|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Province*** | ***Législature*** | ***Session*** | ***Type de discours*** | ***Date du discours*** | ***Locuteur*** | ***Fonction du locuteur*** | ***Parti politique*** |
| Ontario | 36e  | 1e  | Discours sur la santé | 1997 | Jim Wilson | Minister of Health | PC |

**Ontario’s Health Speech: First Session of the 36th legislature, 1997.**

Hon Jim Wilson (Minister of Health): Thank you, Mr Chairman, and members of the committee. I am pleased to appear before you again this year to review the estimates for 1997-98. I have with me today the Deputy Minister of Health, Mrs Margaret Mottershead.

I am grateful for the opportunity to discuss the achievements of the Ministry of Health and our government in health care over the past two years and our direction for the coming years. We are here to put the needs of the patients and clients first, the needs of people who need care in our system not just today but tomorrow and in the future.

Copies of my remarks are currently coming off the photocopier and will be available to members.

To meet patients' needs we must ensure that our health care system adapts successfully to the changing needs of a growing and aging population. We must ensure that we continue to provide the resources to do what is necessary to provide care. The challenges facing the health care system in Canada are considerable. Our population is aging, and as it ages, patients' needs change and the demands put on the health care system change.

Developments of new technologies continue at an astonishing pace. New procedures and treatments are being introduced, it seems, almost on a daily basis. What was considered ground-breaking medical treatment a generation ago is now obsolete medical treatment; diagnostic procedures that were state of the art a decade ago are now commonplace. Through medical advances, new drugs and technology, people are spending less time in hospitals and are recovering at home and receiving services in the community. Our health care system has to reflect these changes.

As the system adapts to changes, so too must governments. The government's role in the system is to ensure that the needs of patients and clients are met with a quality health care system. Our job is to provide a high-quality health care system to the people of this province and to be part of Canada's national medicare system.

For the first time in a very long time, our government is putting the needs of patients first to ensure that they get the right care at the right time in the right place, now and in the future. Our government's vision for health care is truly an integrated health care system -- that's the direction in which we're going -- one in which everyone from doctors to nurses to hospitals to other health care providers are working together to provide services where and when you need them. To make this plan a reality, we are renewing and improving Ontario's health care system now.

I am proud to report that we continue to lead the country on per capita spending. Ontario spends, on average, almost 20% more per capita on health care than any other jurisdiction in Canada. In the most recent budget, health care spending rose another $400 million dollars, from our campaign commitment of $17.5 billion to a record $17.8 billion, the highest amount ever spent on health care in this province.

Beyond the record-level program spending, we are also providing over $2 billion dollars to assist hospitals with the cost of changes such as severance, labour adjustment, job retraining and education, capital and other costs. This increase in funding is despite the $2.1-billion in reductions in health care transfers from the federal Liberal government.

Money issues are always at the centre of a discussion of health care, but there is a consensus within the health care system that the amount of money being spent on health care is sufficient to meet the needs of the patients and maintain a high-quality, accessible system. I'm pleased to say that those sentiments about spending enough money on health care were echoed in my office just two weeks ago by the Ontario Nurses' Association, who made it very clear that we're spending enough on health care; we just have to get our spending right and get our resources directed to the patients and the front-line providers.

For example, in the Toronto Star last December, Professor Greg Stoddart of McMaster University said, "We are not using the money we have in the system as well as we could.

In its pre-budget submission, the United Senior Citizens of Ontario put it this way: "We feel there is enough money being spent on health care in this province, but it is not being spent efficiently."

Yet another observer of public policy said: "I am convinced that there is enough money in the health system. I don't think we are spending it as effectively as we can." That last statement was made in September by Dalton McGuinty, the current leader of the Liberal Party of Ontario.

There is consensus that we are spending enough, but are we getting the most services for patients and clients that we can? Restructuring our health care system means making it better so patients have more and improved services, modern full-service hospitals with the newest technologies, drugs and treatments.

Changing the system is critical if we are to invest in new programs and services for patients. We need to move away from bricks and mortar, remove the duplication and inefficiency in our system and reinvest these savings into services for patients. To do otherwise is to continue to spend money on programs, facilities, services and systems that are outdated, while the needs of patients grow.

