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| ***Province*** | ***Législature*** | ***Session*** | ***Type de discours*** | ***Date du discours*** | ***Locuteur*** | ***Fonction du locuteur*** | ***Parti politique*** |
| Ontario | 35e | 3e | Discours sur la santé | 7 juin 1994 | Ruth Ana Grier | Minister of Health | Ontario New Democratic Party | |

Thank you, Mr Chair. I'm pleased to be back again. I think this is my second time as Minister of Health to defend my estimates. Whatever ministry I'm in seems to be the one that is chosen for estimates, and I rea clly enjoy the opportunity of discussing and questioning. I look forward to our time here.

As I appear for the second time, to present the 1994-95 estimates of Health, I look forward to discussing both the dramatic and the substantive changes that have been taking place as we improve our health care system. It's now been two and a half years since my ministry announced a health restructuring agenda designed to ensure more efficient use of scarce resources and to shift the emphasis from treatment to health promotion and disease prevention. Much hard work has been done since then.

Since I first appeared before this committee in July 1993, we have had a new cancer strategy in Ontario. We are working to meet the special needs of people with kidney disease, diabetes and acquired brain injury. We have a more efficient hospital sector. We have a health system that is less open to fraudulent abuse. We have a plan for long-term care that responds to the needs of seniors and those with physical disabilities, and a plan for mental health services that puts people first.

We have innovative approaches to meeting the health needs of individuals in their communities, approaches that include the use of nurse practitioners, midwives and birthing centres. We have programs that stress good health and disease prevention, such as our tobacco strategy and our program for vaccinating pre-teens against hepatitis B.

I am very proud of these accomplishments and I am proud that Ontario has been a trailblazer in the area of health care restructuring. We've only to look beyond our own situation and our borders to see that others are far behind us in grappling with the many problems inherent to modern health systems.

Over the past couple of years, we've written much of the book on paring back an overgrown health care system with a minimal amount of pain. A possible title of such a book could be How to Improve Health Care Without Spending More Money. But it's a book that has had several authors. It's the result of a collaborative effort, a partnership led by district and local health planners, including health care providers, hospital administrators, the public, unions and planners from the ministry.

I've been particularly pleased by the way that people from all sectors of health care have embraced the idea that change is necessary, indeed inevitable, and have risen to the challenge of coming up with new and better approaches for getting things done.

A vivid example of this comes from our hospital sector, which has been going through a period of intense restructuring. The results are now coming in, results that could not have come about without consultation and cooperation among all the concerned players.

There is a Collingwood newspaper that I know my critic from the third party will be familiar with that said on page 1 a couple of weeks ago, quoting Ontario Hospital Association President Dennis Timbrell, who is of course one of the key players in restructuring: "On the national scene, only Ontario and Manitoba still put faith in local governments' operation of health care. Other provinces have taken central control and abolished local boards. They have absolute central control, but there is no evidence that this improves the quality of health care or cost-effectiveness."

It's good to hear such comments because it reinforces the fact that we're on the right track. Indeed, I believe that our emphasis on involving the health community at all levels throughout the restructuring process has been key to our success. In particular, district health councils throughout Ontario have been playing a key role in making hospitals more efficient and more cost-effective.

Windsor-Essex is a prime example of where the district health council took the role of lead planner. It recently completed two years of work in designing a new hospital system, one that improves efficiency while maintaining jobs and services. Not only did they redesign the hospital system; they recognized that they couldn't do that without redesigning and reconfiguring their entire health services system. With less duplication, there are economies of scale that free up literally millions of dollars to spend on prevention, detection and other needed local health care services.

Look at Doctors Hospital here in Metropolitan Toronto, another success story in the making. It was the first community hospital in Metro Toronto to undergo a major project review as part of our province-wide review of capital projects. That was two years ago. Doctors Hospital is now being redeveloped as a state-of-the-art, comprehensive ambulatory care facility, one of the first of its kind in North America.

Perhaps most exciting about this is the fact that the voices of 1,300 people, representing a wide variety of community interests, were listened to before the Doctors Hospital redevelopment plan was drafted. I'm sure that all those who participated in the consultations will be very proud when the new facility is completed in a few years' time.

We have been working with hospitals to come up with other innovative approaches for cutting operating costs, and one of these has to do with the way that hospital supplies are purchased, distributed and stored. Through a ministry-funded study, we found that hospitals could save $250 million, more than 20% of the $1.1 billion spent on supplies each year, by improving their materials management systems. Much of this saving could be achieved simply through group buying, because Ontario hospitals represent one of the largest purchasing organizations in the world.

