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| Ontario | 39e | 2e | Discours sur la santé | 2 novembre 2010 | Deborah Matthews | Minister of Health | Ontario Liberal Party |

Haut du formulaire

Bas du formulaire

Great. Thank you so much. Chair, members of the committee and anyone who’s watching this, it’s truly a privilege to be here before you. The last time I had this opportunity was one year ago and I had been minister for just a matter of weeks, so hopefully I have learned over the past year more about this ministry. I think I have.

What I can say with real confidence is that I’m very, very proud of what this government has accomplished when it comes to health care in this province. Despite a challenging economic climate, we’ve continued to make investments in Ontario’s health care system, and those investments have paid off for people right across the province.

From the beginning of our government’s mandate, we recognized the complexity of the challenges facing the health system and appreciated the difficulties surrounding its future viability. Simply put, health care was in crisis when we took office in 2003. People could not find a family doctor; doctors were leaving Ontario; hospitals were being closed; nurses were fired; and we didn’t know how long wait times were because nobody was counting. It wasn’t a good time.

When I was elected in 2003 and began serving my constituents, one of the most frequent calls I got in my constituency office in London was from people desperate to find a family doctor. There were literally thousands of people in my riding who could not get access to primary health care.

I also received calls and visits from constituents who were waiting far, far too long for the surgery that they needed—sometimes in the magnitude of years, not months. This was preventing them from working, contributing and just living a normal life. It also resulted in their conditions getting worse. As they waited, their condition deteriorated, and it simply was not acceptable.

There was no confidence in the future of our cherished universal public health care system. This created an opportunity for those who advocate for private health care to make their case. One of our core values—a universal, publicly funded health care system—was under attack.

That’s where we were in 2003. If you compare where we were to where we are today, it’s a complete turnaround. There are thousands more doctors practising medicine in Ontario. We have new nurse-practitioner-led clinics. We’ve had the most ambitious expansion of our community health centres. And I’m delighted to say that one million more Ontarians have access to primary health care today than when we took office. That means we’ve matched 16 people every hour, 24 hours a day, seven days a week, since we took office.

We’ve increased the number of physicians in Ontario. As a result of our expansions in medical school capacity, along with increases in training positions for foreign-trained doctors, the number of doctors graduating and ready to enter practice is expected to double in the period of time of 2003 to 2013.

To make the very best use of the talent our diverse province offers, we’ve supported international medical graduates, or IMGs, to practise in Ontario. In fact, IMGs now make up about one quarter of the physicians practising in Ontario today.

On the hospital side, as I said, we didn’t used to measure how long people waited. Now we wait, we publicly report them, and we’re making strategic investments to bring those wait times down. For the second year in a row, the Wait Time Alliance report card gave Ontario straight As for reducing wait times for hip, knee, cancer, cataract and cardiac surgeries.

We’ve made improving emergency room performance one of our top health care priorities, and we’ve put in place a comprehensive plan that invests in expanding alternatives to emergency room services, improving ER performance and facilitating timely discharge to appropriate care in the community. Under our wait times strategy specifically focused on the ER, people are waiting less time to get the care they need.

I’m pleased to say that our investments and targeted investments are showing real results. Our latest data show promising improvements. For example, 87% of patients with minor conditions are now being cared for and released within the four-hour target. I just want to be clear that when we measure ER wait times, we’re talking really about the length of stay. It’s not how long they wait for care; it’s how long their entire length of stay is, from the moment they arrive to when they leave. So 87% of people with minor conditions are being cared for and sent home within the four-hour period. And 92% of our patients with complex conditions that don’t require admission to a hospital bed are cared for within the eight-hour target. We still have work to do when it comes to the wait times for those who need admission to the hospital, but we know what we need to do, and we’re doing it.

By providing faster service through our emergency departments and introducing initiatives designed to encourage alternative levels of care within the community, we are improving the patient experience as well as the health and the well-being of the people of Ontario.

We also understand that we have to do more to ensure our seniors are aging where they want to. That, of course, is right at home, in their communities, where they have friends and neighbours and family members close by. That’s why we’ve invested $1.1 billion in the aging-at-home strategy, which is helping to shift care to the community, moving care to where patients want it—right at home. There are some excellent examples of where this program is working well, and I’d like to share some with you because I am particularly proud of them.

Clyde is a 69-year-old York region man who suffers from a serious neuromuscular disease called myasthenia gravis. Medication taken to control the disease made Clyde vulnerable to other conditions, including osteoporosis. These side effects, as well as severe bouts related to his condition, often required visits to the emergency department. Clyde worked with a pharmacist through the medication management support service to inventory and cross-reference the many medications he was taking. The pharmacist also modified some drugs to liquid form, making it easier for Clyde, who, because of his condition, had difficulty swallowing. Thanks in large part to the service, Clyde is able to successfully manage his medications and his illness is under control. His recovery is improving, allowing him to continue running his business.

