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**Ontario’s Health Speech: Second session of the 35th legislature, 1992**

Hon Frances Lankin (Minister of Health):

Thank you very much. I will just take a moment and introduce the Deputy Minister of the Ministry of Health, Michael Decter, and a member of my political staff, Rob Smalley, who is the legislative assistant. There are a number of other people here from the Ministry of Health who will be able to be of assistance if questions are raised that fall within their particular areas.

I will begin by saying that over the course of the remarks that the critics from both opposition parties will make, leading to any questions, I'd appreciate it if there were an opportunity for members of the committee to let me know the areas of questions in particular that they have an interest in and the order in which they may wish to receive that information so that I can try to ensure that, as I come to these sessions, I have the most up-to-date information with me. I do have staff in those program areas with me as well in order to facilitate answering your questions.

I'd like to take the opportunity of the opening remarks to stress what I think is the most important driving force in what we are trying to do within the Ministry of Health over the course of the next number of years. I think it's underlined by saying that there's a tremendous need for reform in the delivery of our health care system. There have been many studies, many reviews in other parts of the country, royal commissions, that have looked at the state of our health care system and definitions of health, and I think that one of the things we hope to achieve is to bring to the culture of all parts of government an understanding of a definition of health according to the World Health Organization, which is, as members here will know, much broader than perhaps traditional thinking may be around the issues of state of health as simply an absence of illness or infirmity. I think we are all looking much further than that these days.

It's important for us to say that we do have a health care system that is worthy of pride, and it is one that government after government has sought to protect and enhance. I think in this vein it's important to acknowledge that there have been steps taken in the past that start to lead us down the road of reform. Over the course of the last 10 to 20 years, extensive research has been accumulated that, I think, guides the directions we take now.

That research shows things like health being related to economic status of the citizens of our province. We know that mortality rates for poor Canadians are much higher than for rich Canadians, as an example. We know on a worldwide basis that research shows that people live longer in wealthier countries. We know that access to health care, as it's traditionally defined and delivered, has not in general narrowed the health inequalities between socioeconomic groups. We know there's a strong correlation between poor health and lack of social support mechanisms, networks and relationships. Things like self-esteem and coping skills and the ability to exert control over one's life are important. Early childhood experiences play a potentially critical role; the environment; there is a whole range of issues we know are critically important in establishing the health status of our population. Those things have more recently been defined and listed and referred to in documents as the determinants of health.

I think the debate around the determinants of health -- ie, understanding the importance of them in the establishment of the health status of our population -- brings with it a necessary response from government to try and look at matching the resources we invest in health with the issues we see out there as being the determinants of our population's health, and that I think is a major part of the reform that is necessary for us to take some greater strides to achieving. The necessity then to set ourselves some goals for the reform I think becomes clear.

We're perhaps lucky in Ontario that there have been other groups that have looked at this issue and attempted to identify health goals. We've been able to benefit from the work of the Premier's Council on Health Strategy under the previous government with respect to the health goals it established, which were the shift in emphasis from disease prevention to health promotion, fostering strong support of families and communities, ensuring a safe and high-quality physical environment, increasing the number of years of good health for the citizens in Ontario by reducing illness, disability and premature death, and providing accessible, affordable and appropriate health services for all.

I want to indicate to you that certainly the Ministry of Health is committed to all of those goals. We have adopted those goals and internalized them as part of our framework for assessing initiatives and decision-making within government, and I'm particularly pleased to indicate that the government as a whole has adopted those goals. As I indicated before, it will take some time to have the change in culture that's necessary in government for all parts of government to see these kinds of health goals as screens through which they should filter decision-making and program planning, but I think we're taking steps in that direction. That's important, and those factors will really set the stage for reform.

It is also very important for us right now to acknowledge that there is a fiscal context to the situation we find ourselves in and a fiscal context within which we are attempting to achieve reform. It would be remiss not to acknowledge that it places certain pressures, certain constraints and certain imperatives on the decision-making we are faced with. With respect to the fiscal context, there are three major areas we need to keep in mind that I'd like to address.

