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| Ontario | 32e | 2e | Discours sur la santé | 30 novembre 1982 | Laurence Grossman | Minister of Health | Progressive Conservative Party of Ontario |

I am pleased to present the estimates of the Ministry of Health for the fiscal year 1982-83. Any discussion of our health care system should begin with a description of its magnitude and scope.

The 1982-83 budget of the Ministry of Health totals $6,579,000,000. In relation to all activities of the provincial government, health care represents 29 per cent of the total 1982-83 estimated expenditures of $22,777,000,000.

By comparison, the education field is accounting for estimated expenditures in 1982-83 of 22.7 per cent of the total budget, while the entire resources policy field accounted for 18.1 per cent of the budget. As you can see, health care is, by far, our most costly area of government.

To give members a sense of the impact of this system on both the economy and employment, I would point out that the total employment in the health care sector in Ontario is estimated at more than 130,000 people. The Ministry of Health itself employs 10,781 classified employees and we have 230 public hospitals and 10 provincial psychiatric hospitals in Ontario.

The major components that go to make up the total health estimates in 1982-83 are: payments to physicians and practitioners, which account for $1,796,000,000; public hospitals, which account for $3,206,000,000; and other expenditures, taking in extended care, Ontario drug benefits and clinical education costs, which total $1,577,000,000.

Within the whole institutional system, we fund many thousands of beds in various categories of care. As my friend the member for Bellwoods knows, as of March 31, 1982, we had 36,646 acute care hospital beds, 12,869 chronic care hospital beds, 28,686 nursing home beds and 12,911 nursing home beds in homes for the aged.

In the past three years alone, the cost of the health care system has grown by an average 15.5 per cent per year, while the population growth has been an average of less than one per cent per year.

Later I will give you the figures as of December 1; Hanukkah. There are many pressures on the system which could cause it to grow even larger. For example, we face continuing population growth, estimated at 0.6 per cent in 1982-83. This year, we face an increase of 1.8 per cent in the services delivered per physician. In addition, the number of physicians is expected to rise by 2.5 per cent. Consequently, we are expecting a 4.3 per cent rise annually in the volume of Ontario health insurance plan payments. Some services that must grow to meet demands include home care, the funding of assistive devices, community-based services and additional programs to further health care and disease prevention. The application of high technology to medical care is another growing area that will continue to have significant effects on future health care spending. For the benefit of the members of this committee, I would like to take a closer look at three areas that demonstrate how growth pressures will affect the major components of the system in the future.

Hospital funding has increased from $2.1 billion in 1981-82 to an estimated $3.3 billion this year because of hospital spending levels related to work load increases; negotiated increases in staff salaries and wages; the growth of high technology in medicine and management systems; and an increase in the numbers of physicians. OHIP's budget has increased from $1.8 billion in 1981-82 to an estimated $2 billion this year because of the fee increases negotiated with physicians; the increase in the supply of physicians; and the increase in the use of physicians' services. Other expenditures have increased in the fiscal year 1982-83 because of the expansion of our chronic home care program; the initiation of children's assistive devices programs; hospital capital costs; and the costs of community mental health programs.

If one looks simply at one major growth pressure, the elderly, it can be seen that their impact on the health care system in the future could be enormous. Today, the elderly make up only 10 per cent of the population of Ontario, yet services for them consume 35 per cent of the ministry's budget. By the year 2001, senior citizens will make up about 14 per cent of our population, with potential for a very significant increase in health care costs.

As the pressures for growth increase, the funds available to meet those pressures may not keep pace. Not only have we shared with the rest of the western world the economic misfortunes of the past several years, we have suffered heavy cuts in transfer payments from the federal government. When health care absorbs such a large proportion of governmental expenditures, it cannot escape the consequences of the $1.9-billion cut recently made by the federal government in the revenue guarantees under the Established Programs Financing Act.

As all members are aware, health care financing must also compete within government, and within society itself, with a number of other legitimate demands, such as housing, transportation, education, social service needs and environmental concerns. Resources are finite and it is crucial that we do a better job with the resources available to us. The sheer size of the health care system turns that simple statement into a monumental challenge, but one that must be met. As I see it, the fundamental problem is that while the system is meeting many of the needs of the people in Ontario, it is often doing so more in spite of, rather than because of, the way it has evolved. It began many generations ago with an orientation toward institutional setting for the treatment of disease. Times have changed, and so have society's customs and needs, but the system, in that respect, has not changed as much as we would like. The prospect of an unmanageable and unaffordable system in the 1990s is beginning to loom on the horizon.

We still see some hospitals spending beyond their budgets. We hear repeated and often legitimate expressions of dissatisfaction and frustration from physicians. As subscribers and taxpayers, we find ourselves supporting a medical and hospital system that bears with it a substantial, and increasing, financial burden.

It is difficult, time-consuming and demanding to develop a rational, long-term strategy in a situation where society has failed to reach a consensus on what must be done to ensure the proper evolution of our health care system.

Later in this discussion I will detail a number of possible options, but I want to mention some now briefly to provide a sketch of their range. For instance, there are less costly methods of delivering health care in some areas and these methods are indistinguishable in their effect on health outcomes. We should find incentives which encourage these kinds of alternatives.

In general, research and development can provide us with new ways of delivering health care and of providing medical help. We can find many opportunities, particularly in the hospital field, to rationalize services to eliminate unnecessary duplication as well as waste.

Preventive health programs could be stepped up to assist the members of the public to take more responsibility for their own health and wellbeing. This area of prevention and education offers us one of our best chances of developing a truly healthier public while containing our health care costs.

All of these options, and many others, are being explored and we will consider some of them in more detail during the course of this presentation.

Since coming to the Ministry of Health, might I say that I've been impressed by the reservoir of creative talent throughout the system, including my own ministry. As I mentioned earlier, we have in place now what is in my view the best health care system in the world. It has evolved over the years through a consensus among providers, consumers and government. Today it is our responsibility to move that system forward, to improve upon it where we can, to rationalize it, to modernize it and to readjust our priorities.

To accomplish that goal we must develop a consensus among the providers of care, the institutions that have been created, and with the public at large.

Reorganization: Internally, my deputy, Graham Scott, sitting to my left, has just completed a major ministry reorganization. Beginning in February with a realignment of duties among the assistant deputy ministers, the ministry effected a reorganization that was designed to meet the current priorities in health services.

Dr. Allan Dyer was appointed associate deputy minister of health, to concentrate on the public hospitals, laboratories and emergency health services.

To provide a single focus for both community and institutional services for the mentally ill, responsibility for the entire mental health program was assigned to Assistant Deputy Minister Dr. Boyd Suttie. Mr. Darwin Kealey returned from a secondment in Ottawa to become ADM for community liaison and corporate resources, to co-ordinate and enhance the local planning process and the internal information systems that are the basis for long-range planning in the ministry.

In September, in order to continue to meet the broad organizational objectives of the ministry, several additional executive reassignments were announced.

In keeping with my interest in mental health services as a priority area, a new mental health division was established, with two new branches, mental health operations and mental health planning. David Corder, formerly executive director of the district health council program, has been appointed executive director of mental health, bringing his unique experience in local planning to an area that must increasingly involve communities in the delivery of health services. Giah Eisenstein, an area planning co-ordinator from the district health council program, became the director of the mental health operations branch, and will assist Mr. Corder in co-ordinating and directing the activities of provincial psychiatric hospitals and supporting community psychiatric hospitals and adult community mental health programs.

The vacancies in the DHC program and the new positions in mental health planning will be filled as soon as possible.

To provide the corporate group with a focus for co-ordinating major policy directions which have ministry-wide impact we appointed Glen Heagle, formerly of the Ministry of Community and Social Services, and cabinet office, to become executive co-ordinator of special corporate projects.

The policy development branch and the strategic research and manpower planning branch have been combined to create the new policy analysis and research branch, under the direction of Dr. Eugene LeBlanc. This streamlining will ensure an integration of short and long-term planning proposals with the medical manpower objectives and the research initiatives.

Similarly, the functions and staff of the program advisory branch were redistributed through the ministry to provide several program managers with dedicated staff expertise in the areas of professional consultation and project management.

Dr. Gerry Gold, formerly director of the program advisory branch, has been assigned to direct the special study on health service patterns with the new policy analysis and research branch, a task that is essential to the ministry's goal of achieving more effective mechanisms for patient care.

David Bogart, formerly director of policy development, has been appointed as the director of the fiscal resources branch in an executive rotation designed to improve the ministry's ability to bring a policy perspective to the area of financial planning.

Randy Reid, who was director of the fiscal resources branch and who played a key role in the development of BOND, the business-oriented new development program, has been appointed executive director of the institutional services division, where he will further refine and implement strategies to control the cost of institutional care in the province.

