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| Ontario | 39e | 1e | Discours sur la santé | 4 juin 2008 | George Smitherman | Minister of Health | Ontario Liberal Party |

I don’t have a prepared text per se; just a few speaking notes. But one thing that we have prepared for the benefit of members is this document, Strengthening Health Care for Ontarians, and in a variety of points, I’ll be referring to specific pages. I came to the conclusion, because the Ministry of Health budget that’s before everybody is about $40.4 billion, that sometimes it’s helpful to try to distill it down to a bunch of the key issues that are very, very relevant to all of us and to our constituents. For sure, what that gives us the opportunity to do is to present substantial results that are reflected in these one-pagers.

From the very first day, in October 2003, that I gained the privileged role as Ontario’s Minister of Health, I concluded that the theme of continuous quality improvement was what is necessary for the appropriate approach to health care. There’s absolutely no doubt that for all of the reformist zeal and transformative initiatives that we’ve implemented, there are many areas in health care where we can all acknowledge that there’s more work to be done. I’m really excited about the opportunity in this session to talk about our government’s vision for health care over the next few years.

One of the things that I really think has begun to take root in our health care system is a better concept of patient-centred care. At the heart of it, I try to remind everybody that the patient isn’t just the individual whom the service provider delivers support to; the patient is actually a shareholder. The public health care system is owned by 13 million Ontarians, and the obligation on their behalf is one that we take very seriously.

We’ve done a lot of transformative things in health care, and one of the things we’ve done is to adopt what Roy Romanow said. He once said that accountability was the missing sixth principle of the Canada Health Act. I think that in a variety of ways, through transparency as a means to accountability, we’re dramatically enhancing the amount of access that people have to information about the performance of their health care system.

Local health integration networks have emerged in a way that allows a conversation about health care to take place in a local community and in a local context. Important decisions of the boards of LHINs will be taken in the full sight of the public.

The wait time initiative gives Ontarians the opportunity, with a click of a few buttons, to gain access to a bevy of information—which is in the midst of expanding dramatically—about the performance of a wide variety of health care initiatives.

Patient safety measures, like those that I’ve had a chance to speak about in the Legislature quite frequently over the last several weeks, will dramatically enhance the amount of information that Ontarians have about how their health care system is performing from the standpoint of their safety.

You can look forward to initiatives that the Ontario Health Quality Council will be initiating that will substantially enhance the capacity of the health care system to measure performance, not just on the outcome, not just on the health experience, but also on patient satisfaction. I think that we’re going to work very hard to give greater measure to the voice of the public in our public health care system.

At the heart of the things that I’ve been saying to everybody is that in a public health care environment, where there is no profit-and-loss statement at the end of the year, the confidence that the public has in their public health care system is the dividend payment. That’s the measure of how we’re doing. I think that’s why we’re very dedicated to enhancing the capacity to measure the satisfaction of patients in areas like home care. Clients in home care will have an enhanced opportunity to influence decision-making on the basis of the quality of the care that’s provided; likewise, this will be occurring in long-term care, and also with respect to the patient satisfaction rankings for the performance of Ontario’s hospital emergency rooms. Any successful business knows that to succeed, you have to listen to your customers. Well, for all of those who are privileged to work in a public health care environment, we need to acknowledge that patients aren’t just those to whom we deliver care; they’re actually our bosses. They own the public health care system, and we have more work to do to make sure that we’re all operating with that perspective firmly in place.

I believe that the actions we’ve been able to take have instilled hope and convinced Ontarians that the improvements that they seek can be realized, that our collective aspirations are within reach. But I don’t pretend on this point. I don’t offer a simplistic bromide that says that everything is hunky-dory. There are lots of areas in our health care system where improvements have been made, and there are many areas where much more progress is still required. I think that this estimates process will give us a fantastic opportunity to speak about those things.

I think most people would share the vision of a health care system that wants to help people stay healthy, delivers good care to them when they need it and will be sustained for future generations. Since 2003, our government has taken some awfully substantial steps to strengthen our health care system and to instill greater confidence and to work in a fashion that can sustain it into the future.

For sure, now in my fifth year as Minister of Health and Long-Term Care in our province, I’ve had a chance to deal with a lot of numbers, and one of those that I think is really impressive, insofar as it underscores the extent to which Ontarians believe in their public health care system, is that our spending on health care in 2003 was $29.3 billion and this year it’s about $11 billion more. Spending in the health care sector for this year is proposed to be $40.4 billion, rising to $42.4 billion in 2009-10 and $44.7 billion in 2010-11. This demonstrates that even in challenging economic times, the commitment of the government to continue to support the things that people call for, which are enhancements to their public health care system, is there.