The first of course is the recession we have been experiencing in this province and this country. There is no doubt that people have reached an agreement that this is the worst recession since the last Depression. We know there are tremendous forces that are restructuring our economic base in this province and we know there are effects of that with respect to the fiscal revenues of government and the ability of government to maintain levels of delivery of service and the challenges they present.

Although we find fiscal resources are very constrained, in the budget this year the Treasurer made it very clear that the government had identified three priorities: saving jobs, retaining services and controlling the deficit. Those are our challenges that are set out for all of government, and I assure you that the ministry is seeking to restructure and realign the health care system with those goals in mind. We're seeking to minimize the human dislocation and job loss, and I'll talk in a bit about how we are doing that. We're seeking to retain the necessary existing services and to create new ones where that is indicated, and we're working to introduce management that is geared to deficit reduction, excellence in management through quality assurance and provider planning and collaboration.

The second issue we need to contend with in the fiscal context is the federal withdrawal from medicare. Members will know that provincial governments across this country suffer from the reduction in federal transfers with respect to both the Canada assistance plan and established programs financing. The federal share of Ontario's expenditures on health and higher education has fallen from a high of 52% a decade ago to 31% now. It's important for us to recognize that this is a force with respect to the fiscal context, and here I don't want to simply say we're pounding the table and saying that the federal government should provide more money. I think it is very important that the federal government remain as a partner in our national health care system. I think we need to see an adequate and stable level of financing from the federal government, particularly as we go through this period of transition and restructuring. The need for that stability is important to provinces and to provinces' health care partners -- the transfer payment agencies and our communities.

I can't leave this issue without commenting on perhaps the more serious threat with respect to the continued reduction in the federal share of health care dollars, and that has to do with the federal government's ability to enforce the principles within the Canada Health Act. The fiscal levers they currently have under health financing through EPF are slowly disappearing as we see the deterioration of the level of support from the federal government.

I think we need to put squarely on the table, as provincial legislators in this province and other provinces are doing, our continued support for medicare, for the principles in the Canada Health Act and our message to the federal government of our deep concern at its soon-to-be-realized inability to enforce the principles of the Canada Health Act if it loses these fiscal levers and if those enforcement mechanisms aren't replaced by other mechanisms such as enshrining a social charter in the Constitution.

It's a very important issue that is sometimes hidden behind the scenes and the technical debate around formulas of federal-provincial transfer payments and fiscal relations. I hope it is one that collectively, as provincial legislators, we can bring to the forefront of public understanding and knowledge, because I think it truly is a very dangerous threat to our national health care system. I assume that you, like me, believe our medicare system is worth saving and that the public of this province and this country value very highly our health care system. That is something Canadians and Ontarians hold dear and believe reflects our different values as Canadians and our national identity in many ways. I think that has come through many times in the constitutional discussions that have been taking place.

The third issue that makes up part of the fiscal context we need to be aware of is the record of the escalation in costs in our health care system over the last number of years. I think we have to put squarely on the table a question for all of us to answer: "Is the health care system, as we have known it and have been financing it, a sustainable one?" I doubt there's a person in this room who could argue that it was sustainable. Therefore, if we agree we have a problem, we must find solutions to that problem. I think we're fortunate in that one of the first places we can look in trying to resolve that problem is to much of the study, examination and research that has been done which points us in the direction of waste in the system -- waste in terms of inappropriate treatments; waste in terms of duplication of services. There are many areas that we believe we can effectively reduce expenditures by moving to quality assurance and high-quality management, excellence in management, which will in fact improve delivery of health care services, not jeopardize delivery of health care services. I think in some ways that's a good-news note in the difficult fiscal context we experience.

