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**Ontario’s Health Speech: Third session of the 35th legislature, 1993**

Hon Ruth Grier (Minister of Health): Mr Chairman and members of the committee, I'm pleased to appear here to discuss this year's estimates for the Ministry of Health. I know that the estimates process is both a healthy and a democratic exercise. I already have a flavour that with this committee that is indeed what it will be, and I hope we can make this and the following sessions as useful and as productive as possible.

It's hard in 30 minutes to cover all the activities of the Ministry of Health, but I thought what I would do would be to begin by reporting to you on the status of some of our programs and activities and provide you with an outline of where we stand on the major issues in provincial health care today. In particular, I want to talk about the government's strategy for managing the health care system during this difficult economic period, as well as about the many reforms that are, in most cases, well under way.

Ontario continues to enjoy one of the best health care systems in the world. The fact is that the system works well for the vast majority of people in Ontario. Most citizens get the health services they need, where they need them and when they need them. However, there are many areas where we can do things better, more efficiently and more cost-effectively.

In addition, the traditional health care system, with its emphasis on physician services and acute care hospital-based services, is being threatened by a variety of social, political, philosophical and economic forces. These forces threaten the five principles under which the system operates: universality, accessability, portability, comprehensiveness and public administration -- the principles of the Canada Health Act.

In January 1992, my ministry announced a health reform agenda designed to ensure more efficient use of scarce resources and to shift the emphasis from treatment to health promotion and disease prevention. The reform agenda addresses the financial crisis in the health care system resulting from the spiralling costs of high technology, illness care and the fee-for-service system. It looks at the reduced transfer payments to the provinces for health and the oversupply of physicians.

Through the process of health care reform, we intend to better manage the health care system, invest more in community-based programs, redress long-standing inequities in the system and take a leadership role in preserving medicare.

Ontario's health reforms place new emphasis on health equity by focusing on groups that have historically faced barriers. Other areas emphasized include better management of the health care system, more effective use of health resources, participation and accountability within the system, review of expenditures, implementation of the redirection of long-term care and reform of mental health services.

New strategies are being developed for oncology, diabetic care, community health, tobacco use and human resources in health care, and new priorities are being identified in the areas of aboriginal health, women's health, children's health, AIDS and rehabilitation services.

Today I'd like to highlight our progress on three of those reforms: hospital restructuring, long-term care and mental health reform. Perhaps the best example that our strategy for change is working can be taken from the hospital sector and the reforms that we have introduced over the past two years. As members of the committee know, the reform plan for hospitals was introduced in November 1991 following a ministry review of hospital expenditures that involved all of the major stakeholders.

The main elements of the plan are to improve hospital management, to address duplication of services, to make hospital operations more efficient and to speed up the shift in emphasis from inpatient to outpatient care. The plan is now being implemented in hospitals across the province, and it's being implemented in an open, collaborative manner that is designed to allow the greatest possible level of local control.

During this process, we have created the joint policy and planning committee with the Ontario Hospital Association to improve the quality of ministry management decisions that affect hospitals as well as to give us a forum for working with the local district health councils and hospitals to resolve specific problems.

If we look across the broad spectrum of the hospital sector, there's considerable evidence that we've made major progress towards greater efficiency without compromising the general level of health of the population as a whole. I want to cite some relevant statistics here, statistics drawn from the period between 1987-88 and 1992-93.

Over that six-year period, the number of hospital days per 1,000 of population has decreased by 25%, while the average length of stay in hospital has declined by 17% to 7.2 days. Hospitals closed more than 5,000 acute care beds over that period, but the number of people treated grew by more than 8%, or about 1.2 million cases. This increase in services was made possible by a 23% increase in the number of day surgeries and an 8% increase in other outpatient services. In fact, day surgery, as a percentage of all surgery, increased over the period from 53% to 70%.

I don't have the figures as to what our hospital bill would be today if those 5,000 beds were still in the system, but I can assure you that it would be much higher. The key point I'm making here is that even if those additional beds had remained available, there's no evidence that our population's overall health would be any better.

In addition to the signs of improved efficiency we're seeing across the whole system, there are many local success stories that I could tell you about. Just as one example, I want to dwell a little bit on the efforts of the Windsor-Essex district health council, which recently completed a major local planning exercise that recommended the restructuring of local hospital services. The consultants' report that they've been evaluating and the community dialogue are talking about reducing the number of hospitals from four sites today to two or three sites when the plan comes into effect.

The DHC's work has been designed to eliminate program duplication, to improve coordination and to strengthen the linkages between the hospitals and the local community. While there's no doubt that a massive amount of work was needed to get to this stage, I think everyone involved agrees that the process will pay significant dividends down the road.