We remain very firm in the idea that the health care system that we all aspire to is within our reach. That’s in part why we’ve distributed to members of this committee this orange document. We really think that the discussion with respect to health care, because it’s so big and so much of it is clinical in foundation, sometimes runs the risk of leaving the public out of the conversation because the conversation might be about 1,000 things.

But what I really want to let the committee know, and as I’ve had a chance to speak about publicly over the last little while, is it will take 1,000 different initiatives to make the progress that patients want to see in their public health care system. But our desire is to make sure that we focus key improvements in areas where the public really understands and where the public really has expressed a substantial desire to see improvement. We can fix 1,000 things in health care over the next three or four years, but if we don’t create a better capacity to provide the services people want in our hospital emergency rooms and if we don’t deliver family health care for all, then we will fall short; we will not meet the full test of the confidence that the people desire, demand and deserve to know about their public health care system.

We have two overarching priorities: to continue to reduce wait times, with a particular focus on emergency rooms, and to deliver family health care for all. I’ll speak more about the family-health-care-for-all subject in just a minute.

I want to talk about emergency rooms. All too often, for Ontarians, it’s been a door through which they go to gain access to health care—not always, if we’re honest about it, the most appropriate place to go for care.

This week, as an example, there’s been a little bit of a discussion—a debate and some media interest—on the issue about whether, in the future, pharmacists might have a broadened scope of practice that would allow them, as an example, to renew prescriptions. We know in Ontario today that tens of thousands of people a year go to hospital emergency rooms to have prescriptions renewed. We all understand that that speaks to inadequate access for those patients. We also know that it speaks to inappropriate use of emergency rooms—not the best use of an asset that is designed to be there to address very urgent circumstances.

In order to make the improvement that we seek in our hospital emergency rooms, which had 5.6 million visits last year—about half of those, about 2.8 million, unique individuals. That’s an awful lot of Ontarians, especially when you think that most people, at least from my experience, go to a hospital emergency room with at least one other person in support and sometimes entire families in tow. I think that’s why it’s very important that when we design a focus on improving the performance of hospital emergency rooms, we recognize that much of what must be done to improve that performance isn’t about things that are taking place in the emergency rooms at all.

We have supporting strategies that give us the confidence that we can achieve a better result, things like our aging-at-home strategy, which we’ll launch in just a few weeks and which I’ll talk about a little bit more in a minute. To do a better job to manage the chronic diseases of Ontarians is to say that if we do a better job of focusing all of the resources and capacity that we can on those individuals, who by the nature of their chronic disease demand, deserve and require greater support, we can do that proactively and take pressure off our emergency rooms. If we do a better job in the community of supporting our Ontarians who are experiencing hardship associated with mental health or with addiction issues, similarly, we can get them better care and we can take some of the pressure off our hospital emergency rooms. Even as we admit that it’s a door that many people go through in search of care, we must be honest in acknowledging that not all of the care that is sought there makes for the most appropriate place. We can do better in many ways. And the investments that our government contemplates in this year’s estimates really do underscore how confident we are.

Our confidence too is certainly driven by the fact that we continue to have extraordinary leadership, gutsy leadership, from Dr. Alan Hudson. The Canadian Medical Association—which is not always, I’d say, a big fan of the health care policies of the government of Ontario—did give our team that has led the wait times initiative the best rating of any province in the country. We’re enormously grateful to Dr. Hudson and we’re grateful to the team of people.

On this point about team, what I know for sure, as a health minister with the perspective of now well over four years in this job, is that the health care system today has thousands and thousands of motivated and inspired individuals who are providing leadership in a wide variety of settings. On wait time initiatives, we’ve used coaching teams that have engaged physician leaders, administrative leaders and nurse leaders to work on process, flow and all of those things that are necessary to produce the kinds of results that we have produced. When you look inside this report and see all the lines related to wait times headed in a good direction, you can gain greater confidence that bringing this award-winning team and the kind of cultural approaches that we’ve used to the issues with respect to our emergency rooms holds great promise for substantial progress.

Last week, we put $109 million of new resource into this battle to reduce wait times in hospital emergency rooms. I think it’s noteworthy that of that $109 million, a very substantial portion, certainly the majority of it, is actually allocated outside of the hospital emergency room in building up the capacity of home care to support more seniors by giving an increased number of hours, as an example.

In addition, we’re focusing some resources in a pay-for-performance model, by which I mean to say, you don’t get to keep the dough if you don’t improve your performance. We’re going to work with a starting point of 23 hospital emergency rooms tending to be amongst the highest-volume emergency rooms, many of them being academic health science hospitals, where the performance, based on the waits that people are experiencing, really does call for some substantial improvement.

A major factor, of course, in long emergency room wait times is what has become well known in the vernacular of the health care world as the ALC patient—alternate level of care. To say it clearly in language that people understand, that’s a situation that occurs when an individual is in an acute care hospital bed and would be better served somewhere else. It’s costly for the health care system. It’s also very discouraging for the health care workers. It’s often discouraging for the individuals who are in that situation. We have lots of work to do in this area.

