC to the public problem of facilitating IPC among regulatory colleges, in order to increase access to services. Even

though the idea did not appear to be relevant to the policy issue, the policy actors supported the idea throughout the policy process and, through deliberation and argumentation with each other, used the idea to render their interests of professional development actionable. This demonstrates that, as previously stated, it is interests that influence and shape the behaviours of policy actors, not ideas. The structured consultative processes provided policy actors the venue to participate in the deliberation and argumentation that resulted in the exchange of ideas and, ultimately, derived a common set of interests for the policy actors from those ideas. As such, discourse matters in exchanging ideas and developing interests to address public problems, and who said what to whom, how, and why is important to the policy process and the selection of proposals or alternatives. But while discourse mattered as a venue, to provide policy actors the opportunity to debate policy issues and provide their proposals to the state, discourse only mattered if it supported the ideas and interests of the MOHLTC.

The remaining contributions are empirical and relate to the regulation of Ontario's health professions. The second contribution provided by this thesis was the evaluation and analysis of the relationship between two sets of interest groups (regulatory colleges and professional associations) and the Government of Ontario. Coburn (1993) identified that the medical profession had historically played an intermediary role between other health professions and the Government of Ontario, but due to its financial control over the health care system and the re-structuring of professional organizations through the RHPA, the Government of Ontario had greater influence in shaping the organization and self-regulation of health professions. As such, Coburn (1993) suggested that the medical profession moved from "dominance" towards "autonomy", while all other regulated health professions

“...moved towards autonomy and somewhat away from subordination to medical authority.” (Coburn, 1993, p. 849) This thesis argues that the power relations within this interaction have moved further in the direction identified by Coburn. All of the regulated health professions have moved towards autonomy, including the medical profession, which appeared to have no influence on the consultative processes or discourse initiated to deliberate the enhancement of scopes of practice. Thus, medicine no longer appears to be “the single most powerful occupation within the health care system” (Coburn, Rappolt & Bourgeault, 1997, p. 19), at least at the regulatory level. In addition, results from this thesis supported the argument that regulatory colleges are used by the government to constrain their members, through the external constraints and controls created by the RHPA, as a measure to control the health professions. Although regulatory colleges and professional associations are expected to protect the interests of their members, and were invited to participate in the consultative processes to discuss the methods to improve the delivery of health services, it was clear the Minister of Health already had a proposal in mind.

The MOHLTC governed the majority of the policy actors’ interactions by keeping a firm hand on the substantive content of the discourse through the very structured consultative processes initiated by HPRAC. The manner in which the consultative processes was structured centred the discourse on the proposals outlined in the Minister’s request and influenced the discursive interactions of policy actors to address those proposals. Only a few interest groups deviated from those questions, which resulted in a discourse that was strongly influenced by the MOHLTC. The subsequent fragmented interaction between policy actors and the Government of Ontario suggested that the government had a pre-determined plan to achieve their desired political outcome (to enhance scopes of practice);

the consultative processes were structured to yield a unidirectional discussion on the topics identified by the Minister of Health. Additionally, the dominance of the Government of Ontario was evident by the sudden inclusion of the supervisor and audit provisions, which was achieved without the consultation of policy actors.

The third contribution of this thesis was the analysis of the role of policy actors in the policy process. Scholars have established that interest groups play an important role in democratic governance by providing technical knowledge expertise to policy-makers, who do not always have adequate information about the problems and potential solutions to address policy issues (Pross, 1992; Skinner, 2009). This relationship between interest groups and the Government of Ontario was evident in the case of Bill 179; interest groups were asked to review the scope of practice of their members in order to identify methods to improve health services. But the participation of these interest groups in the health policy process also legitimized the actions of the Government of Ontario. The fact that this technical knowledge and expertise was used in the development of Bill 179 suggests a greater likelihood that the bill will be effective in achieving its desired outcomes. It is important to acknowledge that there were opportunities for individual policy actors to participate in the consultative processes related to Bill 179. However, there appeared to be greater impact within the discourse from the collective action of interest groups. In other words, groups that represented the interests of a larger number of individuals were better able exchange their ideas within the discourse. But common interests must be defined quickly if they are to achieve collective gains for their members from the policy process.

Additionally, there was significant emphasis on the role of interest groups to protect the interests of their members, particularly in the protection of their “turfs”, when proposed

amendments would have created overlapping scopes of practice. This issue was very prominent for the medical profession, which spent significant time trying to prevent other professions from receiving authorization to perform controlled acts, in the absence of medical directives. However, this same determination to protect the health profession could lead to collaboration between interest groups that shared common goals or interests. For example, interest groups representing the same (or similar) profession (i.e. a regulatory college and professional association) would collaborate to protect the interests of their members' profession. Often, these interest groups wrote joint submissions to demonstrate a unified front on the policy issue. In addition, there was evidence of collaboration between interest groups across different professions when their ability to self-regulate members of their profession came into question. In the case of Bill 179, the four “heavyweights” – the Colleges of Physicians and Surgeons of Ontario, Royal Colleges of Dental Surgeons of Ontario, College of Nurses of Ontario, and the Ontario College of Pharmacists – provided a joint submission to respond to the Government of Ontario's sudden inclusion of the supervisor and audit provision. These actions closely resemble the role expected of unions when negotiating conditions of employment for their members.

This evolving relationship between health professional organizations and the Government of Ontario is important because it has considerable implications for our knowledge and understanding of the health policy process. This thesis is a reminder of the need to examine the role of public consultations as tools to legitimize the policy process. Deliberative democracy promises to yield legitimate solutions to political problems (Sanders, 1997) and many scholars have focused their efforts to design effective and legitimate processes that involve informed citizens in the policy decisions that affect them

(Abelson, et al., 2003). Approaches, however, must facilitate two-way interactions between decision makers and the public in order to ensure democratic deliberations. Regrettably, this was not entirely the case for the consultation processes that led to the development of Bill 179. The MOHLTC had significant discursive control over the field, and demonstrated bias by pushing their solution of enhancing scopes of practice to facilitate IPC at the regulatory level. Additionally, the consultative processes were not reciprocal interactions. Instead, the consultative processes appeared closer to “fishing expeditions”; the MOHLTC sought out information that aligned with their preconceived goal to enhance scopes of practice.

The fourth contribution relates to the analysis of the implications of changing scopes of practice for IPC and professional education/development. Throughout the consultative processes and the Committee hearing, it was well established that the purpose of the review of the scopes of practice was to facilitate greater collaboration between health care providers and regulatory colleges. Yet, many of the proposed amendments sought to increase authorization to controlled acts and, inevitably, remove collaboration with the professions that delegate medical directives for those controlled acts. The medical profession attempted to emphasize the detrimental effects that may result from these changes. In particular, the OCFP repeatedly used their slogan “[IPC] can be enabled; it cannot be legislated” throughout their materials to garner attention to this issue. It is evident that these amendments would increase access to services but these amendments would result in overlapping scopes of practice, which has been identified as a barrier to IPC (section 1.1). As such, this thesis supports the conclusions of Heinz & Mietkiewicz (2010) that Bill 179 was largely a missed opportunity for collaboration.

On the other hand, these results have identified an apparent discord between medical physicians and the province of Ontario. The medical profession raised concerns that NPs were being tailored to substitute physicians. This claim appeared to be an initial reaction to the threat of their scope of practice but further analysis of the materials identified the possibility that their concerns were justified. The consistent focus on expanding individual scopes of practice, instead of encouraging collaboration, suggested the MOHLTC was interested in removing the medical profession's role as "gatekeepers" to the health care system. Upon further reflection, there does appear to be a financial motive for the MOHLTC to pursue the implementation of NP-led clinics, instead of contracting physicians.