To assist him in this undertaking, Andy Boehm, formerly director of the institutional operations branch, has been assigned to the executive director's immediate staff for the purpose of planning a new comprehensive audit program for hospitals and nursing homes. Malcolm Walker, formerly a consultant with the institutional division, has been named acting director of the institutional operations branch.

Another initiative is the amalgamation of the management planning and development program within the human resources branch. This will help to avoid any duplication of effort and provides increased organizational resources to achieve the developmental potential of ministry staff.

Overall, we achieved several important goals with this reorganization: integration of both community and institutional services for the mentally ill; establishment of a systematic process for policy development that provides for a thorough and co-ordinated approach to long range planning and policy direction; integration of technical and professional expertise within program management areas to facilitate information sharing and expand the range of resources available to managers; reassignment of individual executives to positions where priority activities require specialized skills; streamlining of the ministry's support services to staff and managers in the areas of management planning and development; and, finally, increased emphasis on financial controls and data collection related to the institutional sector.

With these organizational changes I believe we are better positioned to meet the challenges and changing circumstances in our health care system.

The new Canada health act: Changes which are now occurring in the health care system are not restricted to demographics, to health care providers, or to my ministry. Because health care represents a cornerstone of our society, changes in health care will require adjustments by all levels of government. The question becomes: can the various levels of government come to basic agreement on what these adjustments should be and how to carry them out'?

The provincial health ministers met this fall to discuss a variety of common concerns, but the central issue was the government of Canada's proposed Canada health act. Let me offer a chronology of the events that brought the proposed federal legislation to this point, because I know this issue will be of great interest to the members of this committee.

You will recall that in November 1981 the federal government proposed in its budget that the national standards for health care be clarified and that a mechanism to ensure their maintenance be developed. The federal government stated then that it would develop this mechanism in consultation with the provinces and would incorporate it in new legislation, the Canada health act, by March 1983.

 In May this year, the federal Minister of National Health and Welfare, the Honourable Monique Begin, outlined the federal proposal on national standards for insured health care and for the new health act. I would like to examine briefly, for the benefit of this committee, a few of the specific areas in which the federal government has expressed concern. These are:

Universality: The federal government now wishes this province to report that coverage is available to all Ontario residents. In Ontario, this coverage effectively exists already. We do not believe that our system of premium payment impedes accessibility.

 Comprehensiveness: In this area, the federal government at first demanded unacceptable rights to dictate to the provinces which types of programs would be insured as health services and how they would be delivered. These early demands have since been reduced substantially to a point where future discussions will probably result in agreement.

 Accessibility: We can find agreement here with the federal position that guidelines are needed to ensure all residents of Canada are entitled to a certain standard of health-related services. Ontario has always accepted and practised the principle of accessibility to adequate health services for everyone.

 Extra billing: This is another area where the provincial government must remain the principal arbiter. Perhaps this area could involve individual agreements between provinces and the federal government, but this sort of negotiation is one requiring much further work, study and consultation with the health care providers themselves. For us it is redundant for the federal government to insist this practice be kept under control because we already keep it under close scrutiny in Ontario.

In August, the federal government released a working draft of more detailed descriptions of the minister's proposals. In September, the federal government released a revised version of the working papers. The latest revision incorporated many of the concerns the provinces had expressed earlier in the summer and at our main meeting with Mme Begin.

 Ontario has no fundamental objections to the basic principles behind the current federal proposals. I believe the federal health minister is well intentioned and has made some valid observations in her statements.

I believe also that in the 10 months following the November 1981 budget and in the four months since Mme Begin's statement, the federal government has indicated significant changes in certain proposals in response to provincial concerns. However, like my fellow health ministers I seriously question the need for the Canada health act at this time, particularly when other areas of national concern seem to me to be of far more pressing urgency for the federal government.

It is my feeling that any difficulties that do exist in the delivery of medicare must be resolved at the provincial level. The provinces are all agreed that we must maintain the necessary flexibility in service delivery and program design to respond to our own circumstances. I feel the federal minister now shares this realization and I am optimistic that the provinces and the federal government will be able to agree on the adjustments all of us will have to make.

While I do not think there are major problems of a national character in the delivery of health care, I do believe the issue of health care financing must be settled quickly between the provinces and Ottawa.

The provincial health ministers' recent statement issued in Vancouver centred on the "sudden and recent fiscal transfer reductions from the federal government" as being the single problem that should be addressed on a national scale. This issue, of course, is the elimination of revenue guarantees in the Established Programs Financing Act.

 My colleague, the Honourable James Nielsen, Minister of Health for British Columbia and the chairman of the Vancouver conference, presented Mme Begin at our last meeting with this message:

 1. That the provinces must maintain the necessary flexibility in service delivery and program design to respond to local conditions;

 2. That any proposal by the federal government for expansion of programs of insured services must be matched by appropriate federal funding;

 3. That the provinces will oppose any attempt by the federal government to infringe upon the provincial right and responsibility to administer provincial health care programs; and,

 4. That there are a number of ways the provinces can raise revenue in order to fund their health care programs and that the choice of methods for financing provincial health programs is a provincial responsibility.

Mr. Nielsen has asked for a continuation of the discussions on the Canada health act. I believe this is the appropriate course of action, because I think our discussions over the past year have been productive. I think a continuation of these talks holds potential for even more progress, because, in truth, while some disagreements have been resolved there are some major areas of disagreement remaining and I hope common sense discussions can resolve most of them.

 For example, we find suggestions that Ottawa will use financing mechanisms to enforce its demands on the provinces as being unnecessary and provocative. In summary, Mr. Chairman, I hope we are beginning to see a shift by the federal government towards an understanding of the provincial position in health care supervision.

 Ontario has suggested that these financial issues be referred to our treasury and financial officials, but so far the federal government shows no sign of being willing to discuss these financial matters with provincial experts. That is unfortunate, but I can only hope their position will change over time so we can get on with the task of properly funding and advancing our health care system.

 Health care at the crossroads: Over the next few years, we must try to develop an overall health care strategy for this province, regardless of what the federal government might do. Any successful enterprise, whether it is a large corporation in the private sector or a major government agency, knows that its ability to succeed depends, in a significant way, upon the time and attention devoted to planning.

Health care in this province is very big business. Every dollar we spend today has implications for the system five, 10 or 20 years down the road. If we do not make a concerted effort to direct the future, then the health care system has every potential to control us, rather than we controlling it. Health care in Ontario currently consumes about 30 per cent of the entire provincial budget; over $6 billion a year. That means we are spending more than $18 million on health care every day.

In the past five years, the Ministry of Health expenditures on health care in Ontario have risen by 74 per cent. If that rate of increase were to continue, in another five years health care spending in Ontario would amount to $4,500 a year for a family of four. That, I submit, would make health care costs intolerable.

 Today we do stand at a crossroads. Longrange planning is therefore under way, as is the identification of new policy options that must be made. Today we are facing many stresses that could threaten the quality of care at a time when our financial resources are levelling out. To cope with these realities, the entire health care system will have to be better and more innovative in its approaches. The way we do things must be subject to careful scrutiny.

 To plan properly, we need the input and support from all health care professionals to provide us with the basis upon which we can build a framework that will give us direction on where and how we are to proceed over the longer term.

As we set out on this task, we are committed to a set of basic principles, including the following:

That our health care system must remain one of the best in the world;

that our resources must be used as efficiently as possible;

that we must ensure access to health care services for all Ontario residents in every part of the province;

that we must also ensure continued access to service for all, regardless of the ability of individuals to pay; and

that we must encourage in everyone a continuing awareness of and responsibility for, personal health.

The health care system contains numerous elements, and each of them presents us with a formidable task of evaluation, rationalization and improvement. For example, is there any social utility in tolerating a system which permits hospitals to add programs and staff if that only results in duplication of services already being adequately provided by another nearby hospital?

Is it time to look seriously at the option for hospitals to meet their demand for services, such as elective surgery, by operating on a seven-day week basis rather than the four- or five-day week which is now normal in many facilities? Can we accept a hospital overspending at the expense of the rest of the health care system?

By the same token, should we be re-examining our own method of funding hospitals? Should we be considering reimbursing hospitals on their type of case load, rather than on a global budget basis? What should be done about the increasing numbers of physicians, particularly specialists, relative to the population? Have we too many elderly patients in institutions who could be receiving more appropriate and possibly less costly care at home?

How do we encourage more actively the establishment of placement co-ordination services, to help place individuals in the most appropriate facilities? To what extent can the medical profession help us control the duplication of high-technology procedures and devices? Must every new program be an add-on? Can tradeoffs help fund expansion or change?

