BMC Health Services Research

RESEARCH Open Access

Ontario's health profession regulatory landscape: a mixed-methods study of structures, practices, and perceptions

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Abstract

Background Health profession regulatory colleges in Canada are comprised of public and professional members working collaboratively to regulate a profession and protect the public. Though this general structure has inhered for decades, British Columbia recently amalgamated several colleges into larger agencies that represent multiple professions. This study investigates the landscape of health profession regulation in Ontario with the aim of guiding policymakers, professionals, and the public as they navigate both existing structures and potential changes.

Methods Senior-level staff from each of the 26 colleges in Ontario (regulating 30 distinct professions) were invited to participate in a 28-question online survey and semi-structured interviews in 2022. The survey and interviews explored structures, practices, and perceptions within Ontario's health profession regulatory bodies.

Results Forty-six survey responses were received, with participants representing 22/26 health profession regulators in Ontario. 5 of these participants were engaged in follow-up interviews. Results showed that Ontario colleges range in size, with a mean of 47.4 staff and 16.3 board members (53.8% professional, 46.2% public), that they regulate an average of 8994.6 health professionals, and that they maintain a variety of committees. They receive a minimum of 5 complaints annually and a maximum of 550, with a minimum of 0 and maximum of 25 leading to disciplinary action. Complaints range from sexual assault (< 10% of total complaints) to breach of standards of practice (> 50%). Policy infrastructure is consistent amongst colleges, with most maintaining policies for code of conduct (94.7%) and fewer for speaking and writing engagements (23.7%). Finally, participants felt their colleges were "very effective" in public protection (62.9%), "very ethical" in their activities (68.6%), and with "very functional or functional" (88.8%) councils. 94.2% indicated that a mixture of professional and public members should run councils (the status quo) and 62.9% agreed with the current model of self-regulation.

Conclusions Health profession regulatory systems benefit from a current picture of existing regulatory bodies. Input and perceptions from college staff—individuals embedded in the everyday operation of these institutions—should be considered to guide potential changes to the structure of health profession regulation in Ontario.

Keywords Health profession regulation, Regulatory systems, Regulatory structures, Regulatory models, Regulatory reform, Evidence-based regulation

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Background

In Canada, self-regulated health professions are operationalized through health regulatory agencies called "colleges" that have existed since the mid-nineteenth century, with a significant body of evidence describing the purpose of these institutions and their frameworks for regulation [1–4]. Comprised of both public and professional members—the former appointed by the government, the latter elected by the health profession—colleges are mandated to oversee the certification, investigation, and development of their health professionals, with a primary focus on public protection.

Although there have been sporadic calls for reform, renewal, and reorganization to align with political or policy objectives [5], this modern framework of regulation been the status quo in Ontario since the *Regulated Health Professions Act* (1991) passed into law. In more recent years, however, there have been developments that point towards substantive change. For example, in 2020 a steering committee formed by the British Columbia (BC) Ministry of Health released recommendations to reduce the number of colleges, increase government oversight, and transition health professionals from decision-making to advisory roles [6]. With the introduction of the *2022 British Columbia Health Professional and Occupations Act*, many of these changes took effect in June 2024 [7], with other provinces considering similar shifts towards streamlining and centralization, known globally as "modernization" [8].

Despite changes in BC, there is currently a lack of evidence regarding the benefits of streamlining and centralizing health profession regulators. At the same time, government efforts tend not to focus on collecting, analyzing, and reporting regulatory data. For example, the Ontario (ON) Ministry of Health released a College Performance Measurement Framework in 2019. The framework consists of a set of performance benchmarks that ON colleges report on annually, with summary findings released to the public [9]. While the tool is intended to ensure high performance in key areas, it does not illuminate the nuances of the current system, its inefficiencies, or provide suggestions for improvement.

To better understand and navigate the existing system and its potential changes, this study provides a baseline model of the current health profession regulatory landscape in Ontario, including the structures, practices, and perceptions that shape it.