In general, physicians are autonomous entrepreneurs who have historically resisted state involvement in health care (Naylor, 1986; Skinner, 2009). As contractors, they have greater financial control over their practices and a stronger position to negotiate their fee schedule. On the other hand, nurses are more dependent on employment in hospitals and state-funded community centres and have supported government involvement in health care (Skinner, 2009). Their salaries are considerably lower because nurses have no overhead costs and provincial governments may be able to reduce their health care expenditures by administering their own facilities. Thus, particularly for simple cases involving minor ailments and services related to prescription drugs and substances, there appear to be incentives for shifting the physician's role to other professions.

In addition, the medical profession's perennial concerns about its ability to perform controlled acts identified a potential gap between existing health curriculums, or professional development programs, and the enhancement of scopes of practice. Health care practitioners are trained to perform the practices outlined by their auxiliary acts, but the medical

profession has not identified at what point the other professions should learn to perform the additional practices that are outside of their profession's scope, to meet the needs of patients. As such, the medical profession appears to expect that amendments should not be proposed until after the practice is included into the profession's curriculum. Such measures would further delay efforts to improve the delivery of health services.

In sum, further research is required to develop a better understanding of the interactions between state and policy actors. The decision to use publicly available materials became a significant limitation because only materials from certain actors were made available to the public. As such, it was very challenging to develop a full understanding of the policy process in this case. The policy actors, generally, did not always provide materials that identified their opportunities for interactions with one another or with the Government of Ontario, and did not always provide an explanation for their actions and ideas. The majority of the collected materials were identified through the HPRAC website; a large component of their work is to consult with the public, stakeholders, interest groups, health professions, and others. Thus, providing information about issues related to the regulation of health professions to the general public is necessary to complete their tasks. It is important that future research include interviews with key policy actors to provide a more comprehensive view of the policy process regarding the regulation of health professions. Nonetheless, this thesis has provided a solid foundation to continue research on health policy-making, paying particular attention to the importance of argumentation and deliberation, and discursive interactions. A next step would be to expand the focus to include cross-provincial comparisons, to gain insight into how these interactions might differ from province to province.

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Appendix A: List of Publicly Available Materials Identified for Data Collection

The following table identifies the documents and texts collected for this thesis. Documents are grouped by the profession.

Source	Date Published	Type	Document Name and Source	Relationship to IPC and/or Bill 179
State Actors				
Health Professions Regulatory Advisory Council	2008, Feb 15	Discussion Guide	Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals (The Consultation Guide). Retrieved from http://hprac.org/en/reports/resources/hprac-collaborationDiscussionGuideENFINALPDF.Feb808.pdf	<ul style="list-style-type: none"> - This guide invited all interested individuals and organizations to submit responses to the Minister's request on mechanisms to facilitate IPC - HPRAC provided 43 questions to direct the discussion
	2008, March	Report	An interim Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals. Retrieved from http://hprac.org/en/reports/resources/HPRAC-EnglishInterprofessionalCollaborationInterimReportMarch08.pdf	<ul style="list-style-type: none"> - This report responds to the Minister's request as identified in the Consultation Guide - Provides an overview of the collected responses from the perspective of HRPAC - "HPRAC is strongly committed to the further development of interprofessional collaboration among the health professions in Ontario. This includes collaboration between the regulatory colleges themselves, between the professions generally, and between individual professionals in clinical practice"
	2008, March	Report	A Report to the Minister of Health and Long-Term Care on the Review of the Scope of Practice for Registered Nurses in the Extended Class (Nurse Practitioners). Retrieved from http://hprac.org/en/reports/resources/HPRACExtendedClassNurseReportENGMar08.pdf	<ul style="list-style-type: none"> - This report fulfills the second Ministerial request as identified in the Consultation Guide; HPRAC uses the 2006 CNO proposal and organizes consultations - Concludes that the expansion of the NP scope of practice and changes to the regulatory system "are in the public interest"
	2008, Sep	Report	An Interim Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals: Phase II, Part I. Retrieved from http://hprac.org/en/reports/resources/InterprofessionalCollaborationReportPhaseIIPartIENGSept08.pdf	<ul style="list-style-type: none"> - The continuation of the Interim report published in March 2008 - Focuses on the following professions: pharmacists, midwives, dietitians, and physiotherapists
	2009, Jan	Report	Critical Links: Transforming and Supporting Patient Care. A Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration and a New Framework for the Prescribing and Use of Drugs by Non-Physician Regulated Health Professions. Retrieved from http://hprac.org/en/reports/resources/HPRACCriticalLinksEnglishJan_09.pdf	<ul style="list-style-type: none"> - This report responds directly to the Ministerial request on the prescribing and use of drugs by non-physician professions - Identified as a mechanisms to alleviate the pressure on Health Human Resources - Reviewing competencies and the public interest in expanding the prescribing scope of practice of various professions, including NPs and pharmacists.
Chiroprapist				
Ontario Podiatric Medical Association	2008, May 8	Submission to HPRAC	Submission to HPRAC on Interprofessional Collaboration Among Health Colleges and Professionals. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1414May08OPMA.pdf	<ul style="list-style-type: none"> - OPMA submission to HPRAC on the Consultation Discussion Guide - Concise submission in regards to the questions provided by HPRAC in IPC

Source	Date Published	Type	Document Name and Source	Relationship to IPC and/or Bill 179
Ontario Society of Chiropodists	2008, May	Submission to HPRAC	Submission to: Health Professions Regulatory Advisory Council Respecting The Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1462May30OntarioSocietyOfChiropodists.pdf	<ul style="list-style-type: none"> - OSC submission to HPRAC on the Consultation Discussion Guide - Concise reply to the proposed questions provided by HPRAC
Chiropractic				
College of Chiropractors of Ontario	2006	Annual Report	A Balanced Landscape – Supporting Health Collaboration. Retrieved from http://www.cco.on.ca/english/About-CCO/Publications/	<ul style="list-style-type: none"> - Announcement of participation in FHRCO initiative to promote IPC with other health profession colleges
	2008	Annual Report	Building Strong, Long-Term Relationships with Government. Retrieved from http://www.cco.on.ca/english/About-CCO/Publications/	<ul style="list-style-type: none"> - CCO statement of “taking steps” to remove barriers to IPC; informal meeting with CPSO, CPO, OCP and CMRTO to work collaboratively on future projects - Mentions tandem submission with CCO, OCA, and CMCC to Minister of Health to enhance chiropractic standard of practice - Identifies participation in FHRCO’s initiative for HPRAC consultation on IPC - IPC included in CCO’s strategic planning agenda
	2008, Sept	Newsletter	ChiroPractice. Retrieved from http://www.cco.on.ca/english/About-CCO/Publications/	<ul style="list-style-type: none"> - IPC included in CCO’s strategic planning agenda and states its importance - CCO’s commitment to promoting collaborative patient care.
Ontario Chiropractors Association	2008, Aug 15	Submission to HPRAC	Physiotherapy Scope of Practice Review. Retrieved from http://www.hprac.org/en/projects/resources/1540-physioAug15OntarioChiropracticAssociation.pdf	<ul style="list-style-type: none"> - Response to the HPRAC in regards to the submission by OPA and CPO - OCA supports the enhanced scope of practice as requested by the OPA and CPO - Report states the criteria upon which the review of the scope of practices of the 6 selected professions was unclear - Argues the suggestions offered in the OPA and CPO submission would also be applicable to the scope of practices of chiropractic
Canadian Memorial Chiropractic College			No materials available prior to 2010	
Dentistry and Dental Hygiene				
Royal College of Dental Surgeons of Ontario	2008	Annual Report	Excellence in Self-Regulation: Annual Report 2008. Retrieved from http://www.rcdso.org/WhoWeAre/AnnualReports	<ul style="list-style-type: none"> - Identifies IPC as an accomplishment for 2008 - RCDSDO endorses the shift to expand IPC in health care policy
	2008, Feb/Mar	Newsletter	Dispatch 2008, Vol. 22, No. 1. Retrieved from http://www.rcdso.org/KnowledgeCentre/DispatchMagazine	<ul style="list-style-type: none"> - Discusses the Minister of Health’s and HPRAC’s initiative to address IPC - Provides a comprehensive explanation for the term “IPC” and describes the College’s existing collaborative projects - Statement that RCDSDO is supportive of IPC