In Scarborough, a new program to reduce transfers from long-term-care homes to the Scarborough Hospital emergency department is having a positive impact on patient care and helping to reduce wait times. The Central East LHIN nurse practitioner long-term-care outreach team employs nurse practitioners to provide care for residents in long-term-care homes for whom a transfer to an emergency department is likely.

Let me give you an example. Helen’s 81-year-old husband, Wal, is a resident of a long-term-care home in Scarborough. She says that since Christmas, there were a couple of incidents where her husband might have been sent to the emerg, but the nurse practitioner outreach team was able to look after his needs right in his long-term-care home. She says that she’s happy he’s not going in and out of the hospital. This is an example of putting in place a service that improves care for the patient and also costs the system less money. Better for the patient, better for the system—that’s where we’re going.

Let me give you another example. In the north, Sioux Towers is an established seniors’ apartment building that provides seniors with 24-hour on-site support services. Supportive housing originally served 10 to 12 Sioux Towers residents and now has expanded to serve 29 residents through the aging-at-home program. The supports provided by supportive housing are geared to allow residents to continue to live independently outside of long-term-care homes for a longer time. The support services that are offered include personal care, light meal preparation, medication monitoring, 24-hour on-site response staff, housekeeping, laundry services and weekly grocery shopping. Services are tailored to meet the needs of each individual.

There are hundreds, indeed thousands, of examples of people that I could refer to, because this is happening right across the province, and thousands upon thousands of people are benefiting from our aging at-home-strategy. The aging-at-home strategy allows our LHINs, our local health integration networks, to create health care solutions that are tailor-made to meet the needs of a local senior.

As you heard, the first two years of the strategy resulted in some very innovative and effective projects that are supporting seniors across Ontario. These programs and investments will help seniors live healthy, independent lives in their own homes and decrease the number of alternate-level-of-care—ALC—patients in hospitals. ALC patients are those individuals who are occupying acute care beds but would be better cared for in another setting, whether it be in their own home, in a long-term-care home or another community setting. By giving seniors the supports they need to live at home or in their communities, our investment will help relieve pressures in hospitals and in long-term-care homes.

In addition to the improvements I’ve cited, I’m proud of our reforms to ensure we’re getting the best value for health care investments. One particular example is our efforts with the drug system. Ontario is one of the largest purchasers of drugs in the world, and when I actually saw what we were paying for our generic drugs compared to what those in other jurisdictions pay, I was appalled. I came to understand that we deserved a better deal than the one we were getting. In 2006, our government took bold steps to rein in the cost of drugs and expand patient access to medications. Since that time, we’ve reinvested over $1 billion and added 168 new prescription drugs to the formulary, as well as 45 new cancer-fighting products—drugs like Nexavar, which is helping treat Ontarians with kidney cancer.

In short, the reforms in 2006 did make a difference, but we needed to do more. In June of this year, we started to further reform the prescription drug system to assure a wider availability of more affordable drugs. That initiative brought about the following changes: lowering the cost of generic drugs—that was exactly what we wanted to do—by at least 50% across the board to 25% of the original brand name drug. That’s a 50% reduction for the generic drugs we, the government, buy. It’s also at least a 50% reduction in the price that other people pay. So whether you get your drugs through an insurance plan or whether you’re paying cash for your drugs, you will benefit from the reforms we made on generic prescription drugs.

Another change we brought in was we eliminated professional allowances, to make Ontario’s drug system more accountable, ensuring that pharmacists are fairly compensated for helping patients, by increasing the dispensing fees government pays and by compensating pharmacists directly for the services they provide and supporting access to pharmacy services in rural and underserviced areas with dedicated new funding. We know these reforms are in Ontarians’ interest. They are the right thing to do. There was tremendous opposition to this initiative from those who had a vested financial interest, but we stood firm in our commitment to be there for the people of this province, and we did it.

While our health care system has come a long way, we know that there is a great demographic challenge ahead of us. In fact, we are facing that challenge today. Our population of older people is growing quite dramatically. Escalating health care costs are the biggest threat to ensuring that the system will be there for future generations. I think I probably speak for everyone here when I say that we have an obligation to make sure that people today are getting the very best health care possible, but we also have an obligation to our kids and to our grandkids to ensure that the choices we make today will result in them having access to the health care system that we are blessed to have today because of the decisions of those who went before us.

You’ve heard the numbers before, but I’m going to remind you of them once again: About 46 cents of every dollar, almost half, of Ontario’s program budget goes to health care. Twenty years ago, it was less than a third. If we don’t make important changes to our health care system, it could jump to 70 cents of every dollar in just 12 years. We’re not talking about way off in some unforeseen time period—in 12 years. And just a few weeks ago, CIHI reported that they’re expecting health spending to reach a new high in 2010.

It’s abundantly clear that the past history of year-over-year increases in health care spending—health care spending growing at a rate many times more than our rate of revenues—is just unsustainable, particularly in the context of the serious economic pressures that Ontario, like jurisdictions around the world, continues to face.