These are some fairly tough questions which I think require our serious consideration. First, the growing number of physicians in our society has created a problem. In 1974, the government adopted a physician-to-population ratio of one doctor for every 585 persons. That is a ratio that provides each person in the province with appropriate access to medical care based upon internationally recognized standards.

If the number of medical practitioners in Ontario keeps increasing, we could reach a physician-to-population ratio of about one to 498 by the end of the century. That would create an intolerable burden on the system's overall costs, without a consequent measurable impact on individual health care.

A second problem area is mental health. The issues here have been brought on by a number of factors and are not unique to Ontario. Deinstitutionalization of the mentally ill has created problems throughout North America. This has been made possible by quite remarkable scientific advances in the control and treatment of mental illness.

Unfortunately, public attitudes and the development of social services have not kept pace with the advances of medicine in this area. Consequently legislation, the medical profession, health care workers, and the entire mental health care system must be reshaped to meet this particularly urgent challenge.

I believe we can develop a more effective mental health care system through careful co-ordination of services by my ministry, by other ministries and by social service agencies.

 A third example is the day hospital concept for the elderly. It is one of the more innovative new ideas in the health care system. There are 15 day hospital programs in the province, which should not be confused with the better-known day surgery programs, now in operation at public hospitals across the province.

In a typical day hospital program, an elderly patient can receive physiotherapy and nursing care as well as participate in social programs on a daily basis for two or three days of the week without being admitted to the hospital for overnight stays.

These are just three examples of the kinds of issues and programs that present us with a real opportunity to reduce demand on hospital accommodations. Policies that will encourage their growth are now in development in the ministry.

There are many other basic questions to be asked about the place health care should occupy in government programs and projects. Some of them are:

Whether the role of primary health care should have a higher priority in the future;

how we can encourage the public as consumers to be more frugal or selective in their personal use of costly health resources;

how we can address the urgent needs of the mentally ill and provide the needed aftercare programs;

how we can reorder our health care priorities and services to the elderly to provide a healthier, more dignified existence for our senior citizens;

whether we can focus our spending on medical and health care research to achieve maximum benefits for our population and for the health care system itself;

whether there are more effective vehicles for health promotion which would encourage greater self-responsibility;

how we can assist our hospitals in providing more sensitive care geared to patient needs; and how we can raise morale within the total system and, in particular, among our primary health care providers.

The development of an overview strategy presents us with a chance to plan now for innovative health care measures. It also presents us with a chance to expand and improve upon the excellent health care components that have already been created.

Some new directions: I would like to turn now to the broader perspective. As I have seen firsthand, there is rising pressure on all sides to select solutions which meet particular interests rather than the real needs of the system as a whole.

 If I may, I will quote a statement made by Professors Lomas and Stoddart of McMaster University:

"When acrimonious confrontation becomes the primary tool for health care system management, it is perhaps time to question the appropriateness of the system's structure, Strategic planning and organization of a multibillion-dollar complex system cannot adequately be conducted in such an atmosphere.

"Those who shout loudest profit most and those who have the least ability to shout unfortunately that refers to the patients-suffer most, Planning becomes subservient to short term pragmatics and the system becomes shaped by the dictates of the professional vested interests rather than by the needs of patient populations. "

We still have to respond to single issues such as the demand for more chronic care beds, to nursing homes that cannot maintain standards, and to the serious needs in the community based health services.

As an example, let us consider the community health centre and health service organization system to which I referred earlier.

This system provides low-cost alternatives to primary care, An expansion of this system would deliver more appropriate short-term care to many, It would also reduce future hospital growth pressures in areas where population trends indicate a need for more hospital services.

By expanding our community based health services in an evolutionary way, we could increase our ability to deliver health promotion and illness prevention programs.

A new system could also evolve around nursing homes, Not only would nursing homes take more patients who now stay in hospitals but a support system of expanded home care and day hospitals would evolve to relieve pressure on the nursing homes.

An evolutionary process of change could address the day hospital concept, hospital funding, research and drug benefits, as well as many other issues raised by some observers who point to what they identify as unnecessary surgery, unnecessary laboratory tests, unnecessary hospitalizaton and overuse of drugs.

This process would allow us time for the careful resolution of some problems, a long-term co-ordinated build-up of resources to tackle others, and an avoidance of dramatic changes which could disrupt the delivery of health care to our citizens.

Developing a consensus: If we are to introduce evolutionary reform within the health care system, there are a number of important obstacles that must be overcome.

The first obstacle is the absence of an agreed upon provincial health plan or design that can be implemented at the local level. At this level, the various health-related services are funded from a variety of sources and this has resulted in a lack of co-ordination of programs.

Although we have district health councils assessing community health care needs, these councils have not had a clear overall set of priorities within which to work, The various local health services are often beset by institutional jealousies and competition leading to inefficient duplication in some communities throughout Ontario.

On the government side, we are determined to improve co-ordination, particularly through the efforts of my colleague, the Provincial Secretary for Social Development. For instance, Mrs. Birch and her staff are providing a forum through which the many health-related services of several different ministries can be co-ordinated, Housing for discharged psychiatric patients, care for the aged and medical manpower planning and training are examples that immediately come to mind.

For instance, the ministries of Housing, Education, and Community and Social Services are working through the secretariat in a communications network that will allow for a greater integration of efforts in those service areas that cross ministry lines.

A second obstacle to change, Mr, Chairman, is to be found in our existing funding policies, To the current centralized formula form of funding, we build in pressures for uniformity across the system whether the uniformity in all locations is either desirable or cost-effective, Within our fee-for-service remuneration system we simply do not provide enough incentive for health promotion or disease prevention.

A third obstacle tied directly to government is the issue of cost containment, To maintain the fiscal health of the province, the government has for a number of years been forced to contain or restrain costs, This has had an impact on all programs and ministries.

However, if cost containment has as its only goal the maintenance of an inefficient system without rationalizing it, then cost containment can perpetuate existing waste, duplication and obsolescence, We must continue to control expenditures by eliminating waste and duplication of services, but we must achieve these cost constraints in such a way that real health needs are met and satisfied.

The fourth obstacle is that we, like most jurisdictions, continue to struggle with finding an effective focus on health promotion and illness prevention.

Ontario has excellent medical treatment facilities. But the most efficient health care system is not provided by advanced technology or physician's services. It is provided by avoiding illness, by the prevention of disease and injury, and by rehabilitation. That is a lesson we have to integrate fully into the system.

A fifth obstacle rests in the attitude of the health care providers. There is often a lack of co-operation, not only between government and the providers, but among the professional groups themselves, and, too often, money issues masquerade as quality issues.

I also admit there is a certain amount of hostility between government and some provider groups. I suppose this is a natural result of the way the system has grown until this time, but it creates a major obstacle to the kind of change we must have and it is an issue that must be addressed.

The final obstacle that must be overcome is the attitude of the public. This area of public attitudes is one we must treat as a priority if we are to develop a process that will shift our health care system on to a more realistic and prudent course. We must develop programs to educate the public on ways to maintain and enhance individual health and we must offer more opportunities for consumer participation in health policy.

For any purpose of renewal to be successful, it is vitally important that all participants in the system have an opportunity to study the issues at hand. to be consulted and to have a forum where their views and opinions will be carefully considered. In this regard, I recently held two policy sessions under the sponsorship of the Ontario Council of Health to explore those questions. The concerns of many groups were brought into the discussions: those of the health professions, health care planners, economists and consumers. Those sessions ended with an agreement that a process was needed to identify the actions that could be taken. We are going to begin in two phases.

I have asked the Ontario Council of Health to convene a three-day policy conference on April 24 to 27 of next year. The council will nominate a group of between 100 and 150 individuals representing such interests and groups as the public, the Registered Nurses Association of Ontario, the Ontario Medical Association, the Ontario Hospital Association, other health care providers and planners and our district health councils. The main purpose of the conference will be to provide me with advice on both broad and specific directions for Ontario's health care system in the future.

I have also asked our district health councils to develop a series of supplementary consultative conferences for local participation in this planning process. These conferences will take place between June and September of next year.

I selected these two groups because the district health councils and the Ontario Council of Health represent the community as a whole and do not act on behalf of any special institutional or interest group. They are, in a sense, the honest brokers in the process and can bring to it a high degree of public participation.

I hope that in this consultative process we will be able to lay aside many of the old antagonisms and jealousies which have burdened our health care system in the past. I hope there will be common agreement among us on how we begin to effect needed change.

I would now like to outline several specific health care issues which have been designated for priority attention within the ministry. This list is, of course, by no means an exhaustive one, but it reflects those areas which already have been identified as the starting points from which to begin a full-scale rationalization and co-ordination of health care programming.