In another bid to have hospitals become more efficient, we recently announced $7.8 million in funding for pilot projects that help minimize hospital stays and act as a bridge between hospital and community-based care. Included here are 20 quick-response teams covering more than 70 hospitals across the province which will receive $5.4 million. These teams will help people entering an emergency department find the most appropriate care, which will often mean home care rather than being admitted to hospital.

The remaining $2.4 million will go to four existing hospital-in-the-home projects. These projects provide acute and palliative care at home, and mean the patients may be discharged earlier than in the past or may avoid hospital altogether. According to a recent evaluation of the hospital-in-the-home program, the costs are about 25% lower than in-hospital care, but even more importantly, patients and families say that they are very satisfied with the quality of care provided.

So, as can be seen, all this planning, coordination and cooperation is resulting in a new system of hospital care, one that keeps costs in check without compromising quality and one that is spreading across the province.

It remains a system where miracles can and do happen, such as the 20-hour operation that separated Siamese twins Margaret and Susana this past weekend at the Hospital for Sick Children. It was wonderful to know that our system is capable of conducting such state-of-the-art procedures, and it's heartwarming to know that compassion remains a cornerstone of our system. I can tell you that it made me feel very good when I read that the twins' father had thanked not only the doctors and the nurses who performed the amazing surgery on his daughters, but he also thanked the government and the taxpayers for paying for the operation.

Since the restructuring of our hospitals is well underway and well in hand, we were able this year to turn our attention to another part of the health care system, one that constitutes almost one third of the entire health budget. I'm talking, of course, about OHIP, where we reshaped the eligibility rules to save $48 million and where we introduced a three-month waiting period for OHIP, a move designed to prevent people from returning to Ontario just to receive medical care.

Stamping out health fraud was something that we discussed at length when I appeared before this committee last year, and which is a priority for our ministry. I believe it's important for us to be equipped to investigate any misuse of the system, to crack down on medical fraud by providers and patients. An ex-RCMP officer who had been part of the Ministry of the Environment's enforcement and investigations branch was put in charge of our province's investigative unit, and we are adding to his capacity eight investigators.

These tough new measures are working. We discovered, for example, that over the past year 21 doctors had overbilled OHIP by $1.4 million. All of them have been ordered to repay what they owe. We simply cannot afford to tolerate any abuse of the system if the system is to continue providing quality health care for Ontarians.

A new health card is another example of how we are tackling abuse head on. Security features on the new cards such as the cardholder's photograph, a magnetic strip containing cardholder eligibility information and a holographic overlay to prevent counterfeiting should prove to be strong deterrents against fraud.

We are at the point now in the evolution of our Ontario health care where we can redirect and reinvest our health care dollars in new areas of care. While maintaining our institutional health framework is important, just as important is establishing a community-based approach to health care, and while treating illness is important, just as important is health promotion.

I believe that we are on the right track in these areas and I believe that our system is improving without more money being spent on it.

As far as community-based care goes, we have made considerable progress this past year. While overall ministry spending has declined slightly, both this and last fiscal year, spending for community and public health continues to increase.

This meant that last year, for example, we were able to approve three new community health centres, and just last Friday I announced that four more would be approved in this fiscal year, which will bring the total number of community health centres in the province to 56. For 1994-95, spending on community and public health will increase by 5.3%, a reflection of our commitment to moving towards a more community-based approach to health care.

Our long-term care strategy is an excellent example of this. Ontario's social demographics are going through major changes. Seniors currently account for only 12% of the population. By the year 2010, however, census projections tell us that it will be a very different story. In less than 20 years, the number of seniors in Ontario will increase by 45% and the number of people over 85 will increase by almost 125%. At the same time, the long-term trend towards greater life expectancy for the general population and for people living with disease and disabilities will also continue to rise.

Ontario currently spends over $2.1 billion for long-term care services. This includes institutional care, home care, the integrated homemaker program and other community support programs. But we are committed to moving away from institutional care and increasing the number of community-based services. In fact, over the next two years, we will be investing an additional $199 million to expand community and in-home long-term care services.

The keystone of our new long-term care delivery system will be the multiservice agency or MSA. These will be local, volunteer-led, community-based agencies that offer people easy access to a variety of home care and support services close to their homes.

