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| Ontario | 30e | 4e | Discours sur la santé | 14 novembre 1977 | Dennis Timbrell | Minister of Health | Progressive Conservative Party of Ontario |

Thank you very much, Mr. Chairman. I must say, at the outset, that since ours is a fairly large ministry with a large number of programs, I will ask for the co-operation of the committee in keeping to votes and items so that I can keep the number of staff here to a minimum; otherwise, if I have to have people here to anticipate questions in all the areas of the ministry's budget, we would fill this committee room and that I don't want to do.

Mr. Chairman, it is my pleasure to present the Ministry of Health estimates for 1977-1978 to the committee today.

It has been several years since the Ministry of Health estimates have been reviewed in committee and, of course, it is the first year in which I have been responsible for them. For this 'reason and because several new members of the House are committee members, I wish to initiate this debate with a brief outline of the operational philosophy of my ministry.

Also, Mr. Chairman, at various points in my discourse I shall use some slides to illustrate what I am talking about.

We live, as we are abundantly aware, in changing times, and few areas of public service have been affected more in these circumstances than our health care system. In only a few years, we have seen dramatic changes in philosophies of the responsibilities and duties of government to its citizens. In the health care area these changes have defined and developed an increased, and still increasing, expectation of a very highly sophisticated health service.

It is not unrealistic to state today that health care is now considered to be a fundamental right of all citizens, and that right is predicated on medical necessity regardless of personal financial circumstances. While this may be an obvious truth today, it was not always so, indeed, it has become truth only in the course of one generation.

I must acknowledge that it is my conviction that the Ontario health care System will stand favourable comparison with any in the world. Our task now, in this continually changing world we live in, and certainly our immediate responsibility in my ministry in 1977, is to provide and maintain high health care standards while we contain costs within realistic and affordable parameters.

 This means to me that, while in the past we turned out attention primarily outward to the building of the health care system in Ontario, we have now turned at least some of our attention inward to the operating and refining of the system itself.

We are taking initiatives in the areas of operating efficiencies, cost control and manpower control. We are reviewing our procedures regarding institutions, mental health, localized planning and underserviced areas. We are continuing our deep commitment to increased community involvement and decision-making through the establishment of district health councils. And we are dealing with the problems of over-utilization of the system.

I will have more to say on these subjects later, but now I would like to give you some of the facts, figures and plans of my ministry for 1977-78. As a preface to the debate an these estimates of 1977-78, I believe it is worthwhile to briefly recapitulate some of the changes that have affected the health care system in Ontario.

Regarding health care expenditures-the new federal-provincial agreement, which came into effect an April 1, 1977, of combined tax points and cash to Ontario, reflects ideas which our government has put forward over the past decade.

Rigid adherence to federally-dictated programs, or program content, is no longer demanded to ensure the federal funding. This will allow the demonstrated effectiveness of individual health programs to have a greater bearing on continued funding rather than forcing an emphasis on institutional care, as has been the case in the past. If we can see some way of spending less on some kinds of services, we can do so without being penalized in the contributions we get from Ottawa. In other words, we have more flexibility now than we had before.

 As I noted earlier, Ontario health services have reacted to the changing lifestyles and the resulting changing needs of people like these in communities throughout the province. The government’s role in the health care system, as we know it today, has developed in less than 20 years. Prior to 1959 the functions of the then Department of Health were primarily concerned with institutions the operation of Ontario psychiatric hospitals, and facilities for the mentally retarded. In addition, they covered the coordination and rewriting of certain health oriented Acts, and the provision of public health services through local hoards of health.

On January 1, 1959, however, the Ontario Hospital Services Commission came into being and the emphasis of health care in Ontario changed to improve accessibility and help to those who need it. Hospital insurance became available to all the people of Ontario. In 1961, home care service became a facet of the health system. Later, I will have more to say on recent initiatives in this area.

In 1962, emergency outpatient coverage was expanded under the health plan; and in 1964 this was expanded to include rehabilitation services such as radiotherapy, physiotherapy, occupational therapy, speech therapy and others.

In 1966, Ontario residents were able to insure all physicians' services under the Ontario Medical Services Insurance Plan; and three years later the Ontario Health Services Insurance Plan was established to provide universal medicare.