During the remainder of my presentation I will be bringing the following issues to your attention: mental health services and patients' rights; issues affecting the elderly; the need for an increased emphasis on community-based services; issues facing the hospital sector; emergency health services; the application of technology to medicine; public health; Ontario health insurance; issues affecting the health professions; research; French language health service issues; and health care in northern Ontario.

 The first major issue I would like to review with the committee is mental health. Mental health care is a personal priority of mine, and within the next year or two I hope we will achieve a significant number of changes within the present system. We are currently spending just over $300 million a year on mental health care in Ontario. This figure does not include, I should add, the activities of general practitioners in the mental health care field or the activities of psychiatric units in our general hospitals.

We have 10 provincial psychiatric hospitals which treat the disabled and discharge 12,231 patients a year. We fund 65 psychiatric units in general hospitals which treat thousands of others, many of them elderly. Some of these patients are chronically ill; others are affected temporarily. Stress is a growing reality in our society, especially with our current economy, and it is forcing more and more people to seek therapy and care.

We have come a long way since the early days when treatment meant locking people away. The system then was concerned with the segregation of the insane and the protection of society and property. The big changes have come in the past two decades.

In the early 1960s, the typical length of stay in our psychiatric institutions was more than a year, and a large population of chronic care patients resided in the hospitals' back wards. Then fresh theories of treatment and the discovery of new psychotropic drugs began to revolutionize the system. These drugs were able to stabilize symptoms more quickly, and the average length of stay in hospital declined. Today it is less than two months for nonchronic patients.

New theories of treatment prompted what is called deinstitutionalization, the early return of psychiatric patients to their communities, but for this approach to function properly it requires adequate support services so that patients can make the necessary adjustments. There is the need to provide discharged patients with the skills needed to live and work alongside their neighbours. This is particularly true for those who lack a network of family and friends to help them pick up their lives.

The most serious difficulty in the current system is the shortage of backup support for ex-psychiatric patients. Some continue to live in inadequate housing in conditions that are frequently dehumanizing. The result is that some chronic patients get caught in a revolving door syndrome from hospital to boarding home and back again.

Discharged patients also must face a community that is frequently fearful and hostile. Yet experience indicates that many patients will be much better off in the community with appropriate accommodation and co-ordinated community support than they will be in an institution. It's not just a matter of money. Our community workers and the various organizations that deal with the mentally ill argue that the right course of action is not simply a matter of huge expense. Their advice indicates that the things we need most are organization and understanding. Although we have increased our spending in community health services by more than 50 per cent in the last three years, we must do even more.

Some of my concerns, in terms of my own priorities, relate to issues such as appropriate housing to suit patients' needs; easier access to medical care; availability of proper and nutritious meals; availability of rehabilitation services; assistance, where necessary, with the tasks of daily living; regular access to social and recreational opportunities; and advice on how to handle money. I believe we can achieve these goals soon. Some matters, however, require absolute and immediate attention.

In response to one acute problem, I announced in May that $1 million would be allocated for eight community support services for former psychiatric patients in Metropolitan Toronto. Half of that money is for housing programs. Another $1 million was allocated for funding 12 community mental health programs elsewhere in the province.

One of our major problems in mental health is that there is no single government body or agency to which psychiatric patients or their families can turn to find out what services are currently available. To overcome this fragmentation, the Ministry of Health has accepted the role of lead ministry for all matters relating to adult mental health care. It is a major step designed to develop cohesion in services.

It means that in areas where my ministry does not have direct responsibility, such as in housing or social services, we will see to it that patients' nonmedical needs are brought to the attention of the appropriate ministries, agencies or local governments. Internally, my ministry has already regrouped institutional and community mental health services, bringing them together under a single assistant deputy minister.

Before the end of this review of our estimates, I hope to be able to release the preliminary report of Dr. Gil Heseltine, the executive co-ordinator of mental health policy and planning, and I would like, at that time, to initiate an important dialogue within the mental health care community about some of the concepts that we in government are thinking about.

One major step is to provide psychiatric hospitals with the means of becoming more responsive to their communities through the establishment of community advisory boards reporting directly to me. The overall purpose of these boards will be to assist in providing efficient and effective care to the patients in psychiatric hospitals.

Unlike our public general hospitals, psychiatric hospitals are provincially governed. This has led to some criticism that the psychiatric hospitals are not close enough to the communities they serve. To improve the situation, it has been suggested that our psychiatric hospitals should be subject to the same funding patterns, and benefit from the same degree of local autonomy, as do our public hospitals. I am prepared to look at this option carefully and I would welcome the committee members' thoughts on the advisability of transferring responsibility for such hospitals away from the province to local community control.

Patients' rights: I would like to ask the advice of the social development committee members on an important matter also related to the issue of patients' rights. As most members know, the current Mental Health Act was written in 1978 and represented an attempt to modernize the procedures and practices within the system. People familiar only with today's improved practices might be surprised to realize how far we have come in the mental health field over the last 15 years.

Until 1967 it was possible for a person in Ontario to be confined indefinitely in a psychiatric facility if two doctors simply signed a certificate declaring the person mentally ill.

Even as late as 1977 the period of initial confinement for an involuntary patient was a full month and the criteria for committing a patient were vague.

The 1978 reforms eliminated many of those arbitrary and paternalistic practices. None the less, we must continue to examine the current system to be sure that the patients have a necessary degree of protection of their rights within the system. My dilemma is that the only immediate vehicle I have at my disposal is the two sections of the act that have not yet been proclaimed. These are sections 66 and 67.

Let me remind you briefly of the contents of sections 66 and 67 before explaining why, for the past four years, these sections have not become law. Section 66 requires that when an attending physician completes a certificate of involuntary admission or renewal, he must give notice in writing of the fact to the patient and to the area director of legal aid. Further, it stipulates that the patient is entitled to a hearing by the regional review board.

The provisions of section 67 are intended to do away with the current informal inquiry procedures of the regional review boards and replace them with formal, court-style proceedings. I agree with the objective of those two sections, but following extensive consultations with the leaders in the mental health care field and with a number of patient advocate groups, I must admit to some reservations about their effect.

The majority of medical professionals believe, I think predictably, that our approach to this problem should be primarily medical, not legal or custodial. They say our objective is health and healing, not justice and court hearings. We are not, after all, running a penal system.

At the same time, there are members of the legal fraternity who, also predictably and legitimately, feel that our system of involuntary admission for noncriminal patients requires the adoption of certain legal procedures and safeguards. We are, after all, affecting personal liberty.

First, these are my concerns about section 66. This section in part merely codifies a practice that is already being followed. Regional review boards already make a practice of ensuring that at the time of their hearing, patients are made aware of their rights to have a lawyer of their own choice, or be represented by a legal aid lawyer, if required. It is a desirable procedure and I find nothing wrong with codifying the need to inform the patient of his rights.

The immediate concerns of the involuntary hospitalized patient are likely numerous. The patient may feel stigmatized by being in the hospital and by not wishing to be identified as having a psychiatric problem. The patient may be confronted with the unknown and afraid of being dealt with in a manner he or she may not want. The patient may be uncertain of his or her rights and unable to understand what he or she can do. The family of the patient may be anxious, the employment of the patient may be at risk and there may be a whole variety of other needs requiring assistance.

Critics claim that under section 66, aside from the obvious breach of confidentiality, regardless of the administrative mechanisms in place, the automatic notification to legal aid may do little to assist the patient. They say that it is little more than a superficial attempt to advise the patient of his or her rights. They argue that while the patient has the right to be advised of his or her rights, the patient also has a right to privacy, a right to keep his or her condition confidential, and a right not to be bothered by outsiders.

It is doubtful that much more could reasonably be expected through notifications to legal aid than cursory advice to the patient of his or her rights. Surely there is much more that could be done to help patients through the whole range of their concerns.

As committee members will know, one step we have decided to take is the appointment of patient advocates in each of our 10 provincial psychiatric hospitals. Being concerned with patient-hospital relations in their widest sense, the patient advocate would be the patient's friend. By serving as a liaison between the hospital and external factors, such as the lawyer, doctor, family, employer or whomever, as the case may be, the patient advocate is best positioned for helping the patient deal with the matters with which he or she is confronted.

It has been suggested that the patient advocates could not only address the many general concerns of the patient. but could specifically advise the patient and his or her family about such things as the status and rights of the patient, policies of the hospital, avenues of appeal available to the patient, any changes in the status of the patient, access to the review board, and, of course, the availability of legal aid. In so doing, the interest of all in helpfully dealing with the human issues of a social-medical problem would be best handled.