Luckily for us, under Dr. Hudson’s leadership, we’ve been able to acquire the assistance of Kevin Smith, the chief executive officer of St. Joseph’s hospital in Hamilton, with connections to St. Mary’s in Kitchener. He’s going to work very specifically on the issues of alternate level of care. Of the $109-million investment that we made last week, a very substantial portion of that is to enhance the capacity to provide care for individuals in the most appropriate setting. Sometimes, it’s about the steps that we can take to enhance the supports for individuals, who are exiting the hospital and preferably, going back home. In other cases, it’s about the initiatives that we can make to support people where they are, in some cases to stabilize them in their home environment, preventing a transfer to the emergency room in the first place.

If we think about our population of vulnerable individuals in long-term care, I think the average age is about 83 or 84 years of age. This is not an age group of a vulnerable population already in long-term care—suggesting, of course, that they had some additional need. Transferring those individuals to hospital emergency rooms is very often a hardship for them and creates great difficulty for the hospital emergency room to deal with, as very often they’re grappling with a patient not well known to them who may have several underlying circumstances that must be diagnosed and addressed. We think that we can do better by supporting those individuals in the long-term-care home environment. That’s why there’s an element of that investment from last week that focuses very specifically on that.

I think one of the greatest pieces of policy promise in the health care agenda in the province of Ontario is the aging-at-home strategy. I just want to give a shout-out to all of those people, the thousands of people from the LHINs and from communities all across Ontario, who’ve engaged in dialogue.

There are a lot of exciting new initiatives that within just a few weeks we’ll be launching in each of Ontario’s 14 local health integration networks, all on the premise that we can do a better job to support our loved ones to age in the place that they know best and where they know love best, which is their home.

As a Minister of Health, I took a drubbing very early on—some people would argue, pretty much every day—but one of the things that I learned right from the clear expressions of seniors in the province of Ontario was that for them, the destination point in their minds is not long-term care. People acknowledge, of course, that it may be necessary and that in certain circumstances long-term care may be necessary for them. They don’t want to see government acting in a way which assumes that that is their destiny. The aging-at-home strategy, in a vigorous way, embraces this independent streak: the desire to enhance the capacity of our seniors to live out all of their days, if possible and as preferable, in their home environment with dignity and with independence.

I mentioned a moment ago that creating more capacity for home care is one part of that strategy, but the aging-at-home strategy will be about a whole bunch more: about helping to reduce the barriers that seniors may experience to stay in their own homes. One small but very powerful example of this is in our initiative to buy 100 Dodge Caravans and to place them at the disposal of community agencies, all across the province of Ontario, augmenting many existing drive-to-appointment programs. We’re going to create the capacity for 135,000 more transfers between a resident’s home and the kind of appointment they may need. This is one very good example of an aging-at-home initiative, of which there will be 260 across the province, that is really about knocking down the barriers. Some of them are about additional health services for sure, but some of them are about the things that you need to be healthy in your home environment. For some it’s assistance with bathing, for some it’s assistance with cleaning and for some it’s assistance in going to pick up a week’s worth of shopping or Meals on Wheels. There is a wide variety of the kind of supports that have the capacity as well to leverage the love of community providers and the volunteers who work alongside them.

In the next four years, I’m enormously proud that $1.1 billion in new resources will be dedicated to the idea that our seniors deserve the opportunity to live out all of their days with dignity and independence in the home that they know now. I just want to encourage everybody to keep their eyes open, because we’re going to have very exciting launches all across the province of Ontario.

One thing which is a phenomenon associated with the local health integration network initiative is that LHINs engaged with their communities have chosen priorities, and they’re not all identical. I think that the exciting part about that is that it sets us up for what I call a virtuous competition, where the people in Champlain LHIN may uncork a novel idea and the people in Waterloo–Wellington will say, “Hey, why not us?” The good news is that in the next two fiscal years, aging-at-home resources will continue to increase, so that an idea that is initiated or piloted in one part of our province can be grabbed hold of by the leaders in other parts of our province. That’s a phenomenon that’s possible because local health integration networks have come to life in our province.

When we look at combining the power of the aging-at-home strategy with the enhanced resources for home care that we announced last week to address the alternate-level-of-care patients, we really feel that we’re getting at the heart of the matter, which is offering care to people in the most appropriate setting.

As the first overarching priority, we’re going to drive results and enhance the performance of Ontario’s hospital emergency rooms. I say this with confidence, but I’m not misunderstanding for one second; this is a difficult task and this is a task that people have grappled with to varying degrees of success. But we’ve got great leaders out there, and people have initiated models that give us a lot of confidence that we can make substantial improvements not just in the amount of time that people spend there but in the experience that they have while they are there. Patient satisfaction is not merely a measure of time; it’s qualitative and quantitative. We seek to make improvements on each of these two parts of the experience.