Source	Date Published	Type	Document Name and Source	Relationship to IPC and/or Bill 179
	2008, May 14	Letter	Re: HPRAC Consultation Discussion Guide on Issues Related to the Ministerial Report on Interprofessional Collaboration among Health Colleges and Professionals. Retrieved from http://www.hprac.org/en/projects/resources/RCDSO.pdf	- RCDSO response to the HPRAC Consultation Discussion Guide
	2008, May/June	Newsletter	Dispatch 2008, Vol. 22, No. 2. Retrieved from http://www.rcdso.org/KnowledgeCentre/DispatchMagazine	- Identifies that IPC is high on the Minister of Health's priority list and HPRAC's work to on a referral - Identifies RCDSO's existing project for IPC with other dental and medical groups
	2008, Nov/Dec	Newsletter	Dispatch 2008, Vol. 22, No. 4. Retrieved from http://www.rcdso.org/KnowledgeCentre/DispatchMagazine	- The need for IPE is identified as one of the RCDSO's top challenges - Collaboration with other dental organizations to address amendments to the Dental Hygiene Act - Identifies their submission to HPRAC in regards to the IPC review
Ontario Dental Association	2008, May 29	Submission to HPRAC	Ontario Dental Association Submission to the Health Professions Regulatory Advisory Council Respecting the Consultation Discussion Guide of Issues Related to the Ministerial Referral in Interprofessional Collaboration among Health Colleges and Professionals. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1437May29OntarioDentalAssociation.pdf	- ODA submission to HPRAC on the Consultation Discussion Guide - The ODA provide their perspective on the questions posed by HPRAC and the Minister's request
College of Dental Hygienists of Ontario	2008, May 23	Submission to HPRAC	Response to HPRAC's Consultation Discussion on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1436May29CollegeOfDentalHygienists.pdf	- CDHO's submission to HPRAC on the Consultation Discussion Guide - Address the questions posed by HPRAC - Focus on reaffirming the role of the regulatory colleges to ensure accountability and transparency.
Dietitians				
College of Dietitians of Ontario	2008/09	Annual Report	Annual Report 2008/2009. Retrieved from http://www.cdo.on.ca/en/pdf/Publications/AnnualReports/AR2008-2009-Eng.pdf	- Identifies CDO's re-allocation of resources and expansion to meet the province's direction in supporting IPC - Document demonstrates optimism in the proposed changes to improve IPC, client-centered care, and enhance dietetic practice
	2008, May 30	Submission to HPRAC	Nurturing Interprofessional Collaboration in Ontario. Retrieved from http://www.cdo.on.ca/en/pdf/Publications/Submissions/Dietetics%20Submission%20to%20MOHLTC%20Jan%2030%202009.pdf	- Submission to HPRAC on the Consultation Discussion Guide - Offers recommendation to the questions posed by the Minister's request
	2008, Jun 30	Submission to HPRAC	Application for Review of the Scope of Practice of Dietetics in Ontario. Submitted to HPRAC. Retrieved from http://www.cdo.on.ca/en/resources/publications.asp	- Submission to HPRAC in regards to the scope of practice of registered dietitians - Identifies that the proposed changes could enhance IPC within the delivery of health services
	2009	Newsletter	Résumé Newsletter. Retrieved from http://www.cdo.on.ca/en/pdf/publications/resume/resumesummer09-Eng.pdf	- Provides an update to CDO members about the changes to the RHPA and the upcoming Bill 179 - Offers advice in dealing with other health care providers who also offer nutrition advice and treatment - Identifies the new regulated professions since 2006, offers a description of these new roles in patient care, and how it affected registered dietitians.

Source	Date Published	Type	Document Name and Source	Relationship to IPC and/or Bill 179
Dietitians of Canada	2008, May	Response to HPRAC	Dietitians of Canada (Ontario) Response to The Health Professions Regulatory Advisory Council Interprofessional Collaboration Discussion Guide. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1429May26DietitiansOfCanada.pdf	<ul style="list-style-type: none"> - Response to the HPRAC Consultation Discussion Guide - Concise response in regards to the Dietetic profession in Ontario
Diagnostic Medical Sonography				
Canadian Society of Diagnostic Medical Sonographers	2008, Oct	Newsletter	Interface Newsletter 2008, Vol, 26, No. 2. Retrieved from http://www.csdms.com/docs/interface.pdf	<ul style="list-style-type: none"> - Identifies the ODSMS 20 year pursue for the self-regulation of sonography - HPRAC has been requested to review this issue after the Nurse Practitioner's submission requesting to extend their scope of practice to include sonography - Expect that a decision will be made in late 20h09 on whether or not sonography should be regulated in Ontario
	2009, Sept	Newsletter	Interface Newsletter 2009, Vol. 27, No. 2 Retrieved from http://www.csdms.com/docs/200908_i.pdf	<ul style="list-style-type: none"> - Criticizes CNO's submission to extend the scope of practice of nurse practitioners; states that it demonstrates a lack of knowledge, inconsistencies, inaccurate statements, and confused terminology - Identifies their collaboration with the Canadian Association of Registered Diagnostic Ultrasound Professionals and OSDMS to present to HPRAC and Minister Caplan their concerns about patient safety related to nurse practitioners performing diagnostic ultrasound - The CSDMS, CARDUP, and OSDMS do not support the request of the NPs - State their participation at the Standing Committee on Social Policy hearing
Canadian Association of Registered Diagnostic Ultrasound Professionals			No materials found on their website; focused on professional development	
Ontario Society of Diagnostic Medical Sonographers			No materials found on their website	
Massage Therapy				
College of Massage Therapists of Ontario			No materials found on their website	
Ontario Massage Therapists' Association	2008, May	Submission to HPRAC	Submission to the Health Professions Regulatory Advisory Council Regarding the Consultation Discussion Guide on Issues Related to the Ministerial Referral on Inter-professional Collaboration among Health Colleges and Professionals. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1430May27OntarioMassageTherapistAssociation.pdf	<ul style="list-style-type: none"> - OMTA submission to the HPRAC Consultation Discussion Guide - Support the HPRAC initiative but identify the challenges of massage therapy; private funding of services in a public system - IPC should be a matter addressed by health professions, not at the regulatory level