Methods

The study adhered to the principles outlined in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS 2, 2022). Ethics approval was received from the University of Waterloo Research Ethics Board (43,632) prior to participant recruitment and data collection. The participants were given a cover letter outlining the study, and informed consent was assumed if the participants chose to fill out the survey. Personal identifiers were not collected except for names and email addresses to facilitate communication and follow-up; during analysis, this information was removed from the dataset and replaced with randomized numbers. Paper records and computer-based files were only accessible by authorized staff and researchers.

The study is mixed methods, involving an online Qualtrics survey alongside semi-structured interviews over Zoom. All participants self-identified as senior-level staff at colleges in Ontario (a full list of roles is provided in Appendix A, question 2), with multiple participants allowed from each college as a means of mitigating confirmation and recall biases. In most cases, multiple responses of this kind were included as total n and in reported means, etc.; the exception were data for complaint types as well as staff, board, and registrant sizes, which were limited to single college representation to ensure accuracy at the cost of higher n. Staff from the College of Optometrists of Ontario, this study's funding organization, were excluded as potential participants.

Participants were recruited through emails sent to individual college staff with publicly posted email addresses, as well as to general college accounts with a link that could be distributed internally. As a result of the shareable link, which was intended to increase participant numbers, a response rate was not calculated. Survey completion occurred between April and September of 2022, interviews between October and December of 2022, and follow-up questions were answered during January 2024.

Survey

The survey adhered to the principles of the Tailored Design Method (TDM), using concise language, follow-up reminders, and consistent, streamlined design. It consisted of 28 multiple-choice, open-ended, and Likert scale of agreement questions categorized broadly across three conceptual groupings: structures, practices, and perceptions (Appendix A). Following the survey's initial launch, 3 additional questions were asked over email to fill in gaps related to the number of staff and board members at each college, as well as the number of professionals they regulate (Appendix A). The concept of "structures" collected information related to the size, composition, and resources of regulatory institutions, as well as their embedded modes of election and appointment; "practices" was oriented around the institution's regular activities, including complaint triage, investigations, and policy development; and "perceptions" captured insights related to the value or effectiveness of colleges and the current regulatory landscape, as well as the potential for

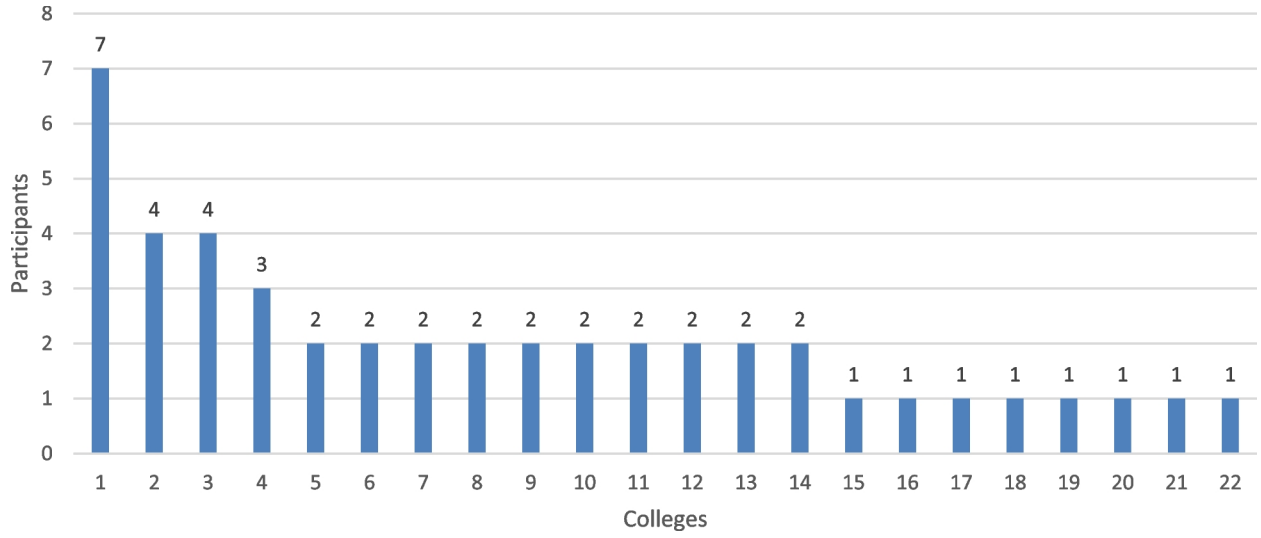

Fig. 1 College representation among participants ($n = 46$)

alternative arrangements to improve on the status quo. Borrowing from existing research [10–12], this tripartite approach was designed to provide a balanced view of regulatory bodies, one that places culture and individual perspectives on equal footing with embedded or institutional factors such as structures and practices.