In 1972 the medical and hospital insurance plans were fully integrated into a single plan-OHIP, the Ontario health insurance plan. Health insurance premium rates have followed the upward trend. For 1977-78, premiums are expected to total $815 million, or approximately 21 per cent of the $3.8 billion estimates. Benefits, of course, have increased substantially 'and are constantly under review.

There have been other significant developments in the health care system. During the 1959 to 1977 period, the philosophy of mental health treatment underwent considerable change. These changes were mostly in social attitudes toward the mentally ill. Major advances in chemotherapy during the 1950s also played a critical role in making mental illness more manageable. Emphasis was increasingly put on community-oriented rehabilitation. Local programs and clinics took over many of the services of the large, monolithic institutions of previous years.

The implications for the health care system were immense. Huge buildings became anachronisms and many more skilled therapists were required. As an example of this trend, the homes for special care program was introduced in 1964. I will deal with this program in more detail later.

This was a period of rapid economic and population growth in Ontario, and the health system struggled to cope with its changing and burgeoning role. Public health services became much more numerous and complex. Some of the initiatives taken in this 18-year period included programs in vaccination and immunization, waste management, private sewage disposal, dental services, school health services, air pollution control, pesticide control, family planning, alcohol education, encephalitis control, exotic diseases control, and many more. Some of these activities have now been transferred to form the nucleus of programs in other ministries.

To put this program in perspective, I would like to give some statistics on the dimensions of health care in Ontario. In 1970-71, Ministry of Health expenditures amounted to $214 for every man, woman and child in the province; in 1973-74, the figure rose to $375, and in 1977-78 it is expected to be dose to $450.

Infant mortality rates appear to indicate a progressive improvement in the health status of Ontario residents. Infant mortality, for example, has dropped from 15.3 per 1,000 in 1971 to 12.8 today. At the other end of the scale, life expectancy at birth has generally increased since 1931, from 60 to almost 70 for men, and from 62 to 77 for women; so we may expect increasing demands on the health care system.

In October of this year, Ontario doctors treated approximately 2.7 million patients, which represents about one-third of the entire population of the province seeing a doctor once a month. It also represents an average annual increase over four years of seven per cent, a rate of increase which would result in a doubling of total claims every decade. This utilization of the health system is one of the most important concerns which my ministry is addressing.

In recent years, hospital bed occupancy has decreased below the generally accepted standard of 85 per cent. As you can see, the average length of stay in an active treatment bed was just over 10 days in the 1960s, while in 1976 it had fallen to 8.1 days. This trend may offer the opportunity to provide further efficiencies in the system.

In the often-publicized area of the number of physicians available to serve Ontario residents, the ratio has changed from one physician for every 602 people in 1973 to one for every 567 in 1977. The average annual attrition rate for physicians, from all comes is only three per cent. Despite immigration controls instituted two years ago, it is expected that by 1985 there will be a doctor/patient ratio of one to 540.

I believe it is appropriate now to give you a brief explanation of the organization and the operational highlights of my ministry. To simplify things enormously, the Ministry of Health operates in these organisational segments: the main office, administration and health insurance, institutional health services, and community health services. The last three are charged with the responsibility of the three basic programs of the Ontario health services.

The ministry underwent a number of organization and program changes prior to its organization in its present form. Today, it combines what I would term a humanistic concern for one of the fundamental social services of government, with the responsibility for management of what is one of the most significant industries in Ontario.

Our emphasis has shifted within the last five years from a process of funding growth to one of increased planning and control of a total $3.8 billion health budget.

Main office is responsible for policy and overall administration of the ministry. In addition it liaises with such bodies as the Ontario Council of Health, the Alcoholism and Drug Addiction Research Foundation, the Ontario Mental Health Foundation and the Ontario Cancer Institute, to name just a few.

As one example of this liaison, our staff works with the Ontario Council of Health which was established in 1966 as the senior advisory body on health matters to the minister and to the government. The council's role is both informative and influential, its work thoughtful and useful. For example, it advises on a co-ordination of health services, techniques of long-term planning, health resources development and maintenance and health manpower requirements. It has produced for us a number of most valuable reports.

Also included under main office responsibility is the management development program, the affirmative action program and the legal branch.