Making sure that the system is there for future generations cannot be achieved by simply throwing more money at the problem. Neither is it reached through indiscriminate cuts in health services or limiting access for patients. Previous governments have tried that approach, and we won’t go down that road again.

Waste, inefficiency and poor quality are very costly to the health care system. Highest-quality care does not mean more expensive care; on the contrary, quality care means cost-effective care. Poor-quality care is very expensive care. When people don’t get the care they need the first time, they’re back the second time. The cost is significantly higher to the system and, of course, the cost to the individual is far higher. High-quality care means care that delivers value for the investment, in terms of a positive patient outcome and satisfaction.

The Excellent Care for All Act, which received royal assent in June, is the first step in improving the quality and value of the health care system. Tom Closson of the Ontario Hospital Association called the Excellent Care for All Act one of the most important pieces of legislation in the province’s health care history. Our legislation means that health investments must produce results that are based on evidence and improved patient care. This means ensuring consistent standards, doing things because they have been proven to work, and not doing things that are not supported by clinical evidence.

If patients get the kind of care they need when they need it, this will reduce the number of hospital readmissions, which takes a toll on both the individual and on the system.

In that light, how do we ensure that future investments in health care will be based on evidence and improved patient care and outcomes? It’s about building and supporting a culture of quality improvements, and we’re going to be doing that across the health system, starting with hospitals. We will achieve it through new funding models and incentives, improved organizational accountabilities and governance, and better supports for providers to deliver evidence-based care.

Under the Excellent Care for All Act, all health care organizations, beginning with hospitals, will have interprofessional quality committees that will report to the board of directors on quality-related issues. Every organization will have quality improvement plans publicly posted. And in the future, executive compensation will be linked to the achievement of outcomes identified in those plans.

What the Excellent Care for All Act will mean is that hospitals across this province will compare their performance on quality indicators to other hospitals across Ontario. The boards will see the information that will tell them whether or not there’s work to do on various quality indicators in their organization.

I’ve been talking to hospital administrators and board members across the province, and they’re all excited about the opportunity that the Excellent Care for All Act opens up for them. They are up for this challenge. The goal is to bring about a focus on quality that will permeate the organization and drive better patient care.

We’re also expanding the mandate of the Ontario Health Quality Council to provide recommendations on standards of care based on clinical practice guidelines for services delivered by health care providers, as well as recommendations on possible changes to the way health care is covered and paid for. This will help ensure that future investments in health care get results and improve patient health.

Other changes we’re championing are about ensuring that the money follows the patient. The current method of funding hospitals, a global funding system, does not support quality improvement and it does not reward efficient provision of care. Under our new system, we will have transparency in terms of how much care should cost and why, based on good clinical evidence, and we’ll deliver more funding to hospitals that are delivering more services and high-quality care to more patients. I want to be clear: We’re moving to patient-based payment for large hospitals. The small hospitals, we recognize, play a unique role in their community, and we’ll continue to fund them as we have in the past.

Before I finish, I want to touch on eHealth. As you know, there have been some changes there, which I’d like to share with you now. Excellent progress has been made in getting eHealth Ontario back on track. In February 2010, the government appointed Raymond Hession as chair of the board of eHealth Ontario; Greg Reed was appointed CEO effective April 1, 2010, and he has brought in a new senior management team which has taken steps to rebuild the agency’s capacity.

I’m very pleased that the agency has dramatically lessened its reliance on consultants. The number of fee-for-service consultants has been dramatically reduced from 394 in April 2009 to 105 in August of this year. Also, the ministry and agency have amended their memorandum of understanding to ensure compliance with the government’s enhanced procurement rules.

What I am most proud of is that, just this morning, I stood up with physicians, patients and eHealth leadership to announce that we have hit a significant milestone when it comes to eHealth: five million patients in Ontario now have their medical file managed electronically. That’s a fivefold increase from 2005. As I said this morning, when it comes to eHealth, we have clicked to the next page.

One final initiative that I want to draw your attention to is the new enhanced health care options website. We know that, thanks to the work we have done with our health care partners, people have many more health care options in the community, but they don’t always know what those options are and where they can find them. It’s important that we do a better job educating them on what those options are, and that’s why we’ve improved the site. The idea is that if people know where to turn, fewer of them will be heading to the ER for issues that can be dealt with in the community. It’s not rocket science; it’s just making sure that people have information and know how to use it. I’m going to encourage you all to take some time on the site so that you, too, can learn about exactly what is going on in your community. It’s a great tool and one I’m very proud of.

To sum it up, reducing wait times, improving access, improving patient outcomes, improving the experience of patients—it’s all about person-centred care. Ontarians want and deserve quality health care when and where they need it. They want better options, they want more choices, and they want a health care system that is accountable and one that will be there for future generations. This government’s investments and initiatives are designed to achieve that for Ontarians today and into the future. We’ve come a long way, and we’re up to the challenge to keep improving the health care system for all Ontarians.

Thank you for your attention, and I’m more than happy to take your questions.