Interviews

Following a semi-structured guide, one-on-one interviews adhered to a similar schema (Appendix B), with a primary aim of exploring and elaborating on the participant's survey responses. At the same time, seeing as the mode was conducive to its exploration, additional emphasis was placed on the more qualitative "perceptions" category. Interviews ranged from 30 to 60 min in length, and participants were recruited from within the survey pool and selected based on positions of seniority, with registrars—the college equivalent of CEOs—given priority due to the likelihood of familiarity with their organizations and the regulatory landscape in general. To maintain interviewee confidence in the anonymity of their participation and responses, interviews were not recorded or transcribed; instead, detailed notes were taken during interviews to capture themes and quotations, as well as immediately post-interview to expand and clarify key points.

Analysis

Survey responses were analyzed using JASP version 0.19.0 (2024, JASP Team, https://jasp-stats.org) and reported using descriptive statistics. Interview notes were analyzed using thematic analysis, with themes elicited within and across interviews by both authors, who discussed and resolved any inconsistencies that emerged. A coding index was developed to systematically organize themes, facilitating comparison across interviews and ensuring consistency in analysis.

Table 1 Roles of participants at Ontario colleges, $n = 46$

Role	*n* (%)
Registrar/CEO	13 (28.3)
Discipline or complaints staff	11 (23.9)
Governance or policy staff	9 (19.6)
Other	8 (17.4)
Deputy Registrar	5 (10.9)

Results

Participants

A total of 46 staff at Ontario colleges participated in the survey, representing 22 out of the 26 health profession regulators in Ontario (Fig. 1), with 5 participating in one-on-one interviews. Most survey questions were optional and full completion was not required; as a result, n was calculated per question. The largest group of survey respondents were registrars (Table 1), and all 5 interview participants were registrars.

Structures

Participants reported on the size of their institutions, including the number of staff, registrants, and board members (professional and public) (questions 29–31): a mean of 47.4 staff and 16.3 board members (53.8% professional, 46.2% public) were found to regulate a mean of 8994.6 professionals.

Outside of the 7 statutory committees specified by legislation—executive; discipline; fitness to practice; inquiries, complaints, and reports; quality assurance; registration; and patient relations—colleges maintained a mean of 2.5 standing committees (min = 0, max = 9) and a mean of 1.1 ad hoc groups (min = 0, max = 8) at their