Our vision for health care is to ensure that patients receive the treatment they need, when and where they need it. Our vision calls for meeting needs of patients in the community and in institutions; to work cooperatively with providers to bring in reforms, to reinvest in priority areas, to expand treatments in cancer treatment, dialysis, cardiac care, community mental health and many others.

Of all the changes under way in the health care system, the most important is that of the Health Services Restructuring Commission. If there is one frustration with the restructuring commission, it is that it was not established 20 years ago. The commission is widely recognized within the health care system, and its work is not always pleasant, but it is extremely necessary and long overdue.

I agree with Tom Closson, the president of Sunnybrook Health Science Centre, when he said in a Toronto Star article last December: "Look at how much money is spent on hospitals and how practices have changed over the last 10 years and yet we still have the same number of physical buildings open in this province."

In fact, we have about the same number of physical hospital buildings in Ontario that we did 20 years ago. The need for change is recognized universally, and Ontario is the last province in Canada to make those changes.

All of the restructuring projects included extensive consultation with hospital and communities across Ontario. I think this is a tribute to all of the district health councils, and this level of consultation is widely acknowledged in the communities where restructuring is taking place. For example, an editorial in the December 14 issue of the St Catharines Standard said this about the DHC's preliminary restructuring report for the Niagara Region:

"It is important to recognize that the controversial report was not drawn up by bureaucrats whose vision is blurred by the Toronto skyline, but by local people who share the concerns of their families, friends and neighbours in the villages, towns and cities which make up Niagara. The report was destined to be controversial; it will be praised and condemned but it is made in Niagara for Niagara."

The time is past for discussing the restructuring of our hospital system. Clearly we have to get on with the job. We have to do this, because between 1989 and 1995 more than 11,000 hospital beds -- the equivalent of about 40 midsized hospitals -- were closed, yet no hospital buildings were closed in this province.

The problems of duplication, excessive administration, overlap and overcapacity were left untouched at the same time that waiting lists for procedures were growing. It is not logical, responsible or compassionate to pour money into bricks and mortar and administration when people are going without care.

Bricks and mortar do not cure patients. The quality of health care in Ontario, the accessibility of services, is not determined by a street address or a postal code. Buildings do not provide the care. Health care is provided by caregivers. In Ontario we are blessed in having some of the best in the world at all levels of the system.

We must listen to those caregivers like Dr Wilbert Keon, director of the University of Ottawa Heart Institute, who said in a submission to the restructuring commission: "Halfway measures will not solve the problem, we must be decisive and we must act now. If not, everyone, particularly the public, will lose"; or Krystyna Gibson, a medical technologist at Grace Hospital in Ottawa who, in a letter to the Ottawa Citizen said, "The reason for restructuring is to preserve health services, not downsize"; or Dr John Malloy, the head of Sudbury Memorial's emergency ward, who said about the restructuring plan in his community: "Someone has finally had the courage to bring some common sense, some economic sensibility to a rather chaotic situation.

In my view the patients are going to be the winners in this."

To appreciate where Dr Malloy is coming from, it is worth mentioning that in Sudbury there are currently two emergency wards treating about 90,000 cases per year. Last year, 3,800 patients were transferred by ambulance from one hospital to another for tests or treatment -- in fact, they were spending about $1 million a year on the shuttle bus between buildings -- an average of more than 10 patients per day shuffled around three different buildings. The new single emergency ward in Sudbury is designed to handle 93,500 cases per year -- an increase of 3,500 cases, all in one building, all under one roof. Everybody can park in the same parking lot. Doctors won't have to decide in which parking lot they start off in the morning and end up in at night. By restructuring the hospital system and reducing the number of hospital buildings, we can improve the quality of care and reinvest these savings into our health care system.

Sudbury is only one example of where we're having fewer but improved hospitals and where we can improve care. In a letter to the Windsor Star on December 17, John Finncy, the director of public relations at Windsor Regional Hospital, wrote, "Although beds have been closed, Windsor Regional Hospital is caring for more patients today than we did five years ago."

That is the critical point of the restructuring process. It is possible to provide better hospital care than what we are currently providing, while preparing for the needs of all Ontarians, including an aging and growing population.