I've singled out the exemplary work done in the Windsor-Essex area, but the committee should be aware that major health system planning studies are also in development or under way in many other communities throughout the province, including Thunder Bay; Sudbury; Guelph; Belleville-Trenton-Picton, which have come together to do the study; Perth-Smiths Falls; Brockville; Durham region; Sault Ste Marie; Haliburton county; Halton; Peel and York region.

I think it's important to point out in this period of change in the hospital sector that the government's goal has been to minimize dislocation and job loss to the greatest extent possible.

In May 1992 we established the hospital training and adjustment panel. As a result, most hospitals now have local adjustment committees and laid-off workers are receiving adjustment services, and a job registry system has been established to match available positions with health care workers who have been laid off. Through the social contract process, there is agreement that the hospital training and adjustment panel's role should be expanded to benefit all workers in the health field.

Through reforms in funding, better utilization and better management of our institutions, as well as by establishing effective partnerships between labour, hospital administrators, the Ontario Hospital Association, other ministries, local communities and health care consumers, I believe that we've made great strides towards meaningful change in the way our hospitals are managed and operated. This progress will reduce cost in the short term, but it will also add to the long-term stability and sustainability of the system as a whole.

Another area of significant progress has been the redirection of Ontario's long-term care system, and I suspect we'll be talking about that in greater detail in the hours ahead. It involves a change in emphasis that involves developing more community-based alternatives to institutional care. Our long-term care reforms are predicated on the dignity and the needs of the individual and on the assumption that people should be able to live at home in their own communities for as long as possible.

After completing an exhaustive consultation process that involved all major stakeholders in long-term care delivery, including, I should point out, talking to long-term care consumers and their families, we recently introduced a package of reforms that will ensure the effective coordination of long-term care with other parts of the health care system. They will improve the way nursing homes and homes for the aged are managed and governed and will increase the involvement of communities, families and individual consumers in the planning, design and management of long-term care program delivery.

As with other aspects of our health care reform agenda, I think it's important to point out that the government is not looking to start from square one and to bring in changes simply for the sake of change. Rather, our goal is to enhance the services and programs that already exist and to make the system even better.

I know that some members of the committee may have seen and I referred in the House to a recent article in the New York Times in which on the front page Canada's care for the chronically ill and the elderly was singled out for special praise. I think it's worth quoting parts of that article to the committee today. It said:

"Americans must use their own money for nursing homes or other long-term care until they deplete their assets; then they can qualify for Medicaid, the federal-state health program, a process that often leads to anguish and humiliation.

"No such restrictions exist in Canada, where there are some means tests for government aid but families are not required to sell off their assets. Those who are better off may be required to pay more but rich and poor live under the same roof, eat the same meals, go to the same social functions.

"So great is the fear in the United States of being forced into poverty by the costs of long-term care that more than 2.4 million Americans have bought costly insurance to cover the cost. In Canada, there is no such thing.

"No country has a perfect system, but Canada's, while continuing a process of creative tinkering, has caught the attention of specialists in the United States."

I was very proud of that story and it dwelt on institutions in Ontario and in the reforms that we've made under our long-term care system.

Our revised funding rules for patients in long-term care mean that seniors will not have to worry about being forced to sell the family home to pay for the care they need. Only a patient's income will be considered when fees are assessed. To be fair to everyone, all patients receiving standard care will pay the same and each person will be assured of a comfort allowance of $112 a month. These changes will mean dramatic savings for many elderly and chronically ill people throughout the province.

I would also point out that our flexible approach to change has already brought new benefits and higher levels of service to many communities. As one example, we can look at Eabametoong First Nation in Fort Hope, some 500 kilometres northwest of Thunder Bay. With assistance from my ministry and the Ministry of Community and Social Services, the first nation is building a new seniors' complex and multi-resource centre to provide care for elders from the five communities of Fort Hope, Marten Falls, Summer Beaver, Lansdowne House and Webequie.

None of these communities could support a seniors' home on its own and the closest facility is the EldCap unit in the hospital at Geraldton. The supportive housing provided by the new seniors' complex will complement the existing homemaker program and enable the first nation's elders to remain in their own community for as long as they like. The cost of the facility is modest, and I understand that the ministry also arranged for the city of Thunder Bay to give the first nation some surplus beds from the city's homes for the aged to furnish the new centre.

I mention this example as one of many instances in which we are managing the system effectively and actually improving the levels of service available to many communities. As Ontario's population ages in the future, our government's long-term care reforms will assume even greater strategic importance.

I'm also happy to report that the government is making significant headway in reforming another major area of our health care system, which is the treatment of people with mental illness.