Finally, in the main office grouping we have the strategic planning and research function, which deals with clinical, applied, operation along other health research. Over the past year this branch has played an important role in initiating and sponsoring innovative extramural health care research and development projects. It has played a leadership role in long-range health planning activities of the ministry and it has contributed to a major study of the health research requirements of the province over the next decade. It has continued to support the project and task force needs of the ministry and the Ontario Council of Health.

Now a few words about the money we have lately been providing for health research from the proceeds of the provincial lottery. Out of the first $25 million available from the Provincial lottery, my ministry is responsible for $15 million. We are allocating our portion according to four principles: 1. Money is to be used for research and development and not for service programs; 2. Funds are to be spent in such ways that we are assured of demonstrable results within three years; 3. All applications must be subjected to established review procedures and the bodies concerned have strong representation from organizations outside of the government; 4. The funds need to be used as far as possible to strengthen existing research and development programs; this is particularly applicable because the funds have been allocated to us on a one-time basis.

Let me give you some examples of the application of these funds. A total of $3.7 million has been awarded in black grants to provincial foundations, cancer, mental health, addiction, the heart foundation and the ministry's health research and development grants program. Another $1.8 million in black grant funds is open for competition among eligible research agencies. A total of $5 million is being directed into major capital facilities, of which $3.5 million has been awarded to the new Ottawa Health Sciences Centre General Hospital.

Another $1 million is earmarked for research equipment for health sciences complexes; $.5 million is open to all universities for equipment acquisition; $1.75 million will support two senior research pasts at each of the five health science centres; $5 million has been .allocated to the health sciences complexes for research and development; and finally $750,000 is allocated for research and development projects by Ontario's district health councils.

 I would like to give you a financial perspective of the three program areas of my ministry. As you can see, administration and Health insurance, together with the main office, accounts for $1.1 billion of the total health care estimate and 23.3 per cent of total staff. Institutional health services requires $2.6 billion and employs 73.9 per cent of our total staff. Community health services, where many of our current initiatives are, is estimated at $119 million with 2.8 per cent of total staff. I will deal with each of these programs in detail in a moment, but I believe it is significant to point out here that my ministry has been accomplishing its tasks over the past four-year period with a reduction of almost 800 in staff.

 I would like to turn now to a short review of the three major programs of my ministry. First, administration and health insurance. Briefly, this program provides many of the necessary administrative support functions to the ministry such as personnel, communications, financial and supply services. Also included are the administration and transfer payment costs of OHIP and of the Ontario drug benefit plan.

 I think it is appropriate here to recapitulate far you what OHIP is today. It provides a wide scope of benefits for medical and hospital services, as well as additional benefits for the services of certain other health practitioners. All residents, regardless of age, health, or financial circumstances are entitled to participate. OHIP is Organized under a general manager into three branches-enrolment, insurance claims and professional services monitoring.

 Some of the highlights of the past fiscal year will show you where OHIP stands today. A total of 8.3 million residents are insured under the OHIP plan-6.8 million under the family plan, and 1.5 million single certificate holders, of these, approximately 2.7 million people are treated each month, about one third of all residents. A total of 53 million claims were processed last year, an increase of 60 per cent aver five years ago, which represents 250,000 every working day, an average of over six claims per person per year.

Over $900 million will be paid in medical and other claims this year, while administrative costs are running at a modest five per cent.

I believe we can be proud of this accomplishment when we recognize that claims processed have been increasing at an average rate of seven percent per year, while administrative improvements have allowed our OHIP claims staff to be reduced at the same rate.

A few words about costs maybe appropriate at this paint. Today OHIP insures almost all of Ontario residents far hospital and medical services. The ministry also funds, wholly or partially, most other components of the health system. Growth and service have been dramatic. So has cost. Ontario’s expenditures an insured health services have more than doubled in the past five years.

Through our administration, particularly our insurance claims branch, our auditing branch and our professional services monitoring branch, we are well positioned to monitor and to detect cost irregularities which may arise with respect to these claims. In addition, the College of Physicians and Surgeons has a well-established medical review committee. It has the right to inspect the practice of a physician or practitioner referred by OHIP If it appears that individual claims, or more commonly patterns of practice, are out of line with the practice of peers.