I want to stress that growth -- if you've read the supplementary budget paper, you will know the kind of numbers we're talking about -- over the past decade was on an average annual rate increase of 11.2%. If you break it down into different components, hospitals are just under 10% a year, OHIP has been growing at about 13% a year and the drug benefit plan has been about 18% a year. Behind those numbers, however, are real programs affecting real people and we have to understand what the effect can be. When I say that, I think there are areas in which we can improve, where we know perhaps there's inappropriate treatment, even harmful treatment.

I can point to examples like statements from the association of hospital pharmacists, which, by its numbers, indicates it believes that 4,000 seniors in this country die every year because of overmedication and there are 200,000 illnesses caused by the same reason. That's why it is important to take action on the recommendations that flowed from the Lowy commission and other reports. The drug reform secretariat is initiating the drug utilization review, bringing pharmacists, seniors, medical practitioners and others to the table to try to change the pattern of prescribing and the pattern of prescription drug use among our seniors population. That can produce better quality care, as well as a more cost-efficient use of our resources.

I want to briefly give you an update on the progress of the components of our reform, as we have indicated in the document we released in January in terms of strategic directions. First of all, the reorganization of the ministry itself is designed to try to meet the priorities we have set out: the establishment of several major groups like the health systems management group, the health strategies group and population, health and community services. We hope we have built the bridges in the appropriate corporate structure to be able to deliver more in the way of effective management of the health care system and provide assistance to our health care partners out there, as opposed to perhaps how government has been seen and the role it has played in the past of a claims payment agency or a funding organization, rather than an interactive partner in terms of the management of health care.

In our estimates book that we've circulated to you -- I think it's on page 6 -- you'll see the organizational chart that sets out that reorganization. You may want to take a look at it.

In the area of hospitals, you will know we have taken major steps with respect to our goal of program reform. The major parties have come around the table to develop the framework for a new funding formula and the priorities and the important areas they believe need to be addressed in the reform of the funding formula for hospitals. That is ongoing.

We have established, I believe, a new and dynamic relationship between community health planners in the district health councils and hospitals, to look more closely at regional needs and ensuring that health decisions that are being made within institutions are no longer centred in individual institutions, that they cut across the delivery of services to the community and that those decisions are guided by good health planning and good needs analysis to ensure the delivery of services is reflective of the community health needs that are identified.

I think the kind of support we are trying to give to the restructuring process, both with the active committees, with the hospital association and other partners that are developing operational plans, and the requirements for how hospitals develop those plans and work with their workers and communities and others to develop the plans, as well as a more proactive process of parties coming around the table and trying to look at the major issues of restructuring over a longer period of time, are all indications of major changes in the hospital sector and an attempt to involve the greatest number of people we can in these discussions and in these decisions.

You will know that there is major restructuring resulting from the transfer payment announcement. But I want to assure you that in addition to the 1%, the additional allocations that have been made have, I think, met with great approval in the hospital sector with respect to things like the $49 million for essential services, expansion of dialysis and bone marrow transplants, chemotherapy and cardiac surgery. Another $46 million helps accelerate the shift from institution-based to outpatient and community care, support high growth areas and reduce historical funding inequities. All of these additional dollars that are very targeted, very specific, I think have been welcomed by the hospital community.

As you know, we also have an established labour adjustment fund attempting to minimize the impact of changes in the hospital sector on individual workers. At this point I should indicate to you -- and although I don't have hard figures for you this week, I hope to have in the near future -- that despite the kinds of predictions we heard about the thousands and thousands of people who were going to lose their jobs as a result of the transfer payment announcement, hospitals and unions and communities have worked very hard to be innovative and creative and to find areas to reduce deficits by other measures. Their efforts are praiseworthy, and a tremendous credit goes to hospitals on this.

I can tell you that when we provide you with the numbers, you will see that it is only a fraction of what had been predicted that has actually resulted out there in the communities. Still, we would rather be in a situation where there wasn't any, but we will be working with those people to help them make a transition to new jobs in the community through retraining and other adjustment measures.