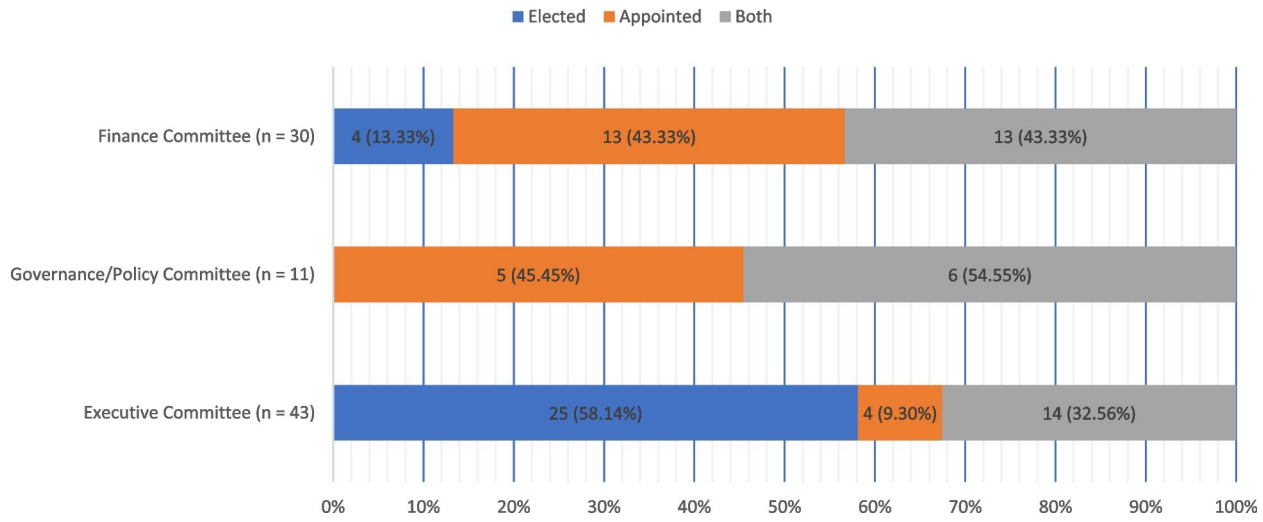

Fig. 2 Committees filled through elections, appointments, or both, *n* (%)

Table 2 Complaint distribution by type, *n* = 30

	< 10%, n (%)	10–< 25%	25–< 50%	50–< 75%	75–< 90%	≥ 90%
Billing issues	13 (43.3%)	8 (26.7%)	3 (10.0%)	3 (10.0%)	2 (6.7%)	1 (3.3%)
Breach of Standards of practice	2 (6.7%)	6 (20.0%)	8 (26.7%)	6 (20.0%)	6 (20.0%)	2 (6.7%)
Delegation or supervision concerns	22 (73.3%)	6 (20.0%)	2 (6.7%)	0	0	0
Incorrect or problematic service	11 (36.7%)	10 (33.3%)	2 (6.7%)	4 (13.3%)	3 (10.0%)	0
Sexual Assault	24 (80.0%)	4 (13.3%)	1 (3.3%)	1 (3.3%)	0	0
Unprofessional conduct (excluding sexual assault)	5 (16.7%)	12 (40.0%)	10 (33.3%)	2 (6.7%)	1 (3.3%)	0

own discretion (*n* = 41, question 7). Using three committees as examples—executive, governance or policy, and finance—question 8 asked how these groups were constituted, with participants reporting whether they are filled through elections, appointments, or both (Fig. 2).

When electing and appointing members to boards and committees, it was reported that a mixture of non-competency (46.3%) and competency-based (39.0%) processes were utilized, with 14.3% of participants unsure which method was used (*n* = 41, question 9). Three of the interviewees emphasized that their colleges are currently developing competency-based models for elections and appointments, which they saw as superior or at least complimentary to non-competency frameworks.

Practices

Responding to question 16 regarding approximately how many complaints are received by their respective colleges per year, participants reported a minimum of 5 complaints annually and a maximum of 550 (*n* = 32). Participants also reported that a minimum of 0 of these complaints and a maximum of 25 lead to disciplinary action (*n* = 26, question 17).

The types of complaints received can be conceptualized within six broad categories, with participants responding to question 18 (*n* = 30) by indicating what percentage of their college's total complaints fall within these groupings: billing issues (43.3% reported < 10%), breach of standards of practice (26.7% reported < 50%), delegation or supervision issues (73.3% reported < 10%), incorrect or problematic service (36.7% reported < 10%), sexual assault (80.0% reported < 10%), and unprofessional conduct (excluding sexual assault) (40.0% reported < 25%), as seen in Table 2. Across interviews, there was general agreement that complaints tend to focus on professional boundaries and conduct as opposed to clinical competency.

Alongside investigating complaints, colleges are simultaneously policymakers and engaged in the act of developing and maintaining related infrastructures (grey literature, etc.). Question 12 asked what types of policies they had in place (*n* = 38): most participants indicated that their colleges maintained policies for code of conduct (94.7%), conflict of interest (92.1%), and terms of reference for statutory committees (84.2%), while fewer had policies covering intellectual property (15.8%), speaking and writing engagements (23.7%), and public interest (36.8%) (Fig. 3).