That is the experience in Winnipeg, where the Centre for Health Policy and Evaluation studied the impact of downsizing hospitals in Manitoba. We didn't do this last year, but I'd like to table that report with the committee. You only have to read four pages to have your mind completely blown with respect to the efficiencies they found. These were academics looking for trouble, they couldn't find the trouble and in fact found things had improved dramatically as a result of restructuring. The report concluded that access to hospital services improved by restructuring and that the quality of services remained unchanged; nursing care per patient went up; the number of hip replacements, cataract and other surgeries went up, some by as much as 33%.

I am confident that with the expertise of our health care providers and administrators, we in Ontario will at least meet, if not exceed, the level of service improvements realized in Winnipeg and other cities in Canada that have already gone through similar restructuring exercises.

When I spoke with you last year, I said the reason restructuring had not taken place 10 or 15 years ago was politics. That is why we established a non-partisan, arm's-length commission to oversee this process.

It remains this government's intention to continue with this process in a non-partisan manner without interference from any political party, including my own. I appreciate that political pressures can be overwhelming, but if we are to meet the challenges of putting patients first, today and into the next century, we must be resolute and let the commission do its job.

The process of restructuring and reformation of our health care system is one in which all three parties have been deeply involved during their time in government. It is my view that the time is long past for us as legislators to show the courage that is being demanded of us to do the job recognized as necessary in this province over 20 years ago. The needs of the patients demand no less.

I do understand that it is difficult for some to accept that our system can be better with fewer hospital buildings. In my community and communities across this province, the local hospitals are more than just buildings. They are where we are born, where we are treated and where loved ones died.

But if there is one aspect to the controversy surrounding hospital restructuring that is most troubling, it is the response of certain union leaders to the fact that some of their members face displacement or job loss. This is an unfortunate reality of the restructuring process, and not one that we take lightly.

I have sympathy for individuals who may lose their jobs, but the system will create new jobs for which former hospital employees will be eminently qualified. Community-based services need the expertise of those who worked in hospitals. While I have sympathy for individuals who are displaced, I will have no truck or trade with those union bosses who are bitterly fighting to preserve the status quo. By doing so, they are putting their own narrow self-interest ahead of people who need care.

Let's put in context what some hospital leaders want. They would prefer that taxpayers pay for bloated organizations and bureaucracies that are providing overlapping and duplicate services, instead of enhancing the access of health care to the people of this province. They would prefer this to freeing up money to put into more services and better health care for the people of this province.

How could any Minister of Health in good conscience keep the status quo, when at the same time Ontarians' need for health care is growing? Yet that is precisely what union bosses are demanding I do. Theirs is a request that I will not fulfil.

To those who may be displaced, understand that the system is changing and that the priority is patient care. Let me also say that every dollar and more saved by this restructuring is being reinvested into the health care system. The new services provided through these reinvestments create new jobs for health sector workers. So far, we have invested almost $1 billion in savings in health care. These reinvestments put the patient first. They shorten waiting lists and travel time for patients out of town.

In the area of cardiac care alone, this year we have made an additional $35-million commitment to reduce heart surgery waiting lists, the largest reinvestment in cardiac care in this province's history. When we made that reinvestment, Dr David Naylor, from the Institute for Clinical Evaluative Sciences, predicted: "These funds will shrink the queue to its shortest period ever. This is a very important major step forward."

Even before that reinvestment, we were already experiencing an increase in the provision of cardiac services in Ontario. The March issue of the Cardiac Care Network communiqué reported that the number of cardiac surgeries provided to Ontario residents was 38% greater in March 1997 than in March 1996. That had much to do with the $8-million investment we made just prior to that time. The number of cases for the full fiscal year 1996-97 was 10% greater than for the year prior.

It is this government's commitment to provide the funds necessary to introduce new programs and to further reduce waiting lists for cardiac care and other critical services. It is my privilege as Minister of Health to make these reinvestments into new programs. For the front-line workers, these reinvestments in our system mean they can provide better care to their patients.

For the patients, it means better treatment.