Source	Date Published	Type	Document Name and Source	Relationship to IPC and/or Bill 179
Medical Laboratory				
College of Medical Laboratory Technologists of Ontario	2008, May 15	Letter	A submission in response to the Health Professions Regulatory Advisory Council's (HPRAC's) <i>Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals</i> , February 2008 (the Discussion Guide). Retrieved from http://www.hprac.org/en/projects/resources/hprac-1418May14CMLTO.pdf	<ul style="list-style-type: none"> - CMLTO submission to the HPRAC Consultation Discussion Guide - Supports IPC but not through regulation; "We therefore do not believe that regulation is necessary to support advancement of IPC"
Ontario Society of Medical Technologists			No materials found on their website	
Medical Radiation Technology				
College of Medical Radiation Technologists of Ontario	2007	Annual Report	Annual Report 2007: collaboration. Retrieved from http://www.cmрто.org/pdf/CMRTO_Annual_Report_2007.pdf	<ul style="list-style-type: none"> - President's message identifies the push for IPC and its requirement in today's health care system
	2008	Annual Report	Annual Report 2008: the evolution of the profession. Retrieved from http://www.cmрто.org/pdf/CMRTO_Annual_Report_2008.pdf	<ul style="list-style-type: none"> - Identifies a joint submission with the OAMRT to HPRAC to amend the profession's scope of practice - Believes there is a growing demand to increase IPC in the health care system
	2008, Spring	Newsletter	Insight Newsletter, Spring 2008. Retrieved from http://www.cmрто.org/pdf/insights_spring_2008.pdf	<ul style="list-style-type: none"> - Announces HPRAC's initiative to review IPC and the opportunity for CMRTO (in collaboration with OAMRT) to conduct a review of the scope of practice for MRTs
	2008, May 30	Submission to HPRAC	CMRTO Response to the HPRAC Consultation Discussion Guide on Interprofessional Collaboration. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1455May30CollegeOfMedicalRadiationTechnologists.pdf	<ul style="list-style-type: none"> - CMRTO Submission to the HPRAC Consultation Discussion Guide - Do not believe changes to the RHPA are required to promote IPC but rather changes to the health care system - Identifying systematic issues: funding and compensation models and lack of EMR
	2008, Summer/Fall	Newsletter	Insight Newsletter, Summer/Fall 2008. Retrieved from http://www.cmрто.org/pdf/insights_fall_2008.pdf	<ul style="list-style-type: none"> - Summarizes the scope of HPRAC's review on IPC and the anticipated public consultations - Offers a link to the final joint submission on the HPRAC website
	2008, Winter	Newsletter	Insight Newsletter, Winter 2008. Retrieved from http://www.cmрто.org/pdf/Insights_Winter_2008.pdf	<ul style="list-style-type: none"> - Highlights the HPRAC review on IPC and CMRTO's participation in the discussion and consultative process
Ontario Association of Medical Radiation Technologists	2007, November	Submission to HPRAC	Submission to the Health Professions Regulatory Advisory Council Regarding Regulatory Change Proposals for the Registered Nurse – Extended Class. Retrieved from http://www.oamrs.org/pdf/1205-2%20SubmissiontoHPRACRegisteredNurse.pdf	<ul style="list-style-type: none"> - OAMRT response to the CNO review on scopes of practice for nurse practitioners - Raise significant concerns about the improper use of terminology in the CNO review
	2008, May	Submission to HPRAC	Submission To The Health Professions Regulatory Advisory Council Regarding The Consultation Discussion Guide On Issues Related To The Ministerial Referral On Interprofessional Collaboration Among Health Colleges And Professionals. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1427May26OAMRT.pdf	<ul style="list-style-type: none"> - OAMRT submission to HPRAC on the Consultation Discussion Guide - Do not support the regulation of IPC; would work better through coordination with the FHRCO

Source	Date Published	Type	Document Name and Source	Relationship to IPC and/or Bill 179
Both CMRTO and OAMRT	2008, June 30	Joint submission to HPRAC	Joint Submission to HPRAC: Request for Change in Scope of Practice – Medical Radiation Technology. Retrieved from http://www.hprac.org/en/projects/resources/CollegeofMedicalRadiationTechnologistsOfOntarioSubmission.pdf	<ul style="list-style-type: none"> - Submission to HPRAC on the scope of practice of medical radiation technology; focus on amendments to the Medical Radiation Technology Act, 1991 - Recommendations supported by the Canadian Association of Medical Radiation Technologists, Ontario Association of Radiology Managers, and Ontario Hospital Association
Medicine				
Canadian Medical Association	1999, 2000, 2002, 2007, 2008, 2009	Resolutions	Canadian Medical Association Resolutions, 1999, 2000, 2002, 2007, 2008, 2009. Retrieved from http://www.cma.ca/aboutcma/annualmeeting	<ul style="list-style-type: none"> - Documents detailing the resolutions passed at the annual meetings - Resolutions included promoting collaborative practice across the medical profession and among other health care workers
	2007	Resolutions	Canadian Medical Association: Collaborative Care Resolutions (2007). Retrieved from http://www.cma.ca/index.php?ci_id=52043&la_id=1	<ul style="list-style-type: none"> - Document detailing the resolutions passed at the 140th annual meeting related to collaborative care - Resolutions support collaborative care and the “evolution” of patient-centred models in Canada
	2005	Report	Primary care reform – a national overview. Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/WhatWePublish/LeadershipSeries/English/national_overview.pdf	<ul style="list-style-type: none"> - Document that outlines the primary care reform initiatives and their progress across Canada - Identifies efforts to work collaborative with other health care providers and the associated challenges - For Ontario, discussion about payment mechanisms and models, including the establishment of Family Health Teams.
	2005	Report	Primary Care Reform. Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Store/English/PDF/PrimaryCareReform.pdf	<ul style="list-style-type: none"> - A document that provides further information in regards to how different payment mechanisms can assist in primary care reform.
	2005	Report	Toward a Pan-Canadian Planning Framework for Health Human Resources: A Green Paper (2005). Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Media_Release/pdf/2005/CMA-CNA-Green-Paper.pdf	<ul style="list-style-type: none"> - Published in partnership with the Canadian Nurses Association - Discussions 10 core principles and strategic directions to achieve reform in health human resources planning - Approaches relate to patient-centred care, planning, and career life cycle
	2007	Report	Collaborative Care Models in Canada: Backgrounder. Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Ethics/collaborative-care-background_e.pdf	<ul style="list-style-type: none"> - Details a study exploring the relationships between physicians and other health care providers within collaborative care practice - Identifies previous reports and initiatives to support collaborative and patient-centred care, interprofessional education, and collaboration - Identifies potential challenges: liability, funding, competition
	2007, June	Newsletter	Working Together: your issues and solution. MDLounge. Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/MDLounge/mdlounge_e.pdf	<ul style="list-style-type: none"> - A newsletter published in partnership with the CMA, the CFPC, and the RCPSC. - Outlines the results of a consultative process to assess member’s views regarding the provision of specialty care in Canada - Respondents identified frustration with collaborative care model and the increasing divide between family medicine and other specialties
	2007, July	Report	Putting Patients First: Patient-Centres Collaborative Care, A Discussion Paper. Retrieved from http://fhs.mcmaster.ca/surgery/documents/CollaborativeCareBackgrounderRevised.pdf	<ul style="list-style-type: none"> - Identifies the CMA’s dedication for collaborative care practice - “Despite all the research, planning and activity targeted at enhancing collaborative care in Canada, challenges and barriers still exist.” - Document lists the principles of collaborative care and what measures are needed to ensure its successful implementation

Source	Date Published	Type	Document Name and Source	Relationship to IPC and/or Bill 179
	2008	Newsletter	Collaborative Care: a necessary evolution (Author: Marla Fletcher, MDPulse 2008). Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/News_and_Publications/MD_Pulse/2008/May/14-MDPulse08_sec3-Collab.pdf	<ul style="list-style-type: none"> - Article to CMA members discussing the benefits of collaborative care and encourages members to collaborative with other health care providers possessing different skill sets
	2008, March	Newsletter	Blazing a collaborative trail. MDLounge. Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/MDLounge/March2008_e.pdf	<ul style="list-style-type: none"> - This article identifies the successful use of collaborative care in providing mental health – the Canadian Collaborative Mental Health Initiative - Challenges with this initiative stemmed from the ministry or governmental level - Urges more Canadian data on the benefits of collaborative mental health care delivery
	2008, June	Newsletter	Teamwork: it's not just for sports anymore. MDLounge. Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/MDLounge/mdloungejun3.pdf	<ul style="list-style-type: none"> - Article discussed the relatively new initiative to establish formal arrangements between physicians and other health care providers in the community - The 2007 National Physician Survey determined the majority of respondents identified a desire to further establish these relationships; need for educational training
	2009	Report	The Wait Starts Here: The Primary Care Wait Time Partnership, Final Report (2009). Retrieved from http://cfpc.ca/uploadedFiles/Resources/Resource_Items/ENGLISH20PCWTP20FINAL20-20DECEMBER202009.pdf	<ul style="list-style-type: none"> - The Primary Care Wait Time Partnership was established with the College of Family Physicians of Canada and the Canadian Medical Association - Collaborative care practice is identified as a potential model for primary care delivery - Focus on providing physicians the skills to manage their primary care practice and to provide specialized care using a myriad of health care providers
	2009, Aug	Discussion paper for annual meeting	Toward a Blueprint for Health Care Transformation: Discussion Paper prepared for the 143 rd Meeting of the Canadian Medical Association General Council. Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Advocacy/HCT/Blueprint-HCT_en.pdf	<ul style="list-style-type: none"> - Provides background information in regards to health care reform in Canada - The CMA identifies 5 directions to reorient the Canadian health care system: building a culture of patient-centred care; incentives for enhancing access and improving quality of care; enhancing patient access across the continuum of care; helping providers help patients; and building accountability/responsibility - Requests members to identify CMA's role in mobilizing public opinion and stakeholder support to achieve the above transformational change
	2009, Aug 14	Submission to the Committee	Transforming Health Care, Securing Canada's Competitive Advantage: The Canadian Medical Association's brief to the Standing Committee on Finance's pre-budget consultation. Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Submissions/2009/Pre-Budget-2010_en.pdf	<ul style="list-style-type: none"> - The brief discusses the possibility of maintaining a universally accessible health care system without long wait times. - CMA calls the attention of the federal government to: enhance patient access across the continuum of care and accelerating EMR and HHR resources