There are also review committees for each of the other disciplines: optometry, dentistry, chiropractic and chiropody. These committees make recommendations to the general manager of the health insurance plan concerning each referral, including recovery of funds where it's appropriate.

The great majority of health care professionals is doing an efficient, honest, conscientious job. If this were not so, we would not have the first-rate system we have in Ontario today and the confidence of its users.

 One other important recent initiative is our drug benefit program, which comes under the drugs and therapeutics branch. This program has three essential components-drug testing, drug benefit and Par cost. The drugs and therapeutics committee, through its testing program, has established standards of practice for all levels of the pharmaceutical industry, from the manufacturer to the community pharmacy. Drug benefit provides essential drugs to about 1.2 million Ontario citizens, including 800,000 residents 65 years of age and over, plus 400,000 persons receiving assistance under the Family Benefits Act and the General Welfare Assistance Act.

The third component of the program is Par cost Key to this component is the drug formulary, updated semi-annually and distributed to physicians, pharmacists and dentists, as well as to hospitals throughout Ontario. The drug formulary lists 1,700 products which are provided free of charge when prescribed for eligible recipients. In addition, the formulary is used in other provinces. Saskatchewan and New Brunswick adapt the formulary in terms of their individual-drug benefit programs. British Columbia regularly purchases a number of copies for distribution to physicians and pharmacists as a basic information source.

Here are a few highlights of the overall drug benefit program: A total of 1.1 million prescriptions are processed each month, which represents 11 prescriptions per year for each eligible person. Since substitution of the lowest-priced drug is mandatory, the program has kept the average price for a prescription to $5.15 compared to $5.50 far prescriptions purchased by cash paying customers. The program also provides assurance of high quality standards for interchangeable drugs, which enables bath physicians and hospitals to select less costly products with confidence. The end result of this program is that citizens of Ontario benefit from lower prescription prices for products of the highest quality. This brief review capsulizes some but by no means all of the activities and the initiatives of the administration of the health insurance program.

Next I would like to deal with the institutional health services program of my ministry which is organized into three basic divisions. In addition, licensing and inspection services are provided through the inspection branch. These include the services of nursing home, x-ray, and laboratory and specimen collection centre inspection.

As a component of the laboratory inspection services, in 1974 and behalf of the ministry, the Ontario Medical Association started the laboratory proficiency testing program to ensure the quality of laboratory services. The laboratory systems division is the information resource to the ministry and the health agencies in the community. It provides data resources to the ministry at all levels of the health care sector. The division is also responsible for the computer systems required for administration and operations. Included in the direct services division are laboratory ambulance, and psychiatric hospital services.

As I mentioned earlier, we are now shifting the emphasis in psychiatric care away from the institutional setting to the community level. This initiative has resulted aver the last 10 years in the reduction of the number of patients in psychiatric hospitals from about 10,000 to 4,300.

An example of this shift in emphasis is the homes for special care program. The program itself was first introduced in 1964. Its goal was to relieve the overcrowding in Ontario psychiatric hospitals, and in mental retardation facilities, by placing these patients as residents in nursing homes and residential homes when they no longer require active psychiatric treatment and institutional care.

The program uses the services of field workers and social service workers, who take the responsibility of selecting and placing of residents, as well as assuring that ongoing care is appropriate for each resident.

In addition to our regular ambulance services, we have an air ambulance capability.

As a part of this service we are conducting a pilot project on a new helicopter ambulance. We will be evaluating this service from the standpoint for its benefit to people and its cost. A special study will be done during the coming 12 months, and the future of the helicopter ambulance will depend largely on an evaluation of that study.

The third area of the institutional health services program is the institutional division. This division assumes responsibility for the funding of all public hospitals, private hospitals, crippled children's treatment centres, rehabilitation hospitals, cancer clinics, and Red Cross hospitals.

As part of its function, the division equitably assigns and manages allocations available to these institutions, both for their operating and capital expenses. It assists them to live within the amounts committed by the ministry. It oversees the development of new programs and facilities, handles capital construction grants and loans, and provides advice on the construction and operation of the facilities.

In line with other regional approaches, we've reorganized to develop management teams of ministry staff for the five regions of the province as well as the teaching hospitals.