To guide policymaking and other practices, Ontario colleges also ask their board and committee members to sign various agreements (question 11, *n* = 36): confidentiality (88.9%), conflict of interest (88.9%), and code of conflict (80.6%) agreements are all common, while

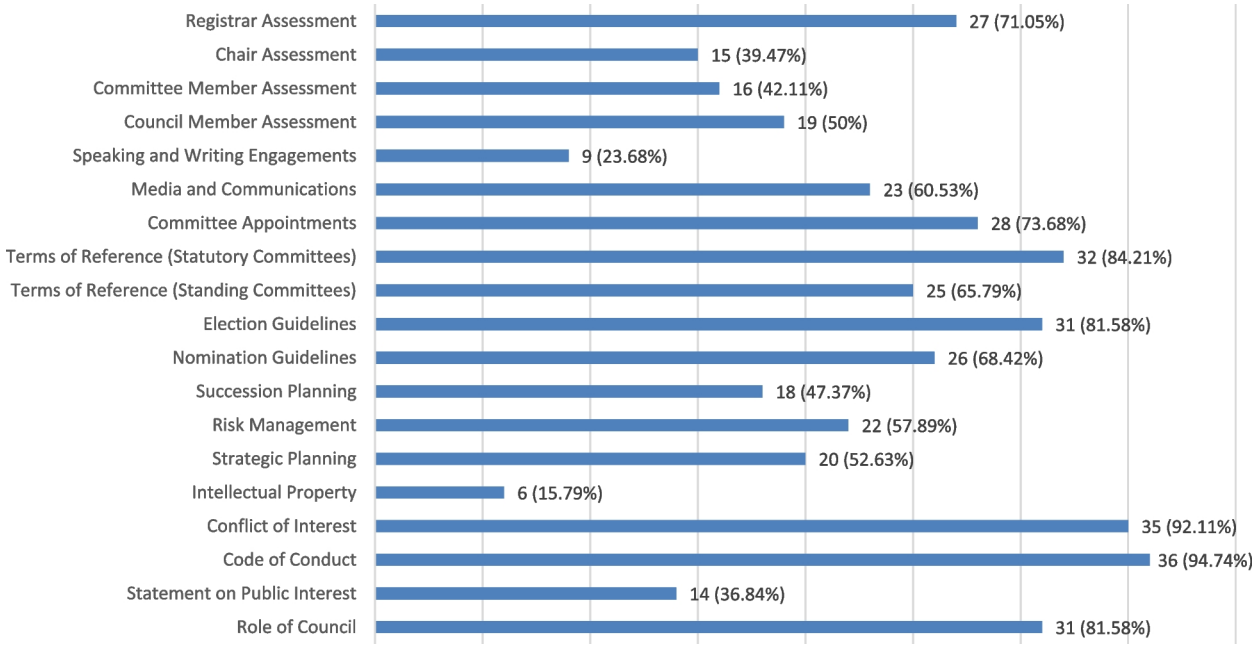

Fig. 3 Types of policies maintained by colleges, $n = 38$, n (%)

