



“Change Is Inevitable and Desirable”: An Interview with Ontario’s Minister of Health and Long-Term Care

Peggy Leatt, our Editor-in-Chief, caught up with The Hon. Tony Clement, Minister of Health and Long Term Care, as he was driving between engagements. Between launching Arthritis Month by presenting a \$500,000 cheque and heading to the Ontario Hospital Association’s sixth annual forum for CEOs, he spoke to us on a cell phone (but not driving) from somewhere on an Ontario highway.

Thank you for speaking with us; we’re really excited about the opportunity. It’s my pleasure to meet you – verbally at any rate.

In your role now as Minister of Health and Long-Term Care, has your sensitivity to the social determinants of health changed given your work in past portfolios?

Thank you for asking that. You know, I’ve been blessed in a sense with all the portfolios, including Transportation, in which, on the safety side, there’s obviously some healthcare impact. Certainly when I was Minister of the Environment the connection between environmental degradation and the effects on health, be it cancer or asthma or cardiovascular, the connections were very clear. So that really sensitized me to why an aggressive stance on improving our air, water and soil was important for future generations. As Minister of Municipal Affairs and Housing, I became interested in the connection to health and cities, specifically the way we plan and run our cities relating to healthcare. I recently attended a meeting of Hazel McCallion, who’s the Mayor of Mississauga. She had a World Health Organization (WHO) meeting on health and the cities, as that organization has a secretariat on urban environments and connections to health. And that makes sense when one looks back historically, as the transmission of many diseases started when people congregated in cities and the passage of germs became simple because of density. When domesticating animals, diseases leapt from species to species, and all of a sudden you’ve got smallpox, or influenza and so on. So clearly the evolution of cities and public health is inextricably linked together, and I think we’ve learned from that.

That’s why I looked at the flu vaccination program, which is second to none in the world and has been recognized by the WHO as such. We can show some demonstrable improvement. Some of our statistics are incredibly positive. Last year, the incidence of influenza in nursing homes declined 97%. That’s an incredible statistic. You can talk about flu strains and severity and so on, but when you have a number like that, it’s very clear that universal vaccination has a huge impact on influenza.

I’ve been very blessed with my past portfolios because they all seem to connect with my present

portfolio, and I believe it’s helped sensitize me to connections that exist. In the government, you have silos so often, which makes it difficult to make progress. I’ve been able to see some connections early on in my political life.

The Romanow commission will be very important, and in getting input across country what three things would you want him to know from Ontario?

He’s got a different time line than we do – 18 months to two years, which I think is significant. A lot of these issues are bubbling up and perking right now. We sent out a healthcare questionnaire to every household in Ontario – I think it’s 4.4 million households over the summer – and we’re still getting responses back. What will be conveyed to the federal commission will be animated by the kinds of things we get back, and we’re in the midst of tabulating right now. Our perspective has always been that this is a joint provincial/federal responsibility. The Canada Health Act has always said it’s a responsibility, 50/50, when it came to financing, and right now federal financing is 14%, so we said one thing on the table is appropriate federal financing. In the past two years we’ve increased hospital funding by more than 20% and last month I announced an annual increase of \$450 million for hospitals. But with a health budget of \$23.5 billion this year, that’s up \$1.2 billion from last year, so spending will once again rise faster than the economy. We do applaud his willingness to think outside the envelope and look at all potential solutions. I think that’s the kind of creativity we need to have for a healthcare system that’s going to expand to meet the expectations of the public in the years to come.

Ontario should be proud and broadcast the work being done on hospital reports cards; this is an initiative the other provinces have not done much work in.

I discussed this in Victoria at the Premiers’ Conference in August. There were three health ministers from other provinces and we had a very good discussion. I was able to share copies of the report card format provided in the daily papers. Since the report is a measure of hospital accountability in terms of peer-based performance improvements, there was a great degree of interest – in the format, methodology and collaborative, cooperative initiative of which we all have a part. We all take ownership, and feedback from the public is that there’s almost a hunger for this kind of information and knowledge. Is it perfect? No, I’m sure there are some improvements that can be made, but it’s more knowledge than we all had a year ago.