Source	Date Published	Type	Document Name and Source	Relationship to IPC and/or Bill 179
	2009, Aug 28	Submission to the Committee	“More Doctors. More Care.” A Promise Yet Unfulfilled. The Canadian Medical Association’s brief to the House of Commons Standing Committee on Health concerning health human resources. Retrieved from http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Submissions/2009/HHR-Brief_e.pdf	<ul style="list-style-type: none"> - The CMA identifies election promises from the “last federal election” (2006) to address HHR shortages. - The brief identifies that collaborative care models are a solution to reduce the burden on HHR - Identifies the need for innovation (i.e. electronic medical records) to facilitate collaborative care in Canada’s system
Ontario Medical Association	2007	Policy Paper	OMA Policy Paper: Interprofessional Care (Author: Dr. Aura Hanna, OMA Health Policy Department) Retrieved from https://www.oma.org/Resources/Documents/2007IPCPaper.pdf	<ul style="list-style-type: none"> - Outlines the requirements for successfully integrated care from the physician perspective, ranging from resources, to liability protection, record keeping, and appropriate review of scope of practice
	2008, Aug	Response to HPRAC	Submission to the Health Professions Regulatory Advisory Council Respecting Issues Related to Scope of Practice: Dietetics, Physiotherapy, Medical Radiation Technology, Medical Laboratory Technology, Pharmacy. Retrieved from http://www.hprac.org/en/projects/resources/1694-OMASubmissionHPRACScopeAug082.pdf	<ul style="list-style-type: none"> - Provides the OMA’s response to the recommendations related to scopes of practice of: Dietetics, Physiotherapy, Medical Radiation Technology, Medical Laboratory Technology, and Pharmacy
	2008, Nov 19	Press Release	Ontario Medical Association raises concerns over expansion of nurse practitioner clinics. Retrieved from https://www.oma.org/Mediaroom/PressReleases/Pages/Ontario%E2%80%99sDoctorsDiscouragedbyProvincialHealthcareSpending.aspx	<ul style="list-style-type: none"> - OMA expresses disappointed of the government’s shift of focus from FHTs to nurse practitioner – led clinics - The Ontario government delayed the addition of 50 new FHTs due to “economic uncertainty” - OMA calls for an evaluation of the effectiveness of the NP model
	2009, May 3	Press Release	Dr. Strasberg calls for additional collaborative care models and expansion of eHealth. Retrieved from https://www.oma.org/Mediaroom/PressReleases/Pages/NewPresidentofOMAsaysEveryOntarianShouldHaveaDoctor.aspx	<ul style="list-style-type: none"> - OMA president identifies eHealth is critical to a sustainable health care system - Need a tool to facilitate communication along the continuum of care
	2009, May 11	Press Release	Statement in Response to Bill 179: Regulated Health Professions Statute Lay Amendment Act, 2009. Retrieved from https://www.oma.org/Mediaroom/PressReleases/Pages/ResponseBill179.aspx	<ul style="list-style-type: none"> - Press release advertises the OMA’s role in review the proposed legislation - Issues that: the level of care that a doctor can provide should not be substituted for expediency.
	2009, June 9	Press Release	Getting a doctor and an electronic medical record will strengthen health care system: Ontario’s doctors. Retrieved from https://www.oma.org/Mediaroom/PressReleases/Pages/GettingaDoctorandElectronicMedicalRecord.aspx	<ul style="list-style-type: none"> - Highlights the Ontario Health Quality Council study - Focus on providing more physicians and availability of electronic medical records
	2009, July 22	Press Release	Ontario’s Doctors Support Collaborative Care to Keep Patients Front and Centre. Retrieved from https://www.oma.org/Mediaroom/PressReleases/Pages/Ontario%E2%80%99sDoctorsSupportCollaborativeCaretoKeepPatientsFrontandCentre.aspx	<ul style="list-style-type: none"> - OMA supports the Government of Ontario’s decision to move ahead with FHTs - Continue to criticize NP-led clinics: “By comparison, independent nurse practitioner clinics run directly counter to these integrated care models.”
	2009, Jul/Aug	Position Paper	OMA Policy on Accountability in the Health-Care Sector. Retrieved from https://www.oma.org/Resources/Documents/2009PolicyAccountability.pdf	<ul style="list-style-type: none"> - Several of the principles of the interprofessional care policy are reiterated in the accountability principles at the end of this document because of their relevance to accountability
	2009, Sept	Submission to the Committee	Ontario Medical Association Submission to the Standing Committee on Social Policy on Bill 179: “An Act to Amend Regulated Health Professions Statutes” September 2009. Retrieved from https://www.oma.org/Resources/Documents/Bill179Sept2009.pdf	<ul style="list-style-type: none"> - Provides the OMA’s opinion on the draft of Bill 179; these issues were presented at the Committee Hearing

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	2009, Sept 29	Press Release	Ontario Doctors Support Collaboration Among Health Care Professionals. Retrieved from https://www.oma.org/Mediaroom/PressReleases/Pages/CollaborationAmongHealthCareProfessionals.aspx	<ul style="list-style-type: none"> - Identifies the OMA's participation at the Standing Committee hearing - Outline the main points of their submission
	2009, Oct	Report	Ontario Medical Association Policy on Chronic Disease Management. Retrieved from https://www.oma.org/Resources/Documents/2009ChronicDiseaseManagement.pdf	<ul style="list-style-type: none"> - OMA identifies the importance of the clinical leadership of an interprofessional team to provide coordination of care for patients with multiple chronic diseases
	2009, Nov 27	Press Release	Statement – New Nurse Practitioners Clinics. Retrieved from https://www.oma.org/Mediaroom/PressReleases/Pages/NewNursePractitionerClinics.aspx	<ul style="list-style-type: none"> - Article expresses continued frustration from the OMA in regards to the push of nurse practitioner-led clinics.
College of Physicians and Surgeons of Ontario	2003, May	Position Statement	Fostering Collaborative Relationship with Nurse Practitioners. Retrieved from http://www.cpso.on.ca/policies/positions/default.aspx?id=1742	<ul style="list-style-type: none"> - Position statement that confirms CPSO's commitment to foster a collaborative relationship with the nursing profession
	2005, Feb	Position Statement	Interprofessional Collaboration. Retrieved from http://www.cpso.on.ca/policies/positions/default.aspx?id=1744	<ul style="list-style-type: none"> - Position statement of CPSO's commitment to foster collaboration relationships with pharmacists
	2008, May	Submission to HPRAC	Interprofessional Collaboration in Ontario: Submission to the Health Professions Regulatory Advisory Council (May 2008). Retrieved from http://www.cpso.on.ca/uploadedFiles/downloads/cpsodocuments/policies/positions/submissions/HPRAC%20submission.pdf	<ul style="list-style-type: none"> - Offers advice on issues related to IPC among health colleges and professions - Emphasis on pressures from HHR, a new generation of physicians, and aging population to promote IPC - Cautions that approaches in urban centres may not be appropriate in rural centres - Identifies barriers, enablers, and structural mechanisms that need to be addressed - Provides recommendations for HPRAC to further investigate IPC in Ontario
	2008, Aug 21	Submission to HPRAC	Scopes of Practice Expansion Proposals. Retrieved from http://www.hprac.org/en/projects/resources/cpso.pdf	<ul style="list-style-type: none"> - Submission on the review of the scopes of practice of various professions.
	2009, Jan	Submission to HPRAC	Submission to the Honorable David Caplan, Minister of Health and Long-Term Care, January 2009, Interprofessional Collaboration. Retrieved from http://www.cpso.on.ca/uploadedFiles/IPCSubmissionsMOHJan_09.pdf	<ul style="list-style-type: none"> - Submission to MOHLTC in regards to the IPC review process - Concerned that the process is neglecting the broader systems issues that will further entrench professional silos - CPSO identifies two systemic issues of particular interest: EMRs and a coordinated payment scheme - Emphasizes the need to consider different practice settings - Addresses amendments of all affected professions
	2009, Sept 25	Submission to the Committee	The College of Physician and Surgeons of Ontario's Submission on Bill 179 – The Regulated Health Professions Statute Law Amendment Act, 2009. Retrieved from http://www.cpso.on.ca/uploadedFiles/policies/positions/Bill179Submission_Sep09.pdf	<ul style="list-style-type: none"> - Submission to HPRAC on Bill 179 - Address some key issues and offers alternatives - Reviews the scopes of practice of pharmacists, midwives, optometrists
	2007, Apr 30	Newsletter	"Inside Out": Number 40. Retrieved from http://www.ocfp.on.ca/docs/communications/april-30-2007.pdf	<ul style="list-style-type: none"> - Identifies access to interprofessional teams as a goal for 2010 - States family doctors should be able to choose from different funding models and variety of interprofessional approaches to fulfill their practice