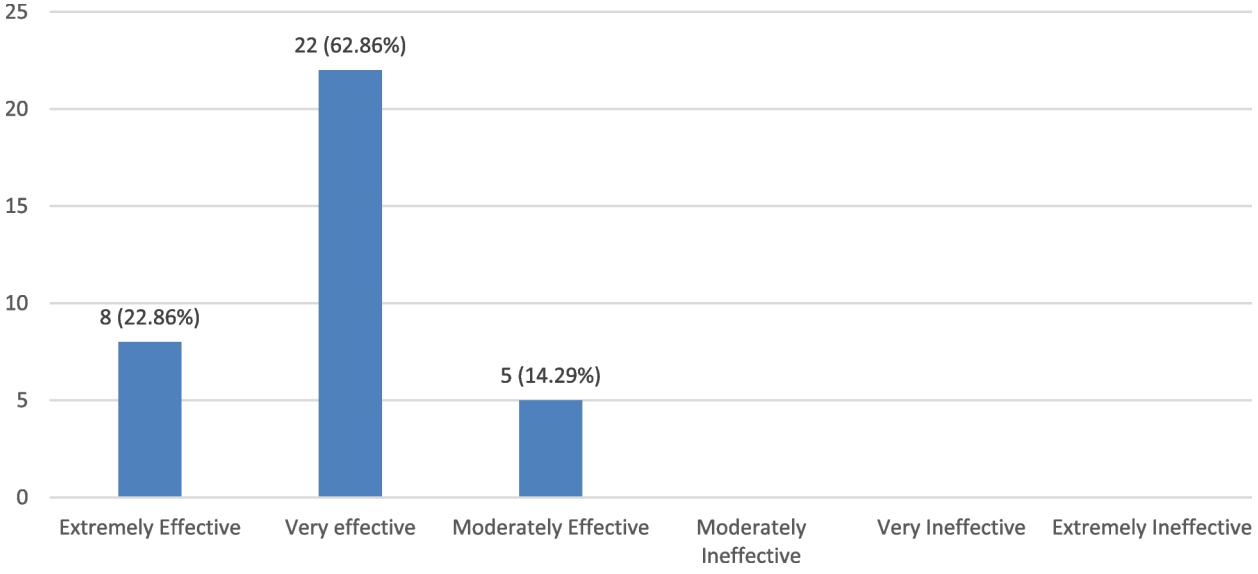

Fig. 4 Perceived effectiveness in the area of public protection, $n = 35$, n (%)

harassment (11.1%) and code of ethics (25.0%) agreements are used by fewer colleges.

Questions 13 and 14 investigated the level of research being undertaken by health profession regulators ($n = 39$): the majority (64.1%) reported their colleges do not perform research, 17.9% were unsure, 7.7% engage in research that is potentially without ethics approval, and 5.1% perform research that is ethics approved.

Perceptions

Participants were asked for their thoughts related to certain aspects of their regulatory organizations, as well as the overall landscape of health profession regulation in Ontario.

Question 22 explored the perceived effectiveness of the participant's college ($n = 35$): all respondents felt their college was either very, extremely, or moderately effective in the area of public protection (Fig. 4).

Participants generally believed their colleges exhibit ethical behaviour (question 23, $n = 35$) as well, with most

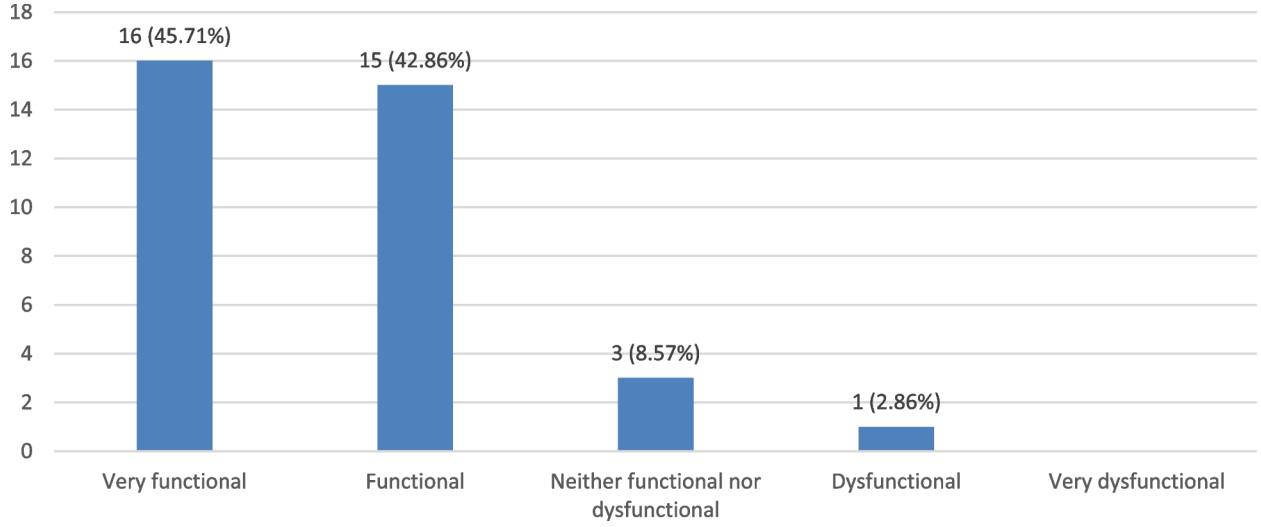

Fig. 5 Perceived functionality in carrying out duties, $n = 35$, *n* (%)

reporting that their college's relationships and activities were either "very ethical" or "ethical" (28.6%). One participant (2.9%) indicated that their college was "unethical", and no respondents selected "neither ethical nor unethical" or "very unethical."