The advocates could conduct personal counselling and ensure that the patients understand their legal rights and what to expect at review board hearings. The advocates could also arrange for the engagement of legal aid lawyers when required. In short, the system of patient advocates could, quite possibly, make the cumbersome and bureaucratic system set out by section 66 largely unnecessary.

In regard to section 67, I wonder whether the inevitable result of proclamation could be to convert what is now a social-medical problem into a legal problem.

In an adversarial setting, treatment could be perceived as an intrusion into the right of the patient, with a corresponding right to resist. To the patient, the motivation of the psychiatrist, or the hospital, could become suspect. The patient who feels that he or she should not be in the hospital views himself or herself not as a person who needs help, but as a person standing by observing a trial on his or her mental status.

Many people have pointed out that successful therapy is dependent on rapport and trust. They say that communication and treatment are diminished without rapport and trust and that if section 67 were proclaimed, patients could be lost within an adversarial proceeding in which the patient was pitted against his therapist or the psychiatric facility.

The psychiatric facility may feel obliged to become a party to the proceeding and engage counsel in order to determine what portions of the clinical record ought to be disclosed or not disclosed. The spouse of an involuntarily hospitalized patient may feel the need to retain counsel in order to express a position concerning the rights of the children of the patient. The psychiatrist may also feel obliged to retain counsel in order to assist himself or herself during cross-examination on the opinions that may be expressed.

Rather than a conference inquiring into the need to detain a patient now, or to treat a patient now, the proposed system would likely concern itself first with procedural rights and obligations, rather than seeking a prompt resolution regarding the patient's status and condition.

A board hearing depends upon the presentation of opinions and professional assessments by psychiatrists and others. Their views, often subjective, do not always lend themselves to the cut and thrust of adversarial testimony or cross-examination. There is also the question of how much potentially valuable information on a patient's history would be excluded from consideration under the formal rules of evidence.

Under the present system, all parties are given full opportunity to express their views not just the patient, but his family and lawyer too. The patient and his lawyer are afforded every opportunity to speak out, produce documents and call anyone they wish.

While this approach appears preferable for the patient, I am not satisfied that the status quo must be maintained uncritically. There is no question in my mind that patients' rights must be afforded certain legal guarantees and that many of the current practices should, in fact, be codified. The dilemma is that while section 66 and section 67 do attempt to move in an appropriate direction, they carry with them a number of difficult consequences which perhaps none of us anticipated in their entirety.

The intent is of course correct, and I believe our new Charter of Rights reinforces that intent and requires us to go beyond the existing practices and procedures. I would prefer, therefore, to see how well the present system will work once it is augmented by a network of patient advocates and a system of community advisory boards.

I do believe that, in devising these innovations, we may have caught the spirit of section 66 and 67, while avoiding some of the disadvantages those sections would impose upon the system. I would certainly welcome the views of the committee on this difficult issue. I simply have not yet decided upon the appropriate course of action.

Should one or both of the sections be proclaimed? Or should they be dropped in favour of some alternative? If so, what alternative would be best? May I say there is little doubt that this is one of the more difficult issues that members of our Legislature have had to deal with, and I would sincerely appreciate, as I said a moment ago, the advice of the members of this committee during our deliberations.

The aged: If one were forced to name a single issue that will determine the fate of our health care system in the long run, that issue would likely be the care of the aged. The Ministry of Health is spending $2.35 billion this year on the care of those aged 65 and over. The elderly make up only 10 per cent of the population, but they absorb 35 per cent of the total health care dollar.

Breaking down those figures, the elderly account for 19 per cent of the OHIP payments; 38 per cent of days of in-patient general hospital care; 79 per cent of days of in-patient chronic care; and 93 per cent of extended care in nursing homes. By the year 2001, the ranks of those over 65 will have grown by 58 per cent. The "older old," who are most vulnerable to physical and social problems, will increase most sharply, with the 85-plus group, for example, expected to double.

Those demographic and financial facts are fairly well known. What is less well known or understood is their implications beyond seeing the issue as a challenge best left to government to find the money to resolve.

Looking at the statistics from a different angle, we see that since the mid-1950s almost a full year has been added to the life expectancy of the average 65-year-old man and more than two years to the life of the average woman.

The fact is, a number of European countries today manage quite well with elderly populations of the size we foresee in the province in the next 20 years. The difficulty is not the number of elderly people, but rather how we as a society care for them.

In Ontario we have one of the highest rates of institutionalization of the elderly in the world. If our response to the demographic trend is mindlessly to increase the number of institutional beds, then we will indeed have a problem. But if we premise our actions on a sensitive understanding of the actual health-related needs of the aged, I believe we will find many effective and sensible options open to us.

Let us begin by recognizing that stereotypes must be avoided. A person does not become a ward of the state upon turning 65. In fact, more than half the senior citizens who reach the age of 85 to 90 in Ontario are still active in the community. Our chief policy objective then must help us to maximize the proportion of senior citizens who are able to maintain an independent lifestyle.

As a society, there is no doubt that we are deeply committed to the concept of dignity and security for the elderly. Yet I am not convinced that we have succeeded enough as a society in strengthening that value within the family unit, although most families recognize their responsibility to help ageing relatives remain self-reliant.

In developing a wide range of outstanding services for the aged, our government has recognized that aging must not be seen solely as a health problem or a financial problem or as a housing problem, with various ministries approaching the issue separately from their own perspectives.

For this reason, the Ontario government created a seniors secretariat under the Provincial Secretariat for Social Development. This group, with Mrs. Birch's committed leadership, has been designed to improve information dissemination, encourage research into issues related to ageing, and support effective policy co-ordination across ministries.

From the point of view of the Ministry of Health, we believe that health care for the aged still suffers from a mismatch between demands and resources- an over-emphasis on the institutional setting, at the expense of less glamorous but possibly more cost-effective and health effective alternatives. Surely this imbalance should be redressed.

As I have said, patients over 65 now require 38 per cent of the days of care provided in general hospitals. Many would be better served in chronic care facilities, which are less expensive to operate and, more important, offer programs specially tailored to the long-term care patient.

Similarly, many of those now in chronic care institutions could perhaps be as well cared for, at a lower cost, in nursing homes. In the final link in the chain, we may find that many of those in nursing homes can be adequately served by home care or day hospital programs.

The expansion of community health care programs, I believe, could be an important key to relieving pressure throughout the system. Home care has been an insured health benefit in this province since the early 1970s. We are now broadening coverage to include programs to serve the chronically ill, which will be in place in 34 Ontario counties by the end of this year. Of the $99 million provided for home care in these estimates, $41 million will be spent on chronic home care services.

We are all familiar with day surgery programs, but the day hospital concept for the elderly, which I mentioned earlier in my remarks, also merits attention. At present there are 15 day hospital programs for the elderly in the province, but day hospitals could well reduce the need for institutional care and for chronic home care as well. With their therapeutic and social components, they are a major example of the new outreach role we foresee for the hospital of the future. Special incentives may be required to stimulate the creation of such programs on a much wider scale.

On an annual per capita basis, day hospitals have been found to be one of the least costly means of providing needed health care and social stimulation to our elderly while, at the same time, providing a means to maintain them in their home environment.

If we do expand home care and day hospitals, one impact will be a new role for Ontario's nursing homes. Greater reliance on community care should free nursing home beds for patients needing higher levels of care. The question is: Will nursing homes adjust to the new situation by admitting more intensive care patients? At present, of course, there are no incentives for them to do so. The homes receive $39 per patient per day without regard for the amount of care required.

The current rate structure also fails to recognize differences in the quality of care among homes. Accredited homes, for example, are paid at the same rate as non-accredited. There is no financial reward for developing smaller homes, more closely linked to the towns and neighbourhoods in which people have spent their lives, or for having more programs designed to keep patients more mobile and healthy.

I do not foresee a significant expansion in the total funding available to nursing homes in the next few years, but we must ask, and we will, how these funds can be better deployed to promote better care and a more responsive system.

Another issue we must address is the right of nursing homes to pick and choose their patients because a profit-motivated system appears to have a built-in preference for patients who need the least attention. The result is not rational in terms of the effectiveness of the health care system. In broader terms, I question whether such freedom of choice is proper for institutions which are essentially publicly funded.

One option could be to establish an honest broker within the long-term care system, an agency with access to all needed expertise and which would assume a case management role. We could well consider a placement co-ordination service as such a central organization. It could assist patients in finding the most appropriate setting to meet their needs. Conversely, the service could assist in moving patients out of homes to more appropriate settings if their health status should change.

Certainly, the future holds many new opportunities for nursing homes to enhance their contribution to society. They could offer day care for the elderly, for example, or short-term admissions to provide relief periods for families with an aged relative at home. Such initiatives may require some form of government encouragement.