The current maintenance rates for these residents range from $23 per day in nursing homes to $9.85 per day in residential homes. This provides a substantial saving over care in larger institutions. But perhaps even more important, the program makes possible a more appropriate setting for the residents.

 In addition to daily maintenance rates, the ministry also ensures that residents in nursing and residential homes are provided with medical, dental, ophthalmic services and clothing. The number of residents in the homes for special care program was 7,481 as of October 1977.

Ambulance services is another important initiative of the institutional health services program and is highly valued by all communities. We maintain direct operational control of 10 ambulance services throughout Ontario and oversee 186 others. We also provide a consulting role to various client groups which include hospital, volunteer, and municipally-operated services.

 The Ministry of Health, in collaboration with the Ministry of Colleges and Universities, has developed training programs in ambulance and emergency care. These programs are at present being offered full time in eight community colleges, and part time in 18. The ministry is also encouraging the development of district ambulance services using a central communications centre and satellite ambulance stations. This ensures better utilization of ambulance resources to obtain maximum emergency response capability.

To give you some perspective on the ambulance services program, almost 541,000 calls were serviced in 1976. Naturally response time rates vary according to distances covered. In a typical mix of urban and rural committees such as south-western Ontario, over 96,000 calls were handled, with an average response time of 10.4 minutes.

The team concept has been well accepted by the hospitals partly because the hospital administrator, financial officer, dietitian, or director of nursing is able to relate to someone on the same organizational level.

The team concept also eliminates the problem of one-person assignment to a hospital or agency. Formerly, if this one person left the ministry, the agency felt cut off. Now it deals with a team which is up to date on current problems.

 The teams respond to inquiries from institutions quickly and appropriately. They assist the division to implement objectives, provide consulting services to the institutions, and discuss with the involved hospital areas in which it appears to be out of line. They even review hospital bylaws, and after any necessary discussions with the hospital, present the bylaws for approval.

The teams also assess proposals for new programs and operating cost implications of proposed construction or renovation projects. They seek to thoroughly understand the institutions in their areas, so that they can assist in the management and control of the institutional health care system in the province.

A quick review of recent accomplishments in hospital facilities is appropriate here, because, even with our restraint program, we have been able to provide new services in a number of areas.

Some examples include: a scanner at London Victoria Hospital; development of the trauma centre at Sunnybrook Hospital; expansion of a neo-natal unit at the Hospital far Sick Children; development of a pacemaker implant unit at the Mount Sinai Hospital; opening of a cardiac care unit at Ottawa Civic Hospital; expansion of the Princess Margaret Hospital in Toronto from 170 beds to 216 beds; expansion of chronic care facilities at Hamilton, Brantford, Cambridge and Windsor; expansion of in-patient and out-patient psychiatric programs at Coderich, Stratford, Woodstock, Timmins, Toronto and Ottawa; opening of the Queensway-Carleton Hospital in Ottawa; replacement of existing hospitals by new, modem facilities in Midland, Atikokan, Kirkland Lake and Chapleau.

During the past few years, there have been a number of attempts to restrain the number of dollars spent in the institutional sector of the health care system. We seek a reasonably balanced system of health care in the province, and we intend to focus on those institutions where efficiencies can be realized, and where there is still room for saving dollars.

In doing this, we are using many methods including making more efficient use of our resources; closing excess hospital beds; amalgamating services; changing staffing patterns; introducing other cost-saving measures, such as increased emphasis on day surgery. Our aim in these procedures is efficient performance coupled with prudent expenditure.

Now, I’d like to give you a quick look at the way people are using our hospitals:

Although there has been a steady growth in the number of hospital beds for all levels of hospital care, it is worth noting that the number of active treatment beds is decreasing.

Conversely, there has been an increase in the number of beds for chronic care patients.

Although more people are being admitted to hospitals for their care, they are staying in our hospitals for shorter periods of time. In fact, hospital days of care have been decreasing over the past six years. In 1977-78, we are continuing to work with hospitals to find acceptable ways of reducing the average length of stay for their patients.

We must recognize that while a standard ward bed in a hospital last year cost an average of $128.95 per day, the per diem cost for nursing home accommodation is $23, and the average per diem cost of home care is $11.01.