Have you had any negative feedback from the boards of trustees, especially in the rural hospitals?

I think there’s a bit of sensitivity to it, which is understandable. As you know, 88% rated the quality of their care as “excellent,”

and 90% rate the skill and courtesy of those health professionals at the bedside as “excellent” or “good.” I was very careful to point out this was a relative scale and perhaps hard to understand. You could have four stars with 84% and three stars with 80%. Suddenly, if you’re at 75% you’re at one star, so perhaps it can be better explained next year. All these hospitals meet rigorous standards and oversight, but it’s a question of relativity – because there’s no single universally accepted benchmark to measure against. Even if you’re superb by many other calculations, it might appear that you’re a one-star hospital and therefore there’s something wrong, so I think we can get that message out a bit more lucidly next time.

I’ve done some work in Regional Health Authorities. Other provinces have been putting them in for the last decade, and Ontario hasn’t gone in that direction. Have you given thought to more decentralization of accountability to local authorities?

I think the jury is still out, quite frankly. When one looks at some of the other provinces and the challenges faced – Alberta comes to mind – I’ve not seen a diminution of challenges because of Regional Health Authorities. On the other hand, there are advocates who see it as a way to integrate health delivery, at a regional level, such as making sure mental health delivery is connected to hospital delivery which is connected to home-care delivery and so on. There are pluses and minuses, and it’s one of the things we’re seeking some advice on in our review of what people are satisfied and dissatisfied with. I think it’s important to not just have central decision-making – after all, there are hospital boards that are independent of the government of Ontario. To say that ours is completely centralized is an inaccuracy as well. In some jurisdictions it’s the national or the local government that actually appoints the hospital boards, and we don’t have that system. Having said that, that’s one of the issues on the table. But in our perspective, more discussion has to take place.

In the work I’ve been doing, the only definitive commonality is that RHAs can deflect questions and criticisms about health-care from the provincial government.

I don’t think that happens, though. Do you think Ralph Klein is off the hook because he has RHAs? I don’t think so.

No, I don’t think so either, but it’s interesting, as that’s how RHAs are being perceived.

I think the politician who believes that is whistling in the wind. Ultimately, the buck stops with the paymaster, and there’s always historical responsibility of the provincial government to ensure the efficacy of the system. I don’t think that will change with RHAs.

Ontario’s been at the forefront of primary healthcare with community health centres and health service organizations, but it’s going so slowly. Is anything planned to speed it up?

Yes. We’re at the stage now where I’m expecting something of our progress in this area. We’re in the final stages of working out contractual arrangements for physicians in the Ontario Family Health Networks – what would be the expectations and how they would deliver care and so on. Once you have that contractual template you’re off to the races, and we’d like to see at least 80% of family doctors join these networks by 2004. We’re also working on telehealth, IT components and “smart” systems for health, so those are pieces of the puzzle that I expect to come into place this fall. It’s a priority, and we’re going to make it happen. Community health centres can still be part of that, I believe. We’re going to find that not every community has the critical mass necessary to have a roster of doctors and patients, but certainly there’s a big role to be played by CHCs as well.

Private sector involvement with healthcare – is there any movement?

As you know, we have a mixed public/private system already – our doctors are private sector deliverers of publicly funded healthcare and half of our nursing homes operate that way. There are lots of examples in our system and I think that will continue to be the case. The measurement I’m always interested in is if a private sector deliverer of publicly funded healthcare has an idea, we’re going to judge it by: Is it faster, is it safer, is it cheaper, is it better? If it is faster, safer, cheaper, better, then we’re interested: if it’s not, then I think we’re not interested. So that’s the measurement by which we judge these things; it’s a very pragmatic measurement, not an ideological template. It’s merely pragmatic: Can we get better healthcare out of this? Our opponents on this issue are very ideological about it – they seem to be unconcerned about whether something works better or not; they judge it merely by whether it is delivered privately or through the public sector, and I think that’s a mistake. Healthcare is too important to be driven by ideology, but that appears to be the agenda of some of the people opposed to the consideration.

Have you any thoughts about problems in human resources, such as shortages in certain physician specialties and nurses?