It has now been 10 years since the introduction of the extended care program. It is time we took a critical look at how it is working and what changes should be made in the future. Accordingly, my ministry has commenced a comprehensive study of the provision of health care to the elderly. Our objective is to identify the most effective means of developing and administering the total system.

We are working with the Ministry of Community and Social Services to extend the examination to all phases of residential and care services which we each provide and, of course, we will look to Mrs. Birch and her advisers for guidance and leadership in the broad area of service for our elderly.

By pointing the way toward more innovative services, our long-term health strategy for the elderly will foster a level of care that is both sensitive to human needs and, at the same time, is within the fiscal capacity of the province.

Community-based health services: There are a number of groups in addition to the elderly that require and can benefit from community-based health services. I believe that the concept on which health service organizations and community health centres are based is one of the great innovations of the health care systems.

When I came to this portfolio last February, I had some familiarity with both of these organizations and it was my hope that we could begin the steps to better establish their role, scope and funding within the health care system. As the members of this committee are aware, earlier this month I announced a new ministry policy aimed at strengthening both health service organizations and community health centres in the health care system. We have taken this step for some very important reasons, and I would like to clarify for committee members the reasoning and rationale behind our action, as well as some details of the new policy.

I believe it is clear, if one looks at our population, that no one means of health service delivery and no single package of services can be expected to meet everyone's health care needs. In the face of the kind of pluralistic society in which we live, I think it is clear that we must increasingly evolve a broader range of approaches to the delivery of health services. The system must be flexible enough to respond both to the kinds of needs people have and to the desires of the health professionals who make the system function. I don't believe there is any single right way. Instead, there is a range of ways of organizing and providing services to people that can contribute to improved health in Ontario.

As you know, we have had for some years now both HSOs and CHCs and they have been described until now as experiments. These have permitted physicians to organize their practices quite differently to what is generally found. Through health service organizations, groups of doctors work together to provide health services to an identified roster of patients, people who have joined the HSO. The services of these doctors are paid for through OHIP on a per capita basis.

We have also provided special incentives for ambulatory care programs, incentives designed to reduce the need for hospital or other institutional care for the patients of HSOs. We are now examining the possibility of expanding these incentives where they have proven effective.

Among these experiments, as they have been called until now, have been a group of organizations that are close to the model described in the Hastings report on community health centres. Generally speaking, the community health centres provide a wide range of services related to health, including medical services. They have had community boards and they have attempted to address the particular health needs of certain groups of people, in some cases those with lower incomes or less education. CHCs have been financed by payments of salaries plus overheads for the professionals involved.

Until very recently, however, the implicit assumption was that CHCs were really just HSOs that hadn't fully matured. Financing was provided on the basis of short-term contracts, assuming that at some point these centres, too, would move to a capitation system. In response to these perceptions we have now made four important decisions. These are:

 1. Health service organizations are no longer going to be trial programs or experiments. Physicians in Ontario who wish to do so will have the clear opportunity to organize themselves into such groups and to receive payment for their services on a per capita basis. Capitation will be a fully legitimate way of funding the provision of these forms of health services.

 2. We will work together to examine new incentives for a health promotion orientation in the operations of health service organizations.

 3. In future HSOs will receive capitation payments for all patients who are Ontario residents.

 4. Community health centres will also no longer be considered an experiment. We will no longer view them as HSOs that have not fully matured. The CHC is a distinct, different and important element in the health services system and it will receive stable and ongoing funding in the same manner as the other established elements within the system.

At the present time, only some two per cent of the people of Ontario receive health services through either HSOs or CHCs, but these organizations have already demonstrated their value within the system and we anticipate the incremental growth of them in the next number of years. We are, therefore, providing $150,000 over the next three years to support the Association of Ontario Health Centres in its activities.

We would hope that the HSOs and the CHCs will concern themselves with accreditation, with the development of management and administrative systems and approaches, with the development of means for setting objectives and evaluating programs to ensure proper accountability, and with the provision of advice and assistance to foster the establishment of new HSOs and CHCs where appropriate.

I believe that this new approach will prove to be most significant over the next several years and may lead, over time, to important new developments in the provision of community-based health services.

Hospital services: In the foreseeable future, our existing institutional system and the network of fine hospitals that we have will continue to serve the bulk of the population of Ontario. Ontario's 230 public hospitals are the foundation of the health care system. They are also the most costly component, absorbing approximately half the ministry's $6.6 billion budget. To put it another way, hospitals will spend 14 cents of every dollar the Ontario government raises this year. They, therefore, have a key impact on the fiscal capacity of the government and, in turn, on the economy of the province.

In consideration of this, I want to make the point that hospital trustees and administrators have a dual responsibility, first and foremost to their patients, of course, for the quality of care, but also to the taxpayers for the prudent use of public funds. To facilitate the latter, we recently restructured the base upon which we fund hospitals to reflect realistically their actual spending.

The base which the ministry had used to calculate hospital budgets was established several years ago, and some hospitals argued that it was unrealistically low. When a hospital reported an operating deficit at the end of the fiscal year, that hospital would then negotiate with the ministry for a full or partial recovery of the amount of the deficit.

To end this inefficient and antagonistic practice, my colleagues have provided us with the necessary funds to make this a turn-around year in hospital financing. All hospitals have been given a new budget base for the current year, which is based upon what they actually spent to provide services last year, that is, in fiscal 1981-82.

In order to bring that level forward to 1982-83, we will add an amount for inflation and an appropriate amount for increases in the work loads. We will also provide additional funds to recognize the cost of salary increases negotiated under the inflation restraint program.

The government provided an additional $110 million this year to implement the new approach and put all hospitals on a balanced financial footing for the future. These additional funds will bring our total hospital support to $3.3 billion for this fiscal year, an overall increase of $500 million over last year's funding. Although other worthwhile programs are being constrained by economic forces, our government is determined to preserve the excellence of our hospital system in the face of inflationary pressures.

However, in return for this additional funding to hospitals, we expect all hospitals to manage their affairs in a manner that will avoid deficits and maintain patient care. I wish to stress the latter because the principal task of hospitals is, indeed, patient care and all functions of hospitals must keep this as their principal focus.

Clearly, inefficient or careless management has an effect on patient care. I want to make it explicitly clear that the ministry will not accept or pay for hospital deficits incurred in this or future years. Furthermore, since the budgets of hospitals will be based on the actual amount they spent in the last fiscal year, hospitals are able to continue the same level of patient service. The ministry has offered to work with hospital boards and administrators who anticipate difficulty living within these new budgets. This new initiative is a part of the ministry's drive to strengthen financial management in the hospital system.

Last year we introduced the BOND, the business-oriented new development program, which created incentives for hospitals to earn revenue and generate economies. Hospitals now retain their net income instead of having to return a portion of such funds to the ministry. I

believe the program is valuable more in terms of what hospitals can save than what they will earn.

Hospitals can and should be run as efficiently as possible, keeping in mind the underlying commitment to the quality of care. BOND was a first step towards introducing more businesslike management. It is a signal that the ministry welcomes the kind of creative independence and flexibility hospitals require to keep their part of the bargain.

It is clear, however, that hospital trustees and administrators must pay close attention to the three major causes of past deficits. These areas will continue to exert financial pressure. The first is adding doctors, particularly specialists, to the hospital staff to duplicate services already adequately provided by neighbouring hospitals.

The second area requiring careful control is the hiring of new service and technical staff. Health care is still a growth industry. We estimate that we are adding about 1,500 health care workers every year, three times the rate of Ontario's population increase.

The third area we will be monitoring is the acquisition of new high technology equipment. While much of the new technology represents major advances in diagnosis and treatment to the great benefit of patients, its proliferation can lead to an oversupply and competition among hospitals, a common problem of the privately owned system in the United States.

Modern advances in rapidly transporting patients, combined with our plans to provide expert paramedical care in transit, lessen the need for hospitals to duplicate high technology. These measures dictate a need to consolidate, particularly for the effective maintenance of life support systems and specialized skills.

Hospitals should also consider introducing state of the art technology on the administrative side, where the private sector has attained substantial economies. Working with the district health council and the ministry, each hospital should now look ahead, determine where it is going to be in five or 10 years, decide what role it should be playing in the community and plan accordingly.

In other words, we have to rationalize the delivery of health care services to best meet the needs of the community. We would like to see this done co-operatively among neighbouring hospitals so patients have access to a wide range of services without duplication or costly competition.

We are moving in that direction by encouraging regional perinatal, trauma and burn programs. I am looking for even more initiative at the local level to co-ordinate health services and share support facilities such as laboratories and dietary departments. I would also like to see hospitals reaching out into their communities, serving as centres for community-based services and program delivery.