Question 24 investigated the participant's confidence in the functionality of their college ($n = 35$). The majority (88.6%) indicated their institutions were either "very functional" or "functional" in their duties, while 2.9% selected that their college was "dysfunctional" (Fig. 5).

Discourse on regulatory modernization and reform often touches on the individuals responsible for decision-making, in particular whether professionals should be more or less involved in regulating themselves. To explore this subject, question 25 asked participants to indicate who they believe should run their boards ($n = 35$). The majority (94.3%) supported the status quo (a mixture of professional and public members), and 5.7% selected "government oversight committee with feedback from professional and public members." None of the respondents felt that boards should consist exclusively of either professional or public members.

Regarding external influence on decision making from the public (question 26, $n = 35$), most participants (48.6%) selected that the public should not have more influence than professional members, with 25.7% selecting they should have more influence and 25.7% indicating that they were unsure. Of course, external influence can also come from the professional population. When asked about this (question 27, $n = 35$), 74.3% reported that professionals should not have more influence on decision-making and 14.3% reported that they should; 11.4% of respondents selected that they were unsure.

The final survey question (question 28, $n = 35$) asked participants if they agree with the current model of self-regulation; specifically, the model defined by professionals playing a central role in the regulation of their own profession. Most respondents (62.9%) agreed with the current model, while 20.0% disagreed with it and 17.1% were unsure.

Discussion

Size and composition of colleges

In all cases, participants reported boards with more professional (53.8%) than public members (46.2%). This finding aligns with Ontario legislation specifying that boards have slightly more professional representation. At the same time, however, interviewees reported difficulty maintaining the specified number of public board members (who are appointed by the Ontario government), with two interviewees noting their boards could not meet quorum in the past due to a shortage of public members. Reasons for these shortages are unknown, but further investigation should be undertaken to review whether this may be due to a lack of public interest, or a slow appointment process at the government level.

In interviews, the notion of a balanced approach to regulation that includes both public and professional perspectives was consistently supported, even when issues with the current model were raised. For example, one interviewee expressed that professional members, with their inherent commitments to advancing their careers and professions, may be in conflict when considering issues of public protection; as a result, "better COI management is needed." For this individual, professional members acting in an advisory capacity or as "subject matter experts" instead of board members could better serve the mandate of public protection, similar to the reforms in British Columbia. This idea has been explored by Adams in 2022 when describing the (global) trend of a

declining role for professionals within the self-regulatory model [13].

Complaints data and proportionality

When analyzing complaints distribution, results show the number of complaints received in each category; however, this number is not analogous to the time or college resources required to investigate the complaint, or to how the specific complaint connects to public protection mandates. For example, while respondents showed sexual assault had the lowest number of total complaints (80% reporting less than 10%), its physical and emotional toll on patients is incredibly high, as are the demands on college resources. Therefore, the total number of complaints may not always dictate the role these complaints play within college policymaking and reform. Analyzing proportionality in relation to concepts such as risk and harm is worth pursuing but is also a more complex undertaking.

Research activities

It is likely true that public policy efforts could benefit from research that is spearheaded by health profession regulatory bodies (either as funders or principal investigators), however, results show that most colleges (64.1%) do not engage in this work. While this study did not ask follow-up questions regarding why research was not undertaken, factors may include a lack of financial resources or personnel. For example, one interviewee emphasized that modernization, while not formalized in Ontario, has introduced pressures for colleges to make changes in anticipation of reform; the result is a lack of firm footing, or as the interviewee articulated, the occlusion of a "safe space" where colleges can engage in innovative or exploratory work. Additionally, many health regulated colleges are not affiliated with educational institutions; as a result, undertaking traditional research efforts with approved ethics may be challenging.