These figures indicate that we must place an increasing emphasis on selecting the most appropriate treatment setting for individual patients. In addition, the alternatives to confinement in a hospital often meet the health and psychological needs of a patient in a more positive way, and serve to accelerate recovery. I'll have more to say about one such alternative a little later.

Community health services is the third of the programs comprising my ministry. The community health services group has the responsibility for the development of policies and programs which will ensure the effective delivery of care in the areas of public and personal health. It is also responsible for health manpower planning, the co-ordination of health disciplines, the implementation of programs for preventing disease and disability, and the major development of district health councils.

May I stress at this time that community health programs for the promotion of healthful living and the prevention of illness have a growing priority with this ministry. Our programs have already played an important role in the history of the health of the people of the province, and they will continue to do so. I think it is quite clear that public health is coming back into its awn. We have a good level of service, but we recognize that in some areas of the province basic preventive services are still thinly and unevenly spread.

To attack this problem, in 1969 we instituted what we called the "underserviced area program," which is designed to provide health care to 176 areas designated as underserviced. These range from Moosonee to Pelee Island. By the end of 1976-77, there were 275 physicians and 69 dentists in the program providing services in 149 rural and isolated areas, particularly in northern Ontario. Nursing stations have been established in 14 other areas.

In addition to providing necessary health care, this program complements activities undertaken in the 'area of health manpower planning. Earlier this year the ministry established a medical manpower advisory committee because the issue of health manpower has become increasingly important due to the over-supply of physicians and nurses.

The committee includes representatives from the College of Physicians and Surgeons, the Ontario Medical Association, the Council of Ontario Faculties of Medicine, the Ontario Council of Health, and the Professional Association of Interns and Residents of Ontario. They meet regularly with government representatives to ensure a common data base and to co-ordinate planning of physician manpower.

The ministry also provides funds for one of the most comprehensive data services in Canada supplying data for the study of manpower needs. It's operated under the auspices of the University of Toronto. Other groups are dealing with specialty manpower nursing requirements.

The objective of our home care program is the reduction of length of stay in hospital, or in many cases, eliminating the necessity of entering a hospital at all. The number of patients in this program has more than tripled since 1971, and while the number of people cared for in the patient days is impressive, the cost per day of $11.01 is far less than for institutional care.

At the community level, the home care program provides services to people in their homes, either in lieu of or following discharge from after-treatment hospitals. There are now 38 local programs, 30 of which are operated by local boards of health and four by branches of the Victorian Order of Nurses. Three are hospital-based programs and the Toronto program is operated by a specially incorporated board.

Services for patients include nursing, physiotherapy, occupational therapy, medical social work, drugs and medical supplies, meals-an-wheels, and homemaking. Not all individual programs, however, provide all services. During the 1976-77 year, services were provided to about 55,000 patients, with an average period of care of 29.8 days per patient.

Three pilot programs in long-term chronic home care services are now under way in the Hamilton, Kingston and Thunder Bay areas. These tests will guide us in the expansion of this service to other areas in the future.

Another initiative to which we are strongly committed is that of area planning co-ordinators and district health councils. The councils are an outgrowth of the concept of increasing community involvement in the planning of health care services on a district basis. Local co-ordination and consolidation, as well as planning for new service programs, are the major activities of the district health council.

There are five area planning co-ordinators, each with his own geographical area of the province. Each co-ordinator has actively assisted in the development and the promotion of these councils. The planning co-ordinator operates as a catalyst, and information source, a focal point, and a co-ordinator of the ministry plans and operations.

Eighty per cent of the population outside of Metropolitan Toronto is now served by district health councils. Councils are made up of volunteers which include members of the professional community, lay people, and local government representatives. A total of 22 district councils will have been established by the end of 1977.

 Among projects the councils have undertaken are: bed accommodation surveys, long-term care studies, rationalization of laboratory services, review of hospital programs for new or expanded facilities, and mental health studies. I am glad to say that based on their findings, the councils have made positive recommendations to ministry, most of which have been acted upon.

Future directions for district health councils will include conducting health service studies on a district basis, developing long-term plans for the district, increasing involvement in co-ordinating services to prevent duplication. They will also be working with other human service agencies in developing plans for health service delivery in harmony with other social services at the district level.

Adult community mental health services are also an activity we provide for people in the local area. We are developing community resources as an alternative to institutional care for psychiatric patients. At present we are considering proposals for the expansion of community support services, day care, and outpatient services.