Hospitals must provide better preventive medicine, encourage people to remain healthy and to keep the mildly ill and the moderately immobile out of institutions. They must move away from the bricks-and-mortar concept of management towards satellite clinics and services.

For example, the ministry is providing funds to St. Joseph's Hospital in Hamilton for community-based outreach programs in Hamilton's east end. Any patient entering the east end clinic will have access to treatment from a multidisciplinary staff with the full resources of a tertiary care hospital as backup support.

Hospitals will remain the fulcrum of the health care system of the future. If hospitals respond to the opportunity to expand community-based services, their role could become even more vital than it is today. They will have to examine every service and every facility they provide, every employee they hire, every appointment they make and every patient they treat to see whether there are better, more economical and less stressful ways to serve the health needs of their communities.

As we consider the future role and function of our public hospitals and the new opportunities and alternatives that we see opening for them, we also remember that two objectives remain constant: the enhancement of patient care and the growth in quality of service offered to the Ontario public.

I am encouraged by the positive response of the Ontario Hospital Association and most hospitals to our new initiatives in planning and funding. I believe we are well on the way towards stabilizing hospital finances and that we can now build on a firm base for future advances in health care and health care services.

Emergency health services: We are now in a phase of development for beginning the discussion on how our hospital network might function with a comprehensive emergency health services system in place. This is certain to raise many issues for all of us, but I believe we must begin attacking any problem areas right now if we are to see the emergency health services concept become a reality.

First, we have to come to some consensus as to what the service priorities will be. We know, for example, that between the ages of 15 and 24, accidents claim more lives than any other causes of death combined. We know that most

trauma deaths are from car accidents which kill about 1,500 people in this province each year. We know that up to age 40 trauma continues to be the number one killer and even beyond that age it ranks behind only heart disease and cancer. Most trauma victims are from the youngest, most productive sector of our society. It would seem obvious that we must focus initially on improving service for them.

That is not to say we should, or will, diminish our efforts to provide emergency health services to cardiac victims. Rather, an emergency response and treatment system would work in tandem to serve both cardiac and trauma victims. That means we are going to need a system of co-ordination, a rationalized system, if we are to provide the best possible response for trauma victims along with other emergencies.

According to the existing Ambulance Act of this province, the trauma victim must be taken to the nearest treatment facility regardless of its level of expertise and resources. If we can change the system to get this patient to the most appropriate facility in the critical 30 to 60 minutes after the accident, then we can have a much better chance of saving more lives. The goal can be stated simply: the critically ill or injured should be taken to the hospitals best able to take care of them.

There have been several studies carried out in this country regarding hospital categorization. The recently published federal report suggests four categories for hospitals and proposes basic standards of measurement for emergency departments. In the past, some hospitals have resisted categorization because they feared loss of prestige and possibly being labelled first-class for only some types of patients.

However, the time has come to begin a rationalization of the health care system of this province if it is to continue to be one of the best. Rationalizing the emergency health care system through categorization ought to be the beginning of a wider co-operation that will make the entire system more efficient.

Once a hospital's capability is determined through the categorization process, that hospital can then define its own role in the context of the regional system. Working with the district health council, it and the Ministry of Health can then determine the resources needed to fulfil that role.

We could begin, for example, with a trauma program across the province with tertiary care trauma centres at certain designated locations, and secondary trauma units located in others. Each of these regions has to be organized to determine which hospitals will serve in which capacity, how patients will be transported to them, how emergency co-ordinating hospitals will operate and how the expertise will be shared.

Our analysis, for example, indicates that if trauma unit teams are to maintain their skills, they should be in a position where they will be attending to at least 500 trauma cases per year. There must be 24-hour-a-day service 365 days of the year. Trauma-oriented doctors must be available within the hospital or able to get there within 10 or 15 minutes.

The ministry is looking to the training requirements of emergency physicians and, as a start, we are funding 15 positions for emergency medical training for the first time this year. The College of Family Physicians of Canada will issue its first certification exams in emergency medicine this month and the Royal College of Physicians and Surgeons will hold its first certifying exams for specialists in emergency medicine next September.

While the new breed of emergency physicians is developing, we should also take a look at getting back to the intended role of emergency departments. An emergency health services system requires hospitals to be pitchers as well as catchers, to reach out into their community and region and to develop co-operative, integrated procedures with the fire, police and ambulance services. The personnel of these three agencies must learn to work together as a team.

In the evolution of an ideal emergency health system, the first responder to an emergency whether it be a police officer, a fireman, a public health officer, nurse or an ordinary citizen should be able to provide basic life support and call on trained paramedics. The paramedics, under the direction of a base hospital, would assess the injuries of the victim and determine the best-not the nearest- hospital for treatment. They would also begin advance life support procedures at the emergency scene and in transit to the hospital.

The selected hospital would have a team ready to get the victim on the operating table within 10 minutes to stop or delay the progression of the medical damage. If the patient is not improving, he or she would be transferred to a tertiary trauma hospital by air or land ambulance. We are now initiating a pilot project for critical care land transfers, the advanced life support transport unit that will soon be operating in London. It is a kind of mobile hospital which initially will be staffed by doctors and nurses, and eventually by paramedics.

We are about to launch a program within the ministry and government to train employees in cardio-pulmonary resuscitation and first aid. We hope it will serve as a good model for private industry to emulate. We feel strongly that active citizen participation is essential for the success of any emergency health system.

Anticipating broad co-operation in developing regional emergency health systems, the ministry is also embarking on a program to train advanced trauma life support paramedics. We expect the first class will be starting up early in the new year and that training will be completed by early summer. They will be assigned to our northern air ambulance system and Metropolitan Toronto. After evaluating and finalizing the curriculum, we intend to initiate the training of these paramedics locally in community colleges across the province as the regions become oriented to trauma system care.

A key building block for the emergency health system will be central ambulance dispatching. Our aim is to co-ordinate ambulance, health and hospital services through a single command post in each region. The communications network is also designed to help in disaster planning. It will service fire and police departments as required. Let me give you an example of several other steps we are undertaking towards developing the system.

 To improve the reach of the air ambulance system, we are building 50 heliports across Ontario able to operate on a 24-hour basis in order to facilitate critical care of transfers. In the north eight of these facilities have already been built in places such as Dryden, Sudbury and Terrace Bay- I opened Mindemoya last week-and 22 more are in the planning stage.

In the south we are upgrading the existing heliports in many locations. Peterborough, Parry Sound and Barrie are three examples. We have also requested DHCs in the southwest and east of the province to evaluate the potential of expanding our Bandage helicopters into their areas.

Finally we are reviewing the current legislation to prepare for a new emergency health services act. This will give us the legal framework to allow these new systems to function and develop. We in the ministry are now prepared to move on these proposals and concepts which I have just outlined for you.

New technology: In the past few decades new diagnostic and therapeutic technology has allowed life threatening conditions to be detected earlier and treated more effectively. Ontario has contributed to and benefited from this evolution.

Our physicians have been involved from the earliest stages in the use of cardiac pacemakers, artificial heart valves, kidney dialysis and other such devices and techniques. Some of our hospitals have been active in microsurgery; eye surgeons are using the laser beam on a routine basis. We lead in developing the technology of insulin delivery systems, kidney dialysis and other such devices and techniques. Nevertheless, it is perhaps time to take a hard look at the real benefits to our society of some of the benefits of medical technology.

We now have 26 CAT scanners, for example, approved for funding in Ontario. These computerized axial tomography units provide cross-sectional "slice images" of the body which cannot be matched by conventional X-ray equipment. The purchase price of a CAT scanner is approximately $1 million, and the ministry allocates $150,000 per year towards the operating costs of each one installed. These and other high-tech machines are constantly succeeding themselves with more advanced models. We have seen three generations of CAT scanners in just seven years, for example.

Yet the costs of a CAT scanner pale in comparison with some of the newer technology, such as the multi-million dollar PET scanner, positron emission tomography. This requires a cyclotron nearby to prepare the short-lived radioactive material for the scanner. It will likely be a number of years before the PET is ready for broad clinical application.

Nuclear magnetic resonance imaging equipment is now gaining clinical recognition. The ministry recently provided Princess Margaret Hospital with $1.3 million to install NMR technology, which uses radio waves instead of X -rays and can detect cancer in soft tissue. If the demand for this equipment follows the CAT scanner demand, we could be confronted with some very difficult choices in the near future.

The ministry controls the proliferation of CAT scanners through guidelines that currently provide for one unit for every 300,000 of referral population. Allowances are made, however, for such factors as case loads, geographical areas and teaching requirements. Based on district health council recommendations, scanners are strategically placed in major referral hospitals where there is an adequate patient load and properly trained staff for their effective use.