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	2008, Apr 28	Submission to HPRAC	Interprofessional Collaboration amongst Health Colleges and Professionals. Respectfully submitted to: The Health Professions Regulatory Advisory Council (April 28, 2008). Retrieved from http://www.ocfp.on.ca/docs/publications/interprofessional-collaboration-amongst-health-colleges-and-professionals.pdf	<ul style="list-style-type: none"> - Slogan: "Interprofessional Collaboration is built upon the bedrock of mutual trust and respect. It can be enabled; it cannot be legislated." - Identifies the barriers and mechanisms to develop enablers for IPC at various levels (college, education, and practice) - Identifies structural mechanisms needed to support IPC
	2008, May	Newsletter	Marchpast. Retrieved from http://www.ocfp.on.ca/docs/chapter-and-member-reports/2008---may.pdf	<ul style="list-style-type: none"> - Document outlines the 2007-2010 strategic plan following their retreat - Includes building a supportive environment for collaborative family practices by preparing family physicians to lead
	2008, Aug 15	Response to HPRAC	Submission from the Ontario College of Family Physicians (OCFP) to the Health Professions Regulatory Advisory Council (HPRAC) in Respect to The College of Physiotherapists of Ontario & The Ontario Physiotherapy Association's Submission For a Review of the Scope of Practice of Physiotherapy. (August 15, 2008) Retrieved from http://www.ocfp.on.ca/docs/publications/final-ocfp-response-to-physiotherapy-august-15-2008.pdf	<ul style="list-style-type: none"> - Submission to HPRAC in regards to the scope of practice of physiotherapy - Argues the amendments are too broad and requires further discussion, particularly in the area of diagnosis
	2008, Aug 15	Response to HPRAC	Submission from the Ontario College of Family Physicians (OCFP) to The Health Professions Regulatory Advisory Council (HPRAC) In Respect to The Ontario College of Pharmacist's Submission For a Review of the Scope of Practice of Pharmacy (August 15, 2008) Retrieved from http://www.ocfp.on.ca/docs/publications/final-ocfp-response-to-pharmacy-submission-aug-15-08.pdf	<ul style="list-style-type: none"> - Submission to HPRAC in regards to the scope of practice of pharmacists - Uses slogan: "Interprofessional Collaboration is built upon the bedrock of mutual trust and respect. It can be enabled; it cannot be legislated."
	2008, Aug 15	Response to HPRAC	Submission from the Ontario College of Family Physicians (OCFP) to The Health Professions Regulatory Advisory Council (HPRAC) In Respect to The College of Midwives of Ontario Scope of Practice Review (August 15, 2008). Retrieved from http://www.ocfp.on.ca/docs/publications/final-ocfp-response-to-midwifery-sop-review-august-15th-08.pdf	<ul style="list-style-type: none"> - Submission to HPRAC in regards to the scope of practice of midwives - Uses slogan: "Interprofessional Collaboration is built upon the bedrock of mutual trust and respect. It can be enabled; it cannot be legislated."
	2009, Feb 24	Response to HPRAC	OCFP's Response to The Health Professions Regulatory Advisory Council (HPRAC)'s Report to the Ministry of Health and Long Term Care "Critical Links: Transforming and Supporting Patient Care" (February 24, 2009). Retrieved from http://www.ocfp.on.ca/docs/publications/ocfp-response-to-hprac-report-to-mohlhc.pdf	<ul style="list-style-type: none"> - Response to HPRAC's recommendation to enhance patient care - OCFP states their disagreement with the proposal to establish a new regulatory framework but agrees with the new drug approval framework
	2009, Sept 28	Submission to the Committee	Presentation to the Standing Committee on Social Policy (September 28, 2009). Retrieved from http://www.ocfp.on.ca/docs/publications/presentation-to-the-standing-committee.pdf	<ul style="list-style-type: none"> - Submission to the Committee Hearing - OCFP is concerned that the increase in scopes of practice for non-physician is perceived by the media and public as a solution to address the shortage of physician

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College of Physician and Surgeons of Ontario, College of Nurses of Ontario, Ontario College of Pharmacists & Royal College of Dental Surgeons of Ontario	2009, Sept 25	Letter to the Standing Committee on Social Policy	Re: Bill 179 – The Regulated Health Professions Statute Law Amendment Act, 2009 [Correspondence to HPRAC]. Retrieved from http://www.cpso.on.ca/uploadedFiles/policies/positions/Bill179_Submission_CPSO_OCP_CNO_CDSO.pdf	- Joint submission to the Standing Committee on Social Policy in regards to the supervisor and audit provision of Bill 179.
Midwifery				
College of Midwives of Ontario	n.d.	Submission to HPRAC	The College of Midwives of Ontario Response to the Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals. Retrieved from http://www.cmo.on.ca/downloads/HPRAC-InterprofessionalCare.pdf	- CMO response to the Consultation Discussion Guide on mechanisms to facilitate IPC
	2008, May 30	Submission to HPRAC	The Midwifery Scope of Practice The College of Midwives of Ontario Submission to the Health Professions Regulatory Advisory Council May 30, 2008. Retrieved from http://www.cmo.on.ca/documents/CollegeofMidwivesofOntarioSubmission_HPRAC_May2008.pdf	- Submission to HPRAC on the potential enhancement of scope of practice for midwifery.
	2008, Aug 6	Response to OMA comments	College of Midwives of Ontario response to the Ontario Medical Association Regarding the CMO's Scope of Practice Submission August 6, 2008. Retrieved from http://www.hprac.org/en/projects/resources/hprac-SOP-midwifery-aug7-CMOResponsetoOMA.pdf	- Provides an opportunity for the CMO to reply to the OMA comments on the enhancement of scopes of practice for midwifery
	2008, Aug 19	Response to OCFP comments	College of Midwives of Ontario – Response to the Ontario College of Family Physicians Regarding the CMO's Scope of Practice Submission August 19, 2008. Retrieved from http://www.hprac.org/en/projects/resources/hprac-SOP-midwifery-aug20-CMOresponsetoOCFP.pdf	- Provides an opportunity for the CMO to reply to the OCFP comments on the enhancement of scopes of practice for midwifery
Association of Ontario Midwives	n.d.	Submission to HPRAC	Submission to HPRAC Regarding the Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration Among Health Colleges and Professionals. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1470May30AssociationofOntarioMidwives.pdf	- AOM response to the Consultation Discussion Guide on mechanisms to facilitate IPC
Naturopathy				
Board of Directors of Drugless Therapy - Naturopathy	2008, May 29	Submission to HPRAC	Submission to the Health Professions Regulatory Advisory Council (HPRAC) on Interprofessional Collaboration among Health Colleges and Professionals. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1439May29BDDTN.pdf	- BDDT-N response to the Consultation Discussion Guide on mechanisms to facilitate IPC