The existing model of professional regulation

Participants were vocal on this subject, with most interviewees (80%) and survey respondents (64.1%) supporting the continuation of a system that includes both public and professional board representation. That said, a range of views were expressed regarding the details of the current model. For instance, one interviewee expressed concern related to political pressures and cycles affecting regulators, concluding that they are "unsure" of the current model's effectiveness and sustainability. Another articulated that it could be beneficial to eliminate elections as the primary mechanism for onboarding professional members, insisting that they are only "popularity contests." Others suggested that increased scrutiny on professional members—an emphasis on competency, for instance—should be applied to public members as well, with one interviewee suggesting that colleges should be able to recruit their own public members. As for methods of regulating professionals, there was general agreement that the "right-touch" paradigm is effective and should be broadly implemented. As shown in a study by Cayton and Webb, the model continues to be practiced and explored by regulators, researchers, and policymakers across multiple jurisdictions [14].

Regardless of the shape that health profession regulation takes, results from this study suggest that views from regulatory staff should be considered, particularly as they relate to potential reforms. For example, during interviews, the concept of a lack of agency in modern regulation and reform surfaced several times. Regulatory reform was described as something that is "imposed" externally by governments, with little to no input from regulators. One interviewee expressed frustration because "I like to be in the driver's seat of my own car." Incorporating the perspectives of regulators as a fundamental ingredient of reform may lead to better regulatory systems, empowering individuals who play a central role in operations and system-level decision-making.

Limitations

This study includes several limitations. First, while the inclusion of survey responses from multiple individuals from a single college mitigates confirmation and recall biases, it also has the potential to skew results in several areas. For example, if a particular college employs a competency-based framework for elections and appointments to its council and committees, multiple participants from this college will lead to a higher reported average (even though it is only a single college) vis-à-vis competency-based approaches. This is an issue that touches other aspects of the survey and is part of the complexity of a study that treats individuals as representative of their institutions (but also as carrying unique perspectives that extend beyond their institutions).

Participants in the study were senior staff at colleges, and though their views and experiences are essential to understanding Ontario's regulatory systems, the study by necessity excluded other populations. For example, board members, researchers, patients, and government stakeholders are only some of the groups that could contribute meaningfully to a study of the health profession regulatory landscape, and indeed, contemporary regulation and governance are often collaborative, multi-stakeholder practices. Senior staff were selected as the best group to develop an accurate picture of these institutions—from within the belly of the beast, so to speak—but this does not mean that other groups could not contribute meaningfully as well.

The tripartite structure of the study, which treats structures, practices, and perceptions as crucial components of regulatory bodies and their overarching landscape, has the benefit of recognizing diverse institutional factors and drawing regulators themselves into the dataset. That said, other concepts and formations could be equally valid, including more detail related to legislative frameworks, government mandates, clinical paradigms, and more.

Conclusions

Provincial governments in Canada continue to evolve their approaches to health profession regulation, necessitating an evidence-based framework for policy development and regulatory reform. As key stakeholders, college staff and regulators are well-positioned to assess existing regulatory structures and to provide informed recommendations on trends and future directions. This study aimed to establish a baseline of evidence on Ontario's health profession regulatory landscape—something previously lacking in a comprehensive form. Effective and ethically sound policymaking requires a rigorous understanding of existing institutional frameworks, including embedded governance structures, operational practices, and stakeholder perceptions—elements best articulated by those engaged in regulatory administration. Such empirical grounding serves as a foundation for informed decision-making. However, this study represents only one piece of a broader and more complex picture. Ongoing research is needed to further refine and guide regulatory strategies and to enhance the effectiveness of health profession regulation in Ontario and beyond.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-025-12719-4.

Supplementary Material 1.

Supplementary Material 2.

Acknowledgements
The authors would like to thank Joe Jamieson, Registrar and CEO at the College of Optometrists of Ontario, for providing input regarding the history of health profession regulation and new developments in British Columbia.

Authors' contributions
CA and LC conceptualized the study, analyzed its results, and drafted the manuscript. CA conducted interviews.

Funding
This study was funded by the College of Optometrists of Ontario.

Data availability
The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Ethics approval for this study was received from the University of Waterloo Research Ethics Board (43632).

Consent for publication
NA.

Competing interests
Both authors have relationships with the study's funding body, the College of Optometrists of Ontario: CA is a staff member and LC is a board member. The authors had full control over the study's design, analysis, and interpretation, and the funding agency had no role in influencing the research process or findings.

Received: 12 December 2024 / Accepted: 8 April 2025
Published online: 15 April 2025

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