The local MSA will coordinate referral, assessment, evaluation and service delivery. And while the ministry has guidelines, we are leaving the exact design of each MSA up to district health councils. This way, they will be developed locally based on local needs and resources. As Dennis Timbrell in the quote that I had earlier mentioned said, developing locally based services based on local planning is unique in Ontario.

The MSA principle is to put people first, to ensure that they can make informed choices and that adequate and consistent services are available in all parts of the province.

Putting people first also lies at the heart of our strategy for helping people with mental illness. Here again we are working with district health councils to transform the current system of fragmented community-based services into one that is strong and coordinated.

In many areas, the transformation has already started. The Hamilton Psychiatric Hospital, for example, now runs the Annex, a supportive housing program for people with schizophrenia. In other areas like Simcoe and Thunder Bay, mental health organizations have set up employment programs to help people live in the community and maintain their jobs.

Last January, we announced that more than $1.2 million a year would go to 10 new supportive housing programs for people with serious mental illnesses, programs that enable people to live independently.

As we address the current and future needs of individuals and their communities, we find ourselves moving more towards a holistic form of medicine, one that relies on the skills of a wide variety of health care providers. While physicians will of course remain an integral part of the system, other health professionals will take on greater responsibility for patient care.

Midwives are among this new breed of care givers. I'm pleased to say that Ontario midwives have a rather special status that no other midwives in the country yet have. Our midwives are officially recognized, and they are being integrated into our regulated health system.

Midwifery services are now available in many communities and the demand for those services has been overwhelming. Midwives are obtaining hospital privileges and some will eventually find their way to one of the three freestanding birthing centres which we are spending $2 million to set up -- one in Toronto, one in St Jacobs and one in Sudbury. A fourth is being planned for the Nee-Gan O'Chee community in Fort Albany.

As I've said, physicians will remain an integral part of the health care system. So it's crucial that appropriate numbers of specialty physicians are available to communities throughout the province. In moving towards this goal, we will be looking to the work now being carried out by the Provincial Coordinating Committee on Community and Academic Health Science Relations, PCCCAR. I don't pretend to be able to rhyme off that acronym without having a note on what that lengthy title is. PCCCAR has three main objectives: to develop a comprehensive policy and planning framework for health human resources, one that is based on community needs; to examine the function and financing of academic health science centres; and to restructure Ontario's post-graduate medical education system.

On this last point, PCCCAR recently recommended that the ministry adopt a new management framework for post-graduate medical education. This framework, which they called the pool system, will enable the ministry, in concert with medical schools and teaching hospitals, to better manage the number and mix of new physicians eligible to practise in Ontario. This will mean that we will be in a better position to respond to population health needs.

This is the first time that the province has systematically approached the issue of health-human resource planning, and I think that it is a fundamental requirement of the kind of planning and the kind of decisions that we will have to make in the future. Indeed, meeting the unique needs of communities across Ontario is itself a critical component of our health planning. Again, I would like to use the north as an example, as its needs are quite different from those of the rest of the province.

To meet those needs, we have set up a northern health programs and planning branch, with offices in Thunder Bay and in Sudbury. The mandate of this branch is to work with local health councils to help improve the delivery and the coordination of ministry programs and services in the north.

For some years now, one concern has been the northern health travel grant, the government program that helps northern residents who must travel for specialized care. Early this year, we made the program fairer and more efficient.

The ministry now pays travel costs based only on the distance between a person's home and the nearest appropriate specialist or designated health facility. People can still choose any specialist, but if there's a specialist closer to home who offers the same service, the grant will help cover only the distance to that specialist.

I believe that this reform will encourage people to use the excellent specialists already available in northern communities. It will also save money and encourage more specialists to practise and remain in the north. And, of course, it will mean more accessible health care for northern residents.

The north is also where we established what I consider to be one of the most significant initiatives of this government: the Northern Diabetes Health Care Network.

Diabetes is the third leading cause of death by disease in Ontario. People with diabetes have twice the chance of having a heart attack or a stroke. Diabetes is the leading cause of adult blindness. It is an unfortunate reality that the incidence of diabetes is higher in the north than in the rest of the province. That is why the network is so very important, because for people with diabetes, it represents a precious chance to prevent the very serious potential complications of the disease.

As with all such initiatives, we listened to the people who will be using the service. The network was established through consultations with francophone, aboriginal and other community representatives. The result is that each of the 34 centres that are part of the $5-million network is a home-town idea. Each centre offers programs that are planned in the community and for the community.