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Ontario Association of Naturopathic Doctors	n.d.	Submission to HPRAC	Response to The Health Professions Regulatory Advisory Council Consultation on Issues Related to the Ministerial Referral on Interprofessional Collaboration Among Health Colleges and Professions. Retrieved from http://www.oand.org/uploads/File/PDF/Govt_Affairs/Response_to_HPRAC_IPC_Consultation_Final_May-30-08.pdf	- OAND response to the Consultation Discussion Guide on mechanisms to facilitate IPC
Nursing				
Canadian Nursing Association	2005	Position Statement	Interprofessional Collaboration. Retrieved from http://www.nanb.nb.ca/PDF/Publications/General_Publications/Interprofessional_Collaboration_e.pdf	- The document identifies the CAN's support for IPC and outlines six principles to facilitate collaboration among professions and professionals
College of Nurses of Ontario	2007, May	Report	Supporting Quality Nursing Care in the Long – Term Care Sector: Results of the 2005-2006 Long–Term Care Teleconference Series. Retrieved from http://www.cno.org/Global/docs/policy/LTCCollaboration_Paper_May2007.pdf	- The report establishes that collaboration is a desired strategy to provide quality care in long-term care settings - The focus shifts from physician-nurse collaboration to nurse-health care provider
	2008, May	Submission to HPRAC	Interprofessional Collaboration among Health Colleges and Professions: Submission to the Health Professions Regulatory Advisory Council. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1433may28collegeofnurses.pdf	- CNO response to the Consultation Discussion Guide on mechanisms to facilitate IPC
	2009, Jan 30	Submission to HPRAC	The College of Nurses of Ontario's response to: <i>An Interim Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration among Health Colleges and Regulated Professionals</i> Retrieved from http://www.cno.org/Global/docs/policy/hprac_InterprofColl_and_NP_Response_Jan302009.pdf	- CNO response to the Interim report to facilitate and support IPC among health colleges and professionals
	2009, Sept 29	Submission to HPRAC	The College of Nurses of Ontario Oral Submission to: The Standing Committee on Social Policy BILL 179, <i>REGULATED HEALTH PROFESSIONS LAW STATUTE AMENDMENT ACT, 2009</i> . Retrieved from http://www.cno.org/Global/docs/policy/Bill179SubmissionStandingCommittee_Final_CouncilApproved.pdf	- CNO response to the Standing Committee on Social Policy - Supports the recommendations for the scope of practice of the NPs
Registered Nurses' Association of Ontario	2007, Mar/Apr	Newsletter	Ontario's FHTs hold promise, but not without nurses. (Author: Jill Scarrow). Registered Nurses Journal. Retrieved from http://rnao.ca/sites/rnao-ca/files/Mar-Apr_2.pdf	- An article published by RNAO highlights the role of nurses in FHTs in ensuring "the best primary health care" - Identifies positive response from physicians
	2008, May	Submission to HPRAC	Response to Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals: Registered Nurses' Association of Ontario. Retrieved from http://rnao.ca/sites/rnao-ca/files/storage/related/3407_RNAO_Response_to_HPRAC_on_Interprofessional_Collaboration_May_2008.pdf	- RNAO response to the Consultation Discussion Guide on mechanisms to facilitate IPC
	2009, Oct	Submission to the Committee	RNAO SUBMISSION TO: The Standing Committee on Social Policy Bill 179: <i>Regulated Health Professions Law Statute Amendment Act, 2009</i> . Retrieved from http://rnao.ca/sites/rnao-ca/files/storage/policy/submissions/5774_RNAO-Bill_168_written_submission_Nov_22_09_-_FINAL.pdf	- RNAO response to the Standing Committee on Social Policy - Supports the recommendations for the scope of practice of the NPs

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Nurse Practitioner' Association of Ontario	2007, Nov	Submission to HPRAC	Submission to Health Professions Regulatory Advisory Council Critical Legislative and Regulatory Steps to Improve Access to Care for Patients and Facilitate Integration of Nurse Practitioners in Ontario. Retrieved from http://hprac.org/en/projects/resources/hprac-nursing_response_CNO.NPAOnew.pdf	<ul style="list-style-type: none"> - NPAO submission to HPRAC on the role of NPs in increasing access to services - Addresses the second point of the Minister's request
	2008, Nov	Submission to HPRAC	Submission to Health Professions Regulatory Advisory Council Non-Physician Prescribing. Retrieved from http://www.hprac.org/en/projects/resources/SubmissiontoHPRAC-Drug-RNAOSubmission.pdf	<ul style="list-style-type: none"> - NPAO submission to HPRAC on non-physician prescribing
	2009, Jan 30	Submission to HPRAC	Response to HPRAC Referral "A Report to the Minister of Health and Long-Term Care on the Review of the Scope of Practice of Registered Nurses in the Extended Class (Nurse Practitioners) March 2008. Retrieved from http://npao.org/wp-content/uploads/2011/07/NPAO-Submission-to-Minister-Caplan-on-HPRAC-Referral-on-RNECs-20081.pdf	<ul style="list-style-type: none"> - Response to HPRAC on the review of the scope of practice of NPs
	2009, Feb 28	Submission to HPRAC	Response to HPRAC's Report Critical Links: <i>Transforming and Supporting Patient Care. A Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration and a New Framework for the Prescribing and Use of Drugs by Non-Physician Regulated Health Professions January 2009</i> . Retrieved from http://npao.org/wp-content/uploads/2011/07/NPAO-Submission-to-Minister-Caplan-on-HPRAC-Critical-Links-Report-20091.pdf	<ul style="list-style-type: none"> - NPAO response to HPRAC on non-physician prescribing - Highlights the need to allow NPs access to categories of drugs, not lists - Addresses the framework for non-physician prescribing; response identifies that the framework was not discussed in the previous report
	2009, Oct 5	Submission to the Committee	Submission to Social Policy Committee Response to Bill 179 Regulated Health Professions Statute Law Amendment Act. Retrieved from http://npao.org/wp-content/uploads/2011/07/NPAO-Submission-Bill-179-Oct520092.pdf	<ul style="list-style-type: none"> - Written submission to the Committee on Bill 179 - Clearly identifies the limitations of the bill as it relates to the NPs
Optometry				
College of Opticians of Ontario			No documents found	
Ontario Association of Optometrists			No documents found	
Pharmaceutical				
Ontario College of Pharmacists	2008, November	Submission to HPRAC	Submission to the Health Professions Regulatory Advisory Council on Non-Physician Prescribing and Administration of Drugs under the Regulated Health Professions Act. Retrieved from http://www.hprac.org/en/projects/resources/hprac-drug-ocpsubmission.pdf	<ul style="list-style-type: none"> - The submission outlines the OCP recommendations for prescribing
Ontario Pharmacists' Association	n.d.	Highlights of the submission to the Committee	Submission to the Standing Committee on Social Policy Highlights. Retrieved from http://www.opatoday.com/files/public/documents/advocacy/Highlights%20of%20the%20Submission%20to%20the%20Standing%20Committee%20on%20Social%20Policy.pdf	<ul style="list-style-type: none"> - A 2-page document that outlines the submission to the Standing Committee on Social Policy.