For example, when we announced we would spend $18.9 million for a new cancer treatment centre in Windsor, Ethan Laukkanen, CEO of the Windsor Regional Cancer Centre, said: "This was absolutely critical. This will enable us to treat people near their home."

The Windsor Regional Cancer Centre is part of a larger cancer treatment commitment undertaken by this government, which includes an additional $24 million for improved breast cancer screening and an additional $16.5 million for improved cancer care, including Taxol and other drugs to help fight breast cancer.

This year the Premier and I announced the establishment of Cancer Care Ontario, a new agency that will link and integrate cancer services throughout Ontario. This will permit us to provide better services closer to home for people who need care. That's putting the patients first.

Unlike previous governments, much of the almost $1 billion in reinvestments in our health care system came from within the health care budget envelope. It is possible through more efficient use of our health care dollars to provide better services, more accessible services and improve patient care.

We are in the second year of our $170-million reinvestment in community-based long-term-care services such as nursing, personal care, homemaking, meal programs, attendant care services and therapies such as speech-language pathology, physiotherapy and occupational therapy.

This year we reinvested $57.2 million to acknowledge population growth and the special circumstances of northern hospitals, $14 million of which is specifically earmarked for northern Ontario. This is in addition to the $25 million invested last year into 18 hospitals in high-growth areas to help them deal with the pressures of a growing population.

We have reinvested $23.5 million into community-based mental health services to treat people with severe mental illness and to build up community support for people to return home and function in their community. We've expanded dialysis services across Ontario, allowing kidney patients to receive treatment closer to home, by reinvesting -- it's not $25 million; the total is $36 million.

These are just a few of the close to $1 billion in reinvestment in providing more health care services to the people of Ontario. I'm proud to say that these reinvestments are already achieving our goal: increasing the number of services delivered to patients and clients in this province.

For instance, in 1994-95, the number of Ontario residents receiving cancer care was 82,864. This year's numbers are projected to be well over 100,000. This number outstrips by half the number of new cases expected in a year.

The number of MRIs done in Ontario last year was 19,000. Compare that to 1994-95, when the total was just around 12,000. With our commitment to triple the number of MRIs, the projected number for this year will increase to about 20,000.

The number of bone marrow transplants has almost doubled in the province since 1994-95, with a projected number this year of 507.

There's more. Our $170-million reinvestment into community-based long-term care is going out to people of all ages across the province who want and need to receive care in their own homes, schools and communities. Already, more than 200 community groups that support people living in their own communities have received more than the $130 million I've announced to date.

Since 1994, nursing visits have gone from 5.9 million visits to 7.3 million visits. This is a 23% increase and it translates into 1.4 million more visits provided to patients, far outstripping the growth in population.

Our reinvestment of $23.5 million into community-based mental health services has resulted in an additional 164 programs. That's on top of the 300 programs already funded by the ministry at the community level. Yet we clearly realize the need for institutional services for people with mental health problems, as our reinvestment of $18 million into that side of the ledger illustrates.

More people are now receiving dialysis closer to their homes, making a profound difference in their quality of life as they struggle with kidney disease. Our reinvestment of $36 million has resulted in an additional 20 dialysis units, many of which are already up and running.

Finally, I'd like to mention the Ontario drug benefit program. We have added 465 new drugs to the formulary through a streamlined approvals process that gets patients the drugs they need in the most expedited system in the country. Our drug benefit program is the most comprehensive and by far the most generous in Canada. By the way, the 465 drugs is after about five years of the previous government almost completely freezing the formulary and delisting 260 drugs.

These reinvestments are only one part of our commitment to maintaining and improving health care services in Ontario. Funding the programs doesn't make much sense if we don't have trained caregivers in place to deliver the care. In this respect, I am pleased to discuss two current government initiatives: the new agreement with Ontario's doctors and our nurse practitioner legislation.

I believe the advancement of nurse practitioners will address two concerns. The first is the future of nursing as we rely less on hospitals. The role of nurses in the delivery of health care is growing. Our nurse practitioner legislation will allow nurses to achieve even greater importance in the system.

Secondly, nurse practitioners will also help in underserviced areas. In the words of Carol Sargo, the president of the Nurse Practitioners Association of Ontario, "A couple of nurse practitioners together with a family doctor in an underserviced area could beautifully service an entire population."