The Ontario drug benefit program reform: Essentially, most of the updates that I can give you with respect to that are contained in the health supplementary budget paper, and I would refer you to that information or answer any questions you have around it. It is moving and moving quickly, and over the course of the next year I think the drug utilization review and other initiatives will see a much more effective management and better product being delivered to the clients of that program.

For the first time, I think, in the history of this program, you will see that this year there is a decrease in the dollars being spent on OHIP in terms of the percentage of the overall health budget. We've gone from 32% of the overall health budget last year to 29% of the overall health budget this year. There are increases in areas of community health, long-term care and other areas that I think are steps towards the beginning of the shift, as well as an investment in other determinants of health and other parts of the government, whether that be job strategy, provincial training programs, the sorts of things that are very important for us to invest in in terms of upfront investment in health.

You know about the agreement with the Ontario Medical Association. There are other negotiations ongoing, and we are certainly prepared to answer questions that we can about that.

The area of mental health reform is next. We have a number of serious problems in our mental health system. We are facing increasing demands on the system which include demands for services and service access issues. There are inefficiencies in services; there are very poor linkages between research, policy development, funding and service delivery; there are labour relations concerns, and there is a lack of a long-term strategy for prevention and early intervention. We are talking about a problem that affects about 1.5 million residents in this province.

We think we need to take steps consistent with recommendations of the Graham report. We have identified mental health reform as a strategic priority. There is a steering committee of the relevant Ministry of Health branches that has begun to develop a work plan to try to link the recommendations that we saw in Graham and other areas, to try to build linkages between the facilities part of our system, whether those be our psychiatric hospitals or psych units in general hospitals, and our community delivery of the services. It is looking at ways to integrate those and looking at ways to truly direct the services to where they are most needed.

In this respect, we have again adopted goals from the Premier's Council on Health, Wellbeing and Social Justice looking at reduction in suicide, increased employment for people with schizophrenia, and reducing the disability from schizophrenia, Alzheimer's and other dementias. We are in the process of developing a multi-year plan for mental health services which will include mental health promotion and prevention of mental illness.

With respect to long-term care redirection, you'll know that we have just completed the consultation on this major reform in government, and here I'm really thrilled to tell you about what I think is a success story in terms of consultation and reaching people. Over 70,000 people participated in over 3,000 organized sessions in this consultation. Seniors and members of their families came out, and persons with disabilities. It really was a tremendous success in actually being able to reach the consumers of this service and hear from them directly about what their needs were, as well as the organized voices of providers and others. It was a tremendous initiative. Almost 2,000 written submissions have been received on this. Well over 2,000 phone calls came into the government's phone line for more information. There were about 80,000 discussion documents distributed in various forms -- audiocassettes, other languages. It really is tremendous.

We heard a lot. I have to tell you that there were some important criticisms that we heard during the process of this consultation. We're in the process right now of reviewing the results of that consultation and giving policy consideration to some of the areas that the communities out there have said must be changed from the program suggested by government.

Again, I'll commit to you that this is a major priority and that the government has allocated $647 million over the next five years; $100 million of that will be flowing in this year. We will be moving to make those final decisions with respect to those dollars very soon, in keeping with the policy decisions that are being made.

The management of health human resources: This is a major challenge and, we believe, a very crucial necessity. A large part of our health care expenditures are invested in people delivering services to other people. There are just under 300,000 workers involved in health care in Ontario, and payments to providers of care, such as physicians, nurses and rehabilitation workers, comprise about 75% to 80% of our health spending. About $13 billion in 1992-93 will be directly related to the provision of direct services. That's not buildings, not technology, not the other things that are also costs in the system. Despite this -- not just in this province; this is right across Canada -- we do not have a history of effectively managing and planning health human resources. We've not looked at what the future projection of population health needs will be and tried to match our resources planning in terms of training and development of health care providers.