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	2008, Winter	Newsletter	Working together: interprofessional collaboration takes hold. The Ontario Pharmacist. Retrieved from http://www.opatoday.com/members/documents/TOP_winter2008.pdf	<ul style="list-style-type: none"> - The newsletter identifies the OPA's support for the HPRAC initiative - Provides background information on IPC and its benefits - Focus on preparing pharmacists for the changing climate
	2009, Feb 27	Letter	Letter addressed to the Honourable David Caplan on the HPRAC report titled "Critical Links: Transforming and Supporting Patient Care ("Final Report")" Retrieved from http://www.opatoday.com/files/public/documents/advocacy/OPA%20Submission%20to%20HPRAC%20Final%20Report_Feb27_09.pdf	<ul style="list-style-type: none"> - Letter written to Minister Caplan; written as a submission - Response in regards to the HPRAC Critical Link report - Offer more recommendations on the enhancement of their scope of practice
	2009, Oct	Document	Submission to the Standing Committee on Social Policy Highlights. Retrieved from http://www.opatoday.com/files/public/documents/advocacy/Highlights%20of%20the%20Submission%20to%20the%20Standing%20Committee%20on%20Social%20Policy.pdf	<ul style="list-style-type: none"> - The document outlines the OPA response to the Committee on Bill 179 - Identify opportunities for the enhancement of scope of practice with and beyond Bill 179
Physiotherapy				
College of Physiotherapists of Ontario; Ontario Physiotherapist Association	2008, Jun 30	Joint submission to HPRAC	Physiotherapy Scope of Practice Review 2008. <i>Submission to the Health Professions Regulatory Advisory Council</i> . Retrieved from http://www.opa.on.ca/pdfs/position/HPRAC_Scope062708.pdf	<ul style="list-style-type: none"> - Submission to HPRAC on the review of scope of practice for physiotherapists - Identifies areas of the scope of practice that should be altered to address the Minister's request to facilitate IPC
Psychotherapy				
Canadian Association for Psychodynamic Therapy	2008, May	Response to HPRAC	Canadian Association for Psychodynamic Therapy Response to the Health Professions Regulatory Advisory Council's Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals. Retrieved from http://psychodynamiccanada.org/system/documents/CAPTtoHPRACInterprofCollab.pdf	<ul style="list-style-type: none"> - CAPT response to HPRAC's Consultation Discussion Guide - Identifies the movement towards a holistic approach to medical care, resulting in the new focus of IPC - Identifies that psychodynamic psychotherapy is "well poised" for the transition because it is rooted in the holistic approach - Identifies the challenge of maintain patient anonymity within psychotherapy - Overall, supportive of the IPC initiative
	2009, Jan 30	Response to HPRAC	Canadian Association for Psychodynamic Therapy Response to the Minister of Health and Long-Term Care Concerning the Health Professions Regulatory Advisory Council's Two Interim Reports in March and September 2008 to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals. Retrieved from http://psychodynamiccanada.org/system/documents/CAPTreHPRAC2interim2009Jan30.pdf	<ul style="list-style-type: none"> - Provides the CAPT response to HPRAC on the report - Majority of the response focuses on the protection of the title "psychotherapist" - Identifies that the presence of the Transitional Council for psychotherapy will not allow time for proper discussion of the use of the title "psychotherapist" by other professions or clearly define the profession
	2009, Feb 28	Response to HPRAC	Canadian Association for Psychodynamic Therapy Response to the Minister of Health and Long-Term Care Concerning the Health Professions Regulatory Advisory Council's Critical Links: Transforming and Supporting Patient Care (January 2009). Retrieved from http://psychodynamiccanada.org/system/documents/CAPTResponseToHPRACsCriticalLinks.pdf	<ul style="list-style-type: none"> - CAPT response to HPRAC on the Critical Links report - Identifies the difficulties of providing clarification on the psychotherapist scope of practice as it is still being developed - Identifies challenges of the regulation of Drug Lists and access to professions who have "prescribing powers"

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	2009, Sep 25	Response to the Committee	Canadian Association for Psychodynamic Therapy Response to The Standing Committee on Social Policy Concerning Bill 179, <i>Regulated Health Professions Statute Law Amendment Act, 2009</i> . Retrieved from http://psychodynamiccanada.org/system/documents/CAPT-Response-to-SPC-on-Bill-179-Sept2009.pdf	<ul style="list-style-type: none"> - CAPT response to the Committee on Bill 179 - Supports the IPC initiative and offers suggestions on the proposed amendments
Ontario Association for Marriage and Family Therapy	2008, May 30	Submission to HPRAC	Interprofessional Collaboration Consultation Response to the Health Professions Regulatory Advisory Council's Invitation to Comment Submitted by the Ontario Association for Marriage and Family Therapy. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1459May30OAMFT.pdf	<ul style="list-style-type: none"> - OAMFT submission to HPRAC on the Consultation Discussion Guide - Provides its recommendations on the questions provided by HPRAC
Ontario Association of Consultants, Counsellors, Psychometrists & Psychotherapists	2008, May 30	Submission to HPRAC	Submission Responding to The Health Professions Regulatory Advisory Council's Discussion Guide on Interprofessional Collaboration Submitted by The Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1469May30OACCPP.pdf	<ul style="list-style-type: none"> - OACCPP submission to HPRAC on the Consultation Discussion Guide
Alliance of Psychotherapy Training Institutions	2008, May 31	Submission to HPRAC	APTI Response to the Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1402May28AllianceofPsychotherapyTrainingInstitutes.pdf	<ul style="list-style-type: none"> - APTI submission to HPRAC on the Consultation Discussion Guide
Respiratory Therapy				
College of Respiratory Therapists of Ontario	2008, May 28	Submission to HPRAC	HPRAC Interprofessional Collaboration Project Submission from the College of Respiratory Therapists of Ontario. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1435May29CollegeOfRespiratoryTherapists.pdf	<ul style="list-style-type: none"> - CRTO submission to HPRAC on the Consultation Discussion Guide - Provides its recommendations on the questions provided by HPRAC
Social Work				
Ontario College of Social Workers and Social Service Workers	2008, May	Submission to HPRAC	Health Professions Regulatory Advisory Council (HPRAC) Consultation on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals Discussion Guide Submission from the Ontario College of Social Workers and Social Service Workers (OCSWSSW). Retrieved from http://www.ocswssw.org/docs/hprac_interprofessional_collaboration_may_2008.pdf	<ul style="list-style-type: none"> - OCSWSSW submission to HPRAC on the Consultation Discussion Guide - Provides its recommendations on the questions provided by HPRAC
	2009, Feb	Response to HPRAC	Response from the Ontario College of Social Workers and Social Service Workers (OCSWSSW). Retrieved from http://www.ocswssw.org/docs/hprac_critical_links_submission.pdf	<ul style="list-style-type: none"> - OCSWSSW response to two HPRAC reports: Interim Report on Mechanisms to Facilitate and Support IPC among Health Colleges and Regulated Health Professionals and Critical Links
Ontario Association of Social Workers			No documents found on the website	
Other				
Children's Treatment Network of Simcoe York	2008, April	Submission to HPRAC	Submission RE HPRAC Interprofessional Collaboration Project. Retrieved from http://www.hprac.org/en/projects/resources/hprac-1390Apr15ChildrensTreatmentNetwork.pdf	<ul style="list-style-type: none"> - Children's Treatment Network submission to HPRAC on the Consultation Discussion Guide - Does not believe that IPC should be regulated; collaboration of the colleges is separate from the collaboration practiced by the profession

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Ontario Hospital Association	2008, Aug 15	Submission to HPRAC	Response to the Scope of Practice Reviews for Dietetics, Medical Laboratory Technology, Medical Radiation Technology, Midwifery, Pharmacy and Physiotherapy. Retrieved from http://www.hprac.org/en/projects/resources/1691-Aug15OHA.pdf	- OHA submission to HPRAC on the Consultation Discussion Guide - Provides a concise evaluation of the proposed recommendations offered by multiple professions
Legislative Assembly of Ontario	2009, Sept 28, 29, Oct 5	Official Report of Debates (Hansard)	Bill 179, Regulated Health Professions Statute Law Amendment Act, 2009. http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2189&detailPage=bills_detail_debates	- Transcript from the Standing Committee on Social Policy hearings