Diabetes is also a leading cause of kidney failure. So we have been planning and investing in services geared to the needs of people with kidney disease. Demand for end-stage renal disease services has been increasing by about 10% per year right across the province. To keep up with this, we just completed a three-phase, $22-million expansion program for dialysis service. The aim was to bring service as close to home for as many kidney patients as possible.

In addition to the expansion program's basic funding of $22 million, we added another $27 million of life support funding to hospital operating budgets for end-stage kidney disease services, and $10.6 million has been spent on new equipment and renovation projects.

At the end of 1988, before the expansion started, there were 2,073 dialysis patients in Ontario. In December of last year, the number had risen to about 3,339 patients. That is an increase of 1,266 people now being served.

Because of all this additional spending on dialysis services, we can now treat 1,400 more patients than we could five years ago. And we have begun the work to enable us to plan to meet future needs, especially in central Ontario. Because the fact remains that never before have dialysis services been as available and as accessible, but we, at the same time, have to plan to meet the growing need in the future.

Our efforts to foster healthy communities are far-reaching and not limited to certain areas of the province. I want to talk a bit about what has been an innovative and multi-award-winning campaign to prevent young people from taking up the smoking habit. It is a province-wide campaign and it is part of our overall cancer strategy which includes the tough provisions of Bill 119, now before the committee of the whole House, as well as funding for education and enforcement officers to make sure that retailers are adhering to Bill 119's rules and not selling tobacco to young people under the age of 19.

Another health promotion initiative is our recently announced $6-million program to vaccinate grade 7 students against hepatitis B, the sometimes fatal liver disease that affects more than 300 mostly young adults annually.

Our new health network, which will provide pharmacists with information about Ontario drug benefit program clients, will help prevent duplications or possible interactions with other medications. This is extremely important, because every year more than 17,000 Ontarians need medical treatment for prescription drug reactions, and about one out of five seniors in hospital is there because of a drug reaction.

The health network has already played a significant role in helping seniors. Let me tell you how it worked in one specific example, to save a 70-year-old Markham man from serious illness. He was taking a blood thinner for a heart valve problem. While visiting his daughter in Niagara Falls last month, his arthritis flared up and he went to a local clinic. He forgot to tell the doctor, whom he'd never met before, about his heart medication. The doctor, who didn't know his medical history, gave him a prescription for an ASA drug. But when he went to the drug store and the pharmacist entered the new prescription on the health network, the computer flashed a warning that the new drug would react with his heart medication. The pharmacist talked to the man and to the local doctor and arranged for an alternative medication.

That's precisely how the network is meant to work and how it is working. What would have happened without that warning? Possibly, for the patient, severe internal bleeding, leading to hospitalization; maybe worse. But because the health network was in place, the outcome was a happy one, just one of what I am sure will be many such outcomes in the years ahead.

We have also, of course, made changes this past year to the Ontario drug benefit program that will save money without compromising drug therapy for those covered by the plan. Among the cost-saving measures that we introduced are prescribing guidelines for anti-infective drugs, the addition of 46 new generic products to the Ontario Drug Benefit Formulary, the addition of 24 new brand-name drugs at no additional cost to the system and no price increases in 1994 for drugs listed on the formulary.

We have also reviewed and subsequently delisted extended-release dosage products. These long-acting medications can be 10 times more expensive than their regular-dosage counterparts. As well, 134 over-the-counter drug products were removed from the formulary, but all are available at reasonable cost without a prescription and their removal will not have a negative effect on health outcomes.

We are all aware that there will always be certain diseases and medical conditions that require specialized treatment and care. Diseases such as cancer and conditions such as acquired brain injury cannot always be prevented. Consequently, it is important that our health care system is equipped to meet the current and future needs of people facing such health crises.

In April, I had the privilege of announcing Ontario's first comprehensive cancer strategy, born out of our discussions with 600 people who told us that while it is important to treat the disease, it is just as important to care for the person. Highlights of our cancer strategy include:

-- The setting up of a provincial cancer network to help coordinate services into a seamless cancer care system, a system that includes everything from health promotion, prevention, early detection and treatment to support services and palliative care.

-- Establishing a task force on primary prevention in cancer to look into the best ways of treating the disease.

-- Providing services that meet each person's physical, emotional and spiritual needs.

In Ontario, we now spend more than $1 billion a year on cancer care, and expanding cancer services is a priority for our government. So in spite of pressures to cut back on spending, we have put $269 million towards expanding, building and renovating cancer centres. This includes $185 million for the nearly completed Princess Margaret Hospital.