The second overarching priority is a comprehensive family health strategy that gives us the chance to deliver family health care to all of those in Ontario who are looking for it. With a 13-million person population in Ontario, at any given time there are a few people who may be conscientious objectors to western medicine or there are some young folks who maybe aren’t active in the search for a family doctor. But what we know for sure and what we’ve seen great strides around is that the number of people who are actively looking for a doctor is lower than the number of people for whom we got a doctor in our first term of office. That’s why we’re confident that over the next four years we can deliver family health care for all.

About two weeks ago, the Ontario Health Quality Council put out a report that I would encourage members to look to. If they have questions, we can certainly use some of our time around that. It said that there are 400,000 people in Ontario who are actively looking for a doctor. That’s a lot of people to be without a doctor, but consider that just three or four years ago, when we were discussing things like this, numbers like 1.6 million and 1.7 million were used. We know that with the strategies we have developed—like family health teams, which have provided care to almost 200,000 who didn’t used to have a doctor; additional community health centres; our nurse practitioner-led clinics; and working with the physicians in Ontario, 83% of whom took on new patients last year—we’ve made great progress, and that gives us the confidence that over the next four years we can unlock what has been a challenge for some people in Ontario.

There is strong evidence of the results of our partnership with the Ontario Medical Association. The people of Ontario have contributed very substantially to enhancing the compensation rates for doctors in Ontario, but the great news for the people of Ontario is that alongside the increased compensation for the doctors was that 650,000 more Ontarians gained access to one. That’s why we believe that we can deliver family health care for all.

Our confidence is also based on the fact that our campaign platform, and now our government’s budget and the estimates that are before you, give us additional capacity for the creation of more family health teams—50 of them—and 25 nurse practitioner-led clinics targeted at those communities in Ontario that have the greatest burden with respect to people being without access to family health care.

In the slides, like the one that you can find on page 2, there’s a one-pager on nurses, and there is a one-pager on page 1 on doctors. These charts show very clearly, if you look at the number of doctors practising in Ontario, that each and every year we’ve seen increases. If we look at the next chart in terms of the number of doctors—that is, those who will be graduating—the projection is for increases. If we look at the number of international medical graduates entering the Ontario physician workforce, what you see is that we’ve got tremendous additional capacity over what we had when we first came to this role five years ago.

If we look at page 2, on the nursing workforce, we see very substantial improvement in the percentages of nurses working full time. In the pie chart, we see that Ontario’s nursing graduate guarantee has been one of the most remarkable program launches ever, and being copied by many jurisdictions around the world. Only one or two places in the world had even initiated such a graduate guarantee for nurses. We had all heard that sad story where we need nurses and then newly graduating nurses wouldn’t transition to opportunities and would go looking to other jurisdictions for them. I don’t pretend that the whole situation is perfect, but last year, with the new-graduate guarantee, 86% of those nurses gained access to full-time employment.

We know that we can do better, and we especially have to do better for registered practical nurses, who, in the field of nursing, did not experience as much success with the program as the registered nurses do.

If we look to the other chart, “Nurses Employed in Nursing in Ontario,” this is data supplied by the College of Nurses of Ontario’s annual membership stats. There is no perfect measure of any of these nursing numbers, but this is widely viewed to be one of those that is most accurate. It makes no argument but that there are more nurses practising in Ontario, and over the next several years we have $500 million to invest towards hiring 9,000 additional nurses by 2011-12.

The most revolutionary change that we’ve seen over the last few years is the evolution to team-based care. We have, in my critic from Nickel Belt, a member who was once the executive director of a community health centre. Our family health team initiative, which has seen these remarkable family health teams come to life in all parts of the province, is built on many of the kinds of ideological or clinical underpinnings of the community health centre model, based on the idea that a team of people working together is better for the team than to be working in isolation and better for the patients insofar as offering them the kind of comprehensive care that can really enable the best-quality health care.

I just want to say that when we first launched family health teams, a lot of people said, “These things aren’t going to be successful. Doctors don’t want to practise in them.” To the contrary: We’re overwhelmed, really, with the requests for more family health teams, and also, from those which have already been launched, for them to continue to grow. We’re just so grateful that the physician community in our province has responded so positively and, alongside allied health professionals and nurses, is making such extraordinary progress.

In conclusion, and in anticipation of the opportunity to listen to or perhaps to answer some questions, we look forward to the next nine and a half hours to talk about the things that we’ve done, the progress that we’ve made and the resources that are embedded in our budget to allow us to deliver, on behalf of Ontarians, two things that are really important to them from the standpoint of the confidence that they enjoy in our public health care system: reduction of wait times, with a particular focus on emergency rooms, and family health care for all.