On nurses, the good news is there’s been a marked and significant increase in applications to nursing schools, upwards of the range of 20%. So that’s a good sign the nursing profession is a desirable profession and women and men are treating it as a career option. I expect that to continue to be the case as we stabilize the nursing environment through our injection of \$375 million a year for nursing recruitment and retention initiatives in hospitals and other healthcare facilities. I think

that’s having an impact, judging by the nursing report that came out last month. So that’s all good news.

As you know, we have a physician shortage in certain areas. If you look at it per capita, overall there isn’t, but in some areas there are a lot of physicians and some areas are underserved. That’s not unusual. There’s a worldwide shortage of some specialists, and every country in the world is trying to attract physicians. We’re faced with the same challenges, and I think our initiatives this year – responding to the McKendry Report, significantly increasing foreign-trained professionals who are going to be considered for certification, [extending] our programs for physician retention in Northern and rural Ontario – this all has been a priority. With 40 new residency positions and community development officers for underserved areas and \$4 million in tuition and location incentives, there’ll be an impact. Of course, when we get the new medical school going in Northern Ontario, over time that will have a significant impact, as well as with the rise of e-health and e-learning.

Another issue getting more publicity is medical and health system errors. We had an issue of *Healthcare Papers* highlighting this. Many countries are changing the term to “health systems errors” so we don’t make the medical associations feel we’re attacking them. Do you think this is going to be a more important issue?

I think it is an emerging issue. It’s generating a lot of interest in Britain and the United States and there’s a growing understanding of costs in human and societal terms. Of course, it affects the whole profession and how the medical profession is held up to the public light. I expect that this issue is going to gain in prominence. I know the Ontario Medical Association has some task forces looking at this issue, but I expect we’ll be part of the public debate on this in the future. This is not about blaming a particular individual or profession – health systems are very complex beasts, and unless one is mindful of that and has fail-safe mechanisms, the system will create human error. We have to be mindful of that and have to be smarter in the way we construct our healthcare systems to really cut down on the possibility.

A problem I hear from some of the smaller hospitals is that physicians in rural areas are holding the hospitals for ransom in demanding so much more money, with some funds coming out of the global budget. This doesn’t seem like the right solution.

We’ve been discussing this in the Ministerial Hospital Advisory Group that reports to me and is made up of representatives from hospital boards and administrators. This is one of the issues where hospitals can be their own worst enemies in leapfrogging each other in trying to retain staff. But it’s a problem that hospitals have to grapple with, I agree.

Another challenge is in physical facilities. Ontario has invested capital spending to upgrade and modernize, but some communities have difficulty raising the percentage they have to come up with.

I can tell you there’s a lot of communities out there I’ve been to – London, Peterborough and communities like that – there’s either been a general acceptance to put the community contribution on the property tax base, or they’ve been able to tie into corporate sector and fundraising abilities. There are solutions out there. From my perspective this has always been part of the contribution, and there’s a good reason for that. It means the community has a stake in their efforts, and that’s an important aspect of accountability. I think the communities will be able to see there are ways to work through this and move ahead.

Last question. You’ve been in the job for seven months. What’s your vision for healthcare?

Of course, we have a lot to be proud of in our publicly funded health system. We’ve seen through the hospital report card initiative, and there’s a high degree of satisfaction generally with care provided by physicians and hospitals and other caregivers. Having said that, we have a challenge. There are

things that need to be improved in our current system, and even to retain what our current system provides is increasingly a challenge as utilization rates go up, our citizens age and long-term care needs increase, as wonderful new medical procedures and wonder drugs come on line that are amazing in terms of our quality of life, but nonetheless cost money – all these things are challenges to the system.

To expect that the system will provide all that we expect of it – and expectations only go one way – in the years and decades ahead, without any changes whatsoever, is expecting too much. So change is inevitable and desirable not only to meet the new changes, but also to preserve the excellence that was already in the system. We can’t continue to increase health spending at the current rate, since by the year 2015 health would consume our entire budget. So responsible choices and tough decisions are needed, not merely to sustain, but to save Canada’s healthcare.

Thank you Minister Clement – we hope we have an opportunity in the near future to check in with you on the progress.

Of course, thank you. It’s been a pleasure. ☞

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