As members may know, approximately 1.5 million Ontario residents, or about 15% of our population, have some symptom of mental illness. Our mental health reform package adopts many recommendations of the Graham report, Building Community Support for People, and is designed to enable communities to tailor mental health programs and services to meet individual needs.

Our strategy is to concentrate the bulk of services on the seriously mentally ill. We're also committed to making services available in a manner that is sensitive to gender, culture and race and to making the system more responsive to the needs of special groups such as forensic patients and victims of violence. In terms of specific outcomes we're looking to reduce suicide, to reduce disability from schizophrenia and other dementias and to create more employment for people suffering from chronic mental illnesses such as schizophrenia.

In the present system, patients are too often hospitalized by default, simply because they can't get appropriate treatment or services in the community. This unnecessary hospitalization is a needless waste of scarce resources. Even worse, it's a tragic waste of lives that could be much more full and productive.

Our goal is to enable people with mental health problems to receive the care and treatment they need, and preferably in their own communities, close to the nurture and support of their families and friends. At the same time, of course, we're committed to investing in modern, well-staffed and well-equipped institutions that can provide appropriate care for those mental health consumers who need it. As proof of that commitment, I would point to our announcement last month that we will spend $133 million to rebuild the Whitby Psychiatric Hospital.

In 1990, our government inherited a health care system that was virtually out of control, a system fed by annual spending increases in the order of 10% a year for the previous decade. Since 1990, a faltering economy and growing public debt have demanded decisive action to reduce costs and improve management in all areas of public spending, and particularly in health, which accounts for about one third of the entire provincial budget.

First, we sought to protect and preserve Ontario's system of universal medicare through better management of resources, controlling costs and reducing the runaway growth in spending that was such a prominent feature of the system for so long.

Second, we've sought to make sensible and strategic reforms by refocusing the system's priorities and placing a stronger emphasis on factors that lie outside our traditional delivery system but which in fact play a major role in determining the population's health.

As you know, the Ministry of Health's budget is over $17 billion this fiscal year, and while that's a tremendous amount of money, I would point out that it is a lot less than it would have been had our government not stepped in and made some hard decisions about putting the brakes on spending. In fact, I say with some pride that in the last fiscal year ministry spending grew not by 10%, as it had for the previous 10 years, but by just 1%, and this year ministry spending will increase only marginally, by about one fifth of 1%. This is a tremendous turnaround.

Through the social contract agreements, we intend to reach throughout the health care sector. We are committed to further reductions in costs totalling $470 million. These additional savings include $208 million for hospitals, $193 million for OHIP and the Ontario drug benefit program and $69 million in other areas of health spending.

Included in the ministry's $17-billion spending plan is a reallocation of some $82 million from the traditional health care system to the health promotion, community care side of the health care system. This will mean more money for family planning, for preventing sexually transmitted diseases and for smoking prevention programs. We'll be putting more ambulances on the road and putting more money into improving treatment for diabetics, especially among northern and aboriginal communities. We're opening a community health centre in a public housing project, and we're converting Burk's Falls Hospital into a community health centre. We're diverting almost $6 million to people with special needs, whether they are brain-injured, addicted or children with mental health problems. In the end, we will have added 4.8% to the health promotion, community side, while decreasing the traditional side of health by 4%.

While we've made excellent progress in slowing the growth of health care spending, let me assure you that the process has not been easy. In fact, for a system that experienced such rapid growth for over a decade, it was often difficult to absorb even the idea, let alone the reality, of major reductions in growth.

I said that putting the brakes on spending meant some tough decisions for the government, but I also recognize that the government's decisions are requiring many others in the health care sector to make equally difficult decisions and choices in hospitals, laboratories, medical offices and other facilities throughout the province.

As members are aware, I recently released a detailed consultation paper on proposed reforms to the provincial drug benefit program. The paper was developed in response to significant concerns from a long list of stakeholders, including prescribers, pharmacists, drug manufacturers and consumers. The paper addresses many issues, including the fairness of drug programs, their cost and their quality assurance and management.

There is no question that reforms are needed in this area. The costs of the Ontario drug benefit program have grown by an average of more than 16% per year since the early 1980s, driven up by increases in the number of prescriptions, by higher drug prices and dispensing fees and by growth in the number of people who are eligible for benefits.

In the 1991-92 fiscal year, the ODB program paid some 42 million claims at an average cost of $24.80 per claim, of which $6.47 is the dispensing fee. Of the $1.2 billion spent on the program in that year, one quarter was for dispensing fees and the remaining three quarters was for drug products. But even with this huge government expenditure, more than two million people in Ontario today have no drug plan coverage at all.