I believe it is worth noting here that as we attempt to make our system more effective, we expect to find many instances in which health services, and social services, can be more closely co-ordinated, or even combined. For example, in the Ministry of Health, we have many areas of interest in common with the Ministry of Community and Social Services. So, for the sake of humanity, as well as economy, we have a duty to treat the people in these programs as individuals, making sure that their health land social service needs are met in compatible ways without distinction between jurisdictions.

 With this as a background, the transfer of our children's services to the Ministry of Community and Social Services took place on July I of this year. We are maintaining our involvement throughout the transition period to ensure no disruptive effect on the children.

The community health protection branch is involved in many activities. Let me cover just a few. We have the area medical officer service in which our people respond to local inquiries or problem situations in every area. We have contingency plans for the control Of dangerous communicable diseases, including familiar ones like influenza, as well as exotic diseases. We're keeping a close watch on possible outbreaks of encephalitis, infectious hepatitis, and even malaria, which is frequently imported into Ontario.

 We supply vaccines to physicians in private practice and local health agencies for vaccine-preventable diseases such as diphtheria, whooping cough, tetanus, polio, measles and mumps. We at the ministry are concerned about the need for more effort in this area. We are particularly concerned with the need for patients to recognize their responsibilities with respect to immunization.

Control of sexually transmitted diseases is one of our major concerns in the area of communicable diseases. In absolute terms, reported cases of syphilis and gonorrhea increased by 13,047 cases, or 184 per cent, between 1969 and 1976. To help solve such problems, we have 29 special treatment clinics operating in the province where all treatment, including drugs, is supplied without charge. We're also training public health workers in improved control procedures for venereal disease. Patient privacy is, of course, protected in all cases of treatment.

Because of lour concern over the rapid increase in the incidence of sexually transmitted diseases, my ministry is presently considering a number of new initiatives to combat them. There are many aspects of our involvement in public health which are far too numerous and widespread to mention here. To single out one as an example though, we have a dental coach project in which about 3,000 children living in remote areas of the province receive preventive and treatment care through five mobile dental units, with five more planned. These are served by six dentists and dental assistants, with plans for an additional four of each. Much of this work has been developed in collaboration with the Ontario Dental Association. In addition, a preventive dental program is available in 43 health units across the province. The dental coach project complements this program.

 The ministry, on the recommendation of the advisory committee on genetic services, is planning to supplement the staff of the genetic centres in university health sciences centres. If just one case of Down's syndrome can be prevented by this project, over land above the prevention of the impact on the family, the cost savings for the health care system are estimated at $250,000. This example gives you some idea of the possible ramifications of the many projects of this kind which are dealt with under the community health services program.

In concluding my review of community heath services, I'd like to mention the public health review undertaken for us by the Canadian Public Health Association. This work was significantly aided by an advisory committee representing major elements from the health care spectrum. Consultation was wide and discussion extensive. The government will be examining all the issues raised. Next spring I will be in a position to declare policy decisions.

Some of the recommendations which have already begun to be implemented are: The evaluation of health promotion; improving delivery of genetic services; major initiatives for family planning; and, as mentioned earlier, continuing expansion of our well-received home care program.

I have given you a brief glimpse, and unfortunately only a brief glimpse of one of the most active and involved programs of my ministry. You will be hearing much of community health programs in the time to come.

I wish now to focus on my ministry in its current and ongoing operations.

We are striving for a working and practical balance among people' s expectations of the health care system, their utilization of it, the quality of the services it provides and its cost. As I mentioned earlier, we are looking hard at the system as it exists, and we are in the process of making adjustments to provide the best possible service and the best possible value for every dollar spent on health care. Our thrust in this regard will continue in three major directions: De-institutionalization; decentralization; and health promotion and disease prevention.

The move to de-institutionalize the health care process is strong and well-grounded. It is found that patients are happier, more comfortable, and therefore more likely to recover rapidly if they are cared for and treated in their own homes or communities rather than in distant, large, and costly institutions. Other alternatives to hospital care are outpatient treatment, day surgery, home care and extended care in nursing homes. Much has been done already in this area, but much remains tore done.