We responded to nurses who asked that we remove the red tape, allowing them to practise, to use the skills they have and practise to their full potential to better help patients across Ontario. This is a major milestone in recognizing the vital role nurses play in today's health care system.

I am particularly proud that it is this government that is finally moving on the nurse practitioner legislation. It is long overdue. Others announced it. It got tied up in review; we finally have legislation on the floor of the House.

When I spoke to this committee last year, we were about to enter negotiations with the Ontario Medical Association. As I noted at that time, for more than 10 years the relationship between various Ontario governments, regardless of their political stripe, and physicians has been unsatisfactory to both sides. Whether it was the extra-billing fight with the Liberals or the social contract dispute with the NDP, each government has had its history of poor relations with doctors. I also noted last year, and it goes without saying, that physicians are crucial to the health care system as a whole. As caregivers, they play a lead role. Despite media reports and opposition grandstanding to the contrary, our goal is to work cooperatively with the province's physicians.

That is what I said last fall. Today I'm here to say that after long and difficult negotiations, we have reached a three-year agreement with Ontario's doctors that I hope will put the years of stress and discord behind us. I am particularly proud of the agreement reached with the medical profession because it allows us to enter into a new, cooperative relationship with the medical profession and it holds the line on increasing medical costs.

In this agreement, there is no new money for higher physician fees. There is, however, an acknowledgment that increased population and demographic changes do increase demand on physician services. Therefore, we are prepared to put new money into the OHIP pool to pay for new physicians, new patients and the increased patients' needs created by an aging and growing population.

There is the possibility of a modest conditional fee increase in the third year of the agreement, if and only if physicians can save money within the system through modernization and tightening of the fee schedule and through utilization controls. There are no new clawbacks on physician incomes in this agreement. However, a 2.9% clawback will continue until next February to make up the social contract commitment of the medical profession. While I understand the 2.9% clawback was a major sticking point during negotiations, the government did not feel it could in good conscience absolve the medical profession from its social contract obligations when everyone else had met theirs.

The government also agreed to continue subsidizing malpractice insurance premiums, a practice that started over a decade ago and continued under governments formed by all three parties. However, we have instituted a joint ministry-Ontario Medical Association committee that has been charged with trying to find ways to reduce the cost of malpractice medical insurance, including seeking a new insurer. Because it is a three-year agreement, it offers some stability and a longer time frame for both sides to come together to collectively address the challenges facing the delivery of physician services.

Through the physician services committee, which is established under the agreement, and other liaison committees, the government and the medical profession will work together to reach solutions on the challenges facing our health care system. This new era of consultation with the medical profession is in keeping with our policy of consulting widely with our partners in the health care system. It is this consultative process that persuaded the government to delay the third-year funding reductions for hospitals. We believe that rescheduling this reduction will allow hospitals to better adapt to the changes without risking the quality of patient care. We listened to the hospitals' concerns and we have responded.

In the course of the last year there was a shift in the direction of Ontario's health care system. It was a change away from the time when the various components of the health care system operated independently and in isolation from each other. It was a change to an integrated health care system where the patient is the only priority.

For too long in this province and this country, the standard response to demands on our health care system was to spend more money. For too many years, health care spending in this province experienced double-digit increases annually, yet the system didn't work as a system and patients weren't always put first. Despite the calls from experts in the field as far back as the late 1970s, we are only now beginning to restructure the health care system and redirect money to where it is needed, that is, into front-line services for patients.

Our vision is that the needs of patients and clients come first. The expenditure of money is targeted at the patient or at our home care clients, not at the providers. That's called patient-based budgeting. It's what we promised in the Common Sense Revolution. In simple terms, it means putting the needs of the patient above the needs of hospital administrators, above the needs of doctors, union bosses and others in the health care system, including politicians.

We are moving into the new millennium. Until recently, our health care system was attempting to impose solutions of the 1900s on the problems of the 21st century. But new challenges call for new solutions, solutions which meet the needs of patients now and in the future. Our government is working with health care providers to find these solutions.

We have made the shift towards the future, and I believe the people of Ontario, and ultimately that means all of us, will be the better for it. Thank you for your patience.