It may interest the committee to know that the average physician in Canada writes between 4,000 and 5,000 prescriptions a year. For family physicians, the average is between 6,000 and 8,000 prescriptions annually. We also know that some 17,000 Ontario residents each year require treatment for prescription drug problems and that a significant percentage of all seniors admitted to hospital are there because of problems with their prescribed medication.

The fact is that although we've been spending more and more money on drug benefits, there's no evidence that the increases in spending have resulted in an improvement in overall levels of health. With an aging population, it is clear that we must manage drug benefit programs better, both to eliminate inappropriate prescriptions and to ensure that the system remains viable.

Our government's drug benefit reform package focuses on several key goals. These include improving prescriber education, controlling costs to keep the program sustainable, expanding the ODB program to cover more people, particularly the working poor, and forming new partnerships with consumers, unions, professionals and industry in the planning, delivery and evaluation of drug programs. If we are to achieve these goals, all the beneficiaries from the program, manufacturers, pharmacists and consumers, will be asked to share the costs.

I'm particularly pleased that our drug reform package will extend drug benefits to some two million Ontario residents who currently cannot afford or qualify for drug insurance. But I would also point out that through the drug reform secretariat we've made considerable progress in reviewing the management of Ontario's special drugs program, which is designed to cover people whose treatment depends on having access to certain high-cost drugs.

In 1986, the only drug covered by the special drugs program was cyclosporine, which is used to prevent rejection in organ transplants. Today, the program covers 11 different drugs and disease groups. Indeed, my office has received many letters of thanks from patients and parents of children with cystic fibrosis, a formerly fatal illness. The special drugs program allows cystic fibrosis patients to lead nearly normal lives. Indeed, one patient wrote that the program makes her more employable since it prevents her from becoming a drain on her workplace drug insurance plan.

The drug reform consultation paper was released last month, and we've asked for comments from stakeholders and the general public by the end of September. Once the ministry has had an opportunity to analyse the comments and incorporate them into the proposed changes, our intention is to get on with the process of reform.

In the meantime, we're moving ahead with a number of successful initiatives such as the province-wide computer network that will track prescriptions issued to seniors. This measure should help address the problems of overmedication and inappropriate prescriptions.

There are a number of areas that I've not mentioned which are high on our health care agenda. These include a range of aboriginal and northern health issues, they include initiatives designed to promote health for both women and children, they include measures to deal more effectively with HIV- and AIDS-related illness, to manage the demand and supply of health care professionals in Ontario and to promote more community-centred health care delivery throughout the province.

Ontario is Canada's largest province, and at more than $17 billion a year, our expenditures on health care alone are larger than the entire budgets of most other provinces. As I've said several times already this afternoon, we must not equate size with quality, because when it comes to delivering health care services, there's increasing evidence that this equation simply does not work. Despite its vast size and large population, Ontario is a network of communities both large and small. Our health care system must be flexible enough to serve people who live in all of those communities, people in Metro Toronto as well as people in Moosonee.

The fact is, our health care system provides a high level of service to most of our people despite the fact that their needs differ just as widely as do the communities and environments in which they live. As one example, I can tell you that the ministry operates 16 nursing stations in northern Ontario. Under this program, the basic health care needs of people living in these remote communities are met at the relatively modest cost of about $2 million a year. Northern nurses do everything from providing pre-natal care to sewing up cuts and applying bandages. They provide community-based care to the elderly, the sick and the frail, and they serve local residents in a timely manner, backed up by visiting doctors and air ambulance services for the seriously ill.

My point is that in order to ensure the effectiveness of the health care system, we must plan and deliver services based on the needs of the local people and the communities in which they live. Our success or failure will depend on the extent to which those needs are met.

I'm pleased that our government has had the courage and the conviction to curb the growth in health care spending, and I'm especially pleased and proud that, at the same time, we've made significant progress in reforming that system. We couldn't have achieved so much without the cooperation of our health care partners and other stakeholders, and I'm confident that we have acted together in the public interest by making the difficult decisions that were needed to save the system for future generations in this province.

While I think we can recognize that some of the seeds of change we are putting in place were sown by previous governments, it's clear that no previous provincial government has had the courage or commitment to tackle the need for real change in the health care system by controlling costs and introducing major reforms. I make this point not by way of apology for any shortcomings you might perceive in the ministry's activities; rather I make it to impress upon you how successful and productive our actions have been in such a short time, which has been one of the most difficult periods ever in the province's economic life.

I suspect I have provoked questions and comments, and I look forward to being with you. There are people here from the ministry with all the information that I think anybody could think of asking for. We certainly intend to attempt to provide whatever is needed so that the committee can have a fruitful and constructive discussion of our estimates. Thank you very much.