Decentralization is the ongoing attempt to make more and more of the health care decisions at the community level, where local needs and conditions can be most readily appreciated and acted upon. The objective is to develop maximum service standards with maximum cost efficiencies.

The establishment of district health councils, which serve as local co-ordinators and advisers to the ministry, has been a significant move in this direction. District health councils have been instrumental in developing cost reductions by consolidating services and scrutinizing capital expenditure requests for equipment, construction or programs. They have also been effective in improving patient care and in planning health care services.

The health promotion and disease prevention initiative is designed to persuade people to accept more responsibility for the maintenance and promotion of their own health as well as more effective use of the system, for their own benefit and also for the benefit of the health care system itself, because prevention of overloading or overuse of facilities will result in significant cost efficiencies.

The methods used are most of the tools of modern communications. We use posters, advertising media such as television, radio and print publications, and pamphlets such as these. The subjects covered will range very broadly; they will cover the spectrum of the services and concerns of this ministry.

Some of the most recent and extensive campaigns in this correction have been preventive educational campaigns on alcohol abuse, dental health and venereal disease. This is an age of communication. Some of the most powerful health care aids we can use today are the techniques of communication available to us to encourage people to use the system, but not abuse it.

To sum up, the ongoing thrust of my ministry will be to create a working balance in the health care delivery system of expectations, utilization, quality and costs, with continuing emphasis on de-institutionalization, decentralization, health promotion and disease prevention.

I'd like now to give you a brief overview of the estimates of each of the programs under consideration.

The administration and health insurance program represents $1.1 billion, or 28 percent of the total Health ministry estimates. OHIP and the Ontario drug benefit program represent over 95 per cent of this program's costs. It is significant to note that $915 million, or 96.5 per cent, of the OHIP portion of the program estimate is passed as transfer payments to physicians and other health practitioners. Main office estimates, at $3.9 million, represent 0.36 per cent of the program total.

In 1977-78 the estimated program expenditure increase will be $92 million. Of this amount, OHIP costs will rise $72.4 million, resulting from a population growth of 1.25 per cent, an increase in utilization of three per cent and a provision for an increase in fees of approximately 6.5 per cent. The other major increase of $16 million will be for the drug benefit program to cover a rise in the user ratio from 40 per cent to 47 per cent per month for those eligible, as well as increases in the drug dispensing fee.

An estimate of $1.5 million is forecast for the information services area, while research costs will rise $1 million over last year's estimates. The remaining $1 million in the total program increase is made up of such items as personnel services, audit services et cetera.

 The institutional health services program represents $2.6 billion, or 69 per cent of the total estimates. As you would imagine, the major portion of this amount is for hospital operations, but it also covers psychiatric services, ambulance services and provincial laboratory services. This major segment of the health care estimate is expected to increase $241 million or 10 per cent over last year's budget. Over 86 per cent of this is attributed to the hospital and related services areas.

The community health services program represents $119 million, or three per cent of the total ministry estimates. The estimates for 1977-78 call for 'an increase of $10 million, or nine per cent over the previous year's estimates. In addition to spending reductions in some areas, specific increases include $6 million for home care 'assistance, $4 million for local health agencies, $2.2 minion for various personal health services and a little over $1 million for district health councils.

Mr. Chairman, I thank you and the members of the committee for your attention to the summation of the work and aspirations of the people of Ontario through my ministry.

In conclusion, may I quote a maxim that dates from the year 42 BC. "Good health and good sense are two of life's greatest blessings." I suggest that this is as true today as it was then.

Good health is the hope of every resident of Ontario, and it is the responsibility of my ministry to provide the means to achieve that hope. It is also the duty of my ministry to exercise good sense in the provision of health care services. But I believe it is just as much a duty of all segments of our population to exercise good sense in their demands on the system. And my ministry foresees the possibility that we may not yet have sufficiently addressed ourselves to this question.

This poses a hard dilemma, Mr. Chairman, that may have to be solved in the months ahead. We must begin to temper the most damaging inflation of all, the inflation of our expectations beyond practical means to satisfy them.

We have an excellent health care system in this province, one of which we are all proud. My ministry is determined to keep our standards of health care high. But we are equally dedicated to ensuring that all participants of the system, patients, taxpayers and health practitioners, are contributing and receiving fairly.