Let me say that I very much welcome the recent announcement by Princess Margaret Hospital and the Toronto Hospital which will see the two facilities working together to coordinate their cancer services. This fits perfectly into our strategy of creating a cancer network for Ontario.

This year, we will increase funding for cancer services by $15 million to help plan regional services, expand the Toronto Bayview, Kingston and Ottawa regional cancer centres, and fund bone marrow transplants, breast-feeding programs and community support groups.

As members know, there have always been services for people with cancer in Ontario, but the same cannot be said for those with acquired brain injury. Consequently, for many years people had to seek treatment in the United States, a situation which, I am pleased to say, is changing.

Each year, as many as 15,000 Ontarians receive brain injuries that require hospital care. It only makes sense that the road to recovery for these people might be improved if treatment facilities were available close to home where they have the support of families and friends. That's why we are investing heavily in hospital and community service programs to help Ontarians with ABI.

For example, last summer we announced $4.26 million to strengthen community-based behavioural programs in Hamilton, London, Kingston and Toronto; $3.9 million has gone to the ABI program at Chedoke-McMaster Hospital, and a further $2.85 million is being spent on community outreach and repatriation. In 1991, we spent $4 million for 12 hospital and community projects across the province. In 1993, we awarded almost $1 million to Thunder Bay and Sudbury for hospital ABI service improvements, and in March, Premier Rae announced $2.1 million for a major expansion of rehabilitation services in Toronto for people with acquired brain injuries.

The progress that we're making in helping people with acquired brain injury is consistent with our overall strategy for health care in Ontario. That strategy is based on the notion that if we are to ensure the effectiveness of the system, we must plan and deliver services based on the needs of local people and the communities in which they live. Whether we succeed or fail will depend on the extent to which those needs are met, and while history will be the final judge of this, I believe we are succeeding.

As I said at the outset, it has been two and a half years since we introduced our health restructuring agenda. That agenda has been to ensure more efficient use of scarce resources and to shift the emphasis of our health care system from treating disease to preventing it.

What we are really talking about is an evolution of health care in this province. Evolution is a gradual process, one that takes time. While I think that we can acknowledge that part of this evolution was started by previous governments, and I do acknowledge that, it is clear that no previous government demonstrated the courage, the conviction and the resolution to make the substantial changes that we have, especially in the areas of cost containment and the introduction of major reforms.

Such changes have dramatically sped up Ontario's health care evolution. They have led to a system that is already better in tune with the needs of people in communities as diverse as Toronto and Dryden. They have produced a system that is well prepared to meet the needs of future Ontarians and the communities of tomorrow.

Our government has great faith in this new health system. Not only is it good for the health of Ontarians, but we believe it can also contribute to Ontario's good economic health. Health industries are responding to the changes in the health care system, to the shift of patients from institutions to home and community settings, to the need for innovative health promotion programs and to the demand for cost-effective technologies. At the same time, international demand for a wide variety of health services is growing rapidly.

We want to help our health care industries bring their products and expertise to this burgeoning market. We are doing this by listening to the recommendations of such groups as the health industries advisory committee, which came up with a strategy for improving the competitiveness and accelerating the growth of our health industries. We are providing $7.65 million to bring that strategy to light and to help give Ontario's health industry a boost. Industry leaders say that this investment could lead to 40,000 new jobs in the province by the year 2004, and I think the bottom line here is that if industry succeeds, we all succeed.

As a government, we're committed to getting Ontario back to work. We believe that making sure people have jobs and job security is a key factor in their personal health, the health of their families and the overall health of the communities in which they live. But such a state of health does not stop at employment. Ensuring people have access to decent housing and education and to a clean, safe environment are also important factors, and we have been working to include them in our formula for the health and wellness of Ontarians.

I'm very proud that what we are doing fits with the World Health Organization's definition of "health," that it is a state of complete physical, mental and social wellbeing and not merely the absence of disease and disability. Indeed, this definition, this philosophy, if you will, forms the foundation of our approach to ensuring the healthiest possible Ontario.

I'm sure that members of the committee will have comments and questions both on what I've said and on the issues that are of concern to them. I look forward to addressing them. There will be representatives of the ministry here to help me do this, as they have all of the information that I think anybody could think of asking for. We will certainly attempt to provide whatever is needed so the committee can have a constructive discussion of our estimates. I look forward to the response from my critics in the opposition parties and to the questions that will follow.