This is a tremendous challenge. We're undertaking a number of initiatives, both provincially and nationally, to address a number of key issues. You will know that one of those key issues is physician resource planning.

At the same time, we're also looking at trying to increase space for non-medical health professionals to assume full scopes of practice. The recent changes to the health professions legislation certainly allow for that evolving scope of practice. It's an important change, one that other provinces have looked at and are looking to copy in fact.

It is certainly necessary for us to be able to move to a mix or variety of health care providers in the delivery of primary care and other health services. In order to match the training and supply, there needs to be very active work in developing that kind of strategy.

We are working on the development of a community health framework. Here again I want to say that these are not new, radical ideas. What we have are some experiments that have taken place over the last decade that we think we can learn from and build on and for which we can try to develop a framework. We had the experiment of community health centres as one type of community delivery of primary health care. There are health service organizations. There has been discussion of comprehensive health organizations. All of these are various organizations of funding and individuals, and they vary in terms of their structure and goals, but they are essentially primary care delivery at the community level and different experiments in that.

We think we can move to develop a framework of comprehensive community health and public health strategy for delivery and funding of primary care, including more delivery sites and an expansion of what is on the ground now.

The plan we are working on, and we are working on it in conjunction with people from the community, is looking at determining the role of the primary care and health care delivery system, especially regarding accessibility and equity issues; developing a policy and planning framework that complements the role of institutions. As you know, we've moved and been able to establish a planning guideline framework for institutions so that district health councils and hospitals and communities have something to judge their planning by and to guide them. We are looking, with our partners out there, to develop a similar kind of planning framework for primary care and community delivery of that service.

We are hoping to be able to evaluate the effectiveness of existing models, including CHOs and independent health facilities and other sorts of experiments that are out there. We've never done much evaluation of what we do in the health care system, and as we become more rigorous about that, it needs to be applied to the community sector, not just the institutional sector.

We are looking in our plan to ensure that we're developing culturally sensitive services to meet the needs of specific communities and the changing needs of the communities that need to be served, and to develop mechanisms to ensure accountability and to have informed choice.

Let me conclude by briefly saying that the kind of restructuring and reform we are embarking on in this province collectively out in the communities and in government is not easy; it will not be easy. I don't bring a Pollyanna approach to this, but I do believe it is crucial to our ability to create a truly sustainable health care system. I come back to the premise I put to you, that everyone I have talked to in the system, irrespective of the sector he or she comes from, irrespective of political background, agrees that the system we have is not sustainable as it is, that there needs to be a change.

Therefore, I think the question of reform is a redundant question. Reform must take place. The nature of the reform, perhaps, becomes more debatable among various parts of the community, and various members of the Legislature even, but there have been almost two decades of research in Ontario and across this country and in the United States and internationally that I think really provides us with a great basis to be sure we're actually taking the right steps in terms of the reform we're trying to achieve.

I don't claim that we're pioneering this reform. I believe other governments started down this road. I can point to examples under the Conservative government. I can point to even more examples under the Liberal government, and I can point to many examples under this government. It is a period of acceleration of reform for many reasons, in many situations. The time is right. There is a historic window of opportunity. I hope the ministry, with myself in the role of minister, will be stepping through that window of opportunity, along with our health care partners, to truly achieve the kind of reform that will allow us to have continuation of a very valued resource and national heritage, our health care system into the future.

I think that gives you an overview of my feelings with respect to reform. We hope that in reforming the system, we'll be putting the issues of enhanced quality of care and reform to a new vision in the driver's seat, as opposed to the fiscal context within which we are doing it, being in the driver's seat. In this way, I think we can implement the kind of policies that we need to bring to life the consensus of directions in health care that have been held by all governments for some time.

I think we also allow ourselves to deal with the fiscal situation through enhancing the kind of quality in care that we provide, which will achieve objectives that are both fiscally and socially responsible, and those are the goals we have set for ourselves in the Ministry of Health. I thank you for the time to make the introductory comments.