The ministry intends to adopt a similar review process for the dissemination of other high priced equipment, such as the NMR. A special working group has been created within the ministry to design an ongoing mechanism to manage the introduction of new medical high technology.

A major cost factor is how the technology is employed once it is in place because efficient utilization is essential to obtain the greatest benefit from the equipment. Yet, surprisingly, despite the price of high-tech equipment, we are frequently finding that low-ticket technology is

just as likely to generate runaway costs.

The multi-channel machines for blood testing are a pertinent example. The machines can do a large number of tests on an individual patient at a relatively low cost. However, questions arise about the number of tests needed. Lab service volumes increased dramatically between 1975 and 1980. This raises the question of whether unnecessary tests are being ordered. In fact, the sheer volume of blood testing and routine chest X-rays in hospitals far outweighs the cost to government of any other form of medical technology.

We believe each hospital is responsible for the allocation and use of its resources and the onus is on the hospital administration and the committees of the medical staff to ensure that technology is employed productively. At the same time, hospitals should consider the potential cost savings modern technology offers on the administrative side of hospital operations.

Today we see computers being used widely for medical records and financial management, but there frequently is little compatibility of computer systems within hospitals-and practically none between hospitals. Some institutions, for example, have three different systems within their operations, which can't interact with each other.

Clearly, there can and should be more co-ordination of computer technology within and among institutions. In the interests of efficiency, the ministry may have to take a more aggressive stance in encouraging this kind of integration.

I don't know how they speak for three hours in the Kremlin. I would raise my hand for some vodka.

 Their way must be more interesting; they get better attention.

Public health: This year marks the hundredth anniversary of the founding of the Ontario Board of Health, the forerunner of my ministry. The scope of community medicine has changed greatly since those times when the major health worries were communicable diseases and poor sanitation. Ontario's 43 local public health units are the major statutory agencies whose primary focus is the prevention of disease rather than treatment.

I certainly do not need to review the thrust and details of the Health Protection Act with members of this committee. During the past few months you have been involved in a detailed and excellent review of the legislation and you are most knowledgeable about it. I believe your scrutiny of it and the changes you have made will be a major contribution to the health and wellbeing of our citizens for the years to come.

For those following the text, might I say, Mr. Chairman, we'll move on to paragraph 3 on page 44.

When this act, Bill 138, is returned to the Legislature, I do believe that we will have an excellent piece of legislation that will provide us with the framework for implanting preventive attitudes and opportunities throughout the health care system as a whole. I would in all seriousness like to thank literally all members of the committee who have worked to make this a better bill. You really did a fine job. I would particularly like to commend the parliamentary assistant, Jim Gordon, for his excellent work in guiding that bill through the committee stage.

Ontario health insurance plan: I would now like to turn to a brief review of OHIP. Our health insurance division has thousands of daily transactions with the public. It is the part of the Ministry of Health with the highest visibililty, except for the minister, and for many people in Ontario, OHIP and the Ministry of Health are one and the same.

Two years ago OHIP undertook a major reassessment of its administrative practices. A key element was a thorough review of its customer service capability. As a result, proposals were made to reorganize the head office and district office operations to make them more adaptable to the needs and requirements of our clients. Most of the proposals have since been implemented and I will describe some which may be of interest and helpful to you.

The first category is service to the public. For years OHIP operated with nine district offices strategically located across the province. Over time it became evident that we were not as readily accessible to the people as we needed to be. The idea of satellite offices was born. These are located in smaller communities but under the supervision of a district office. We now have 10 such satellite offices in operation, along with our special services unit here in Toronto. This brings to 20 the number of OHIP offices directly servicing the public. Additional ones are scheduled to be opened soon.

Another improvement we have developed in the past two years is the "one window system" through which people can pay their premiums, apply for and receive OHIP coverage, obtain premium assistance if they qualify and get information on their current OHIP status in the offices where medical claims are also processed.

To carry out these expanded functions, the ministry has installed an online information retrieval system in each district and satellite office to eliminate the need of forwarding to head office most requests from the public for information. We established our special services union at Overlea Boulevard to handle inquiries about OHIP, not only from Ontario residents but from all around the world. Hospitals in the southern United States, where many Canadians spend the winter, regularly use the service to find out about an individual's OHIP status and to which regional office a claim for payment should be sent. Because we have this readily accessible information with an easily remembered telephone number, which, no doubt, all of you remember-965-1000-we have also reduced the number of OHIP-related complaints received by MPPs, the Ombudsman and others.

I would like to turn now to the providers of service, the physicians and other practitioners, and give this committee some examples of how we've taken positive action to improve our relationship with this important group.

 In the early days doctors complained regularly about red tape, problems with filling out claims forms and about what they regarded as bureaucratic nit-picking on the part of OHIP district office personnel. In response, the Ontario Medical Association and the ministry set up a joint committee to arbitrate them. Appropriately, it was called the Ontario Medical Association's harassment committee, which gives you some flavour of the situation.

For our part, medical consultants in our OHIP district offices were encouraged to go out into their communities and to talk with physicians and their secretaries. This gave us a good insight into the conditions and circumstances under which doctors were practising. As a result, a better understanding of each other's problems has developed and the numbers of claims needed to be reprocessed have been substantially reduced. We have initiated the policy of notifying doctors beforehand when there is to be any change in OHIP procedures and practices, and this has helped both of us.

We have also improved the system of payment to doctors. When OHIP was first initiated, doctors were on a monthly billing system and frequently there were lags of from four to six weeks between the time a doctor saw a patient and the time he was paid, so we developed the physicians interim payment system.

We have introduced a direct deposit plan making OHIP payments to doctors directly to their bank accounts to overcome lapses caused by mail distributions or delays. We've just extended this service to pharmacies under the Ontario drug benefit plan.

We are also currently examining the feasibility of developing and implementing the unique personal identification number into the omp system. I hope before spring to have reached a decision on this major innovation. This will allow us to register each individual resident and give each a separate OHIP number rather than the present system of registering patients either individually or as part of a family. This will eliminate many of the complaints from residents and physicians about coverage.

There are two other areas in the OHIP system I want to touch on briefly. The first is service to our agents. OHIP is sensitive to the contribution of industry and other employers who do extensive amounts of work collecting and submitting premiums. To support them in this effort and to improve our service to them, we have developed an automated group billing system now being tested on a pilot project basis.

 We will provide employers with an actual employee list, making it easier for them to calculate monthly payments and to account for personnel who have left the company or have been transferred. Our plan is to offer the service to small organizations first, and as it becomes better tested, then to move to a wider-scale application.

Secondly, regulatory reform: Two years ago OHIP undertook a study of more than 170 regulations which had developed over the years for governing claims. As a result of that study, nearly 50 per cent of these rules were scrapped without any financial impact and without changing our claims payment policies.

It should be noted that none of the efforts for improved service delivery has required the hiring of additional personnel. This is a major efficiency gain, especially when you consider that during the same period the OHIP work load was increasing by five per cent annually. So you can see that we are making steady progress in our operations and that we have made significant improvements for the public and for physicians.

The medical profession: As this committee knows, the medical profession plays a pivotal role in the health care system. Physicians make most of the key decisions involving the use and allocation of hospital and medical resources. Hence, the evolution of the system will depend directly on the co-operation of doctors in planning and implementing change.

Since the beginning of medicare the relationship between the government and the medical profession has had an adversarial aspect and an economic orientation. Unfortunately, in recent years these dimensions have come to dominate the relationship. Many doctors see the profession as in constant conflict with the political process and resent what they perceive as government interference with the practice of medicine.

 Government, on the other hand, has tended to view the profession as preoccupied with self-interest and hostile to any attempt to reform the system. This atmosphere of mistrust is a major obstacle to progress in the health care system and must be overcome. To improve the interaction between the government and the profession, it is first essential to acknowledge the very real frustrations felt by both parties. Through the fee negotiations this spring and other contact with physicians, I am aware of several of their concerns.

Physicians contend, for example, that medicare has eroded their autonomy by regimenting the practice of their profession. They say the system has created an assembly line type of medicine which fosters mass production and rewards high output, but offers no financial recognition for experience or superior performance.

Most doctors are uncomfortable with the union-style bargaining system they feel has been thrust upon them. They dislike the bitter, confrontational tone, and resent the public scrutiny of their incomes. Many doctors feel powerless. They believe the system excludes them from decisions affecting health policy, forcing them to accept federal and provincial directives over which they feel they have no influence.

Finally-and embracing all these issues-many physicians have expressed deep concern about their freedom to practise medicine as they see fit. The right to opt out of medicare has become a symbol of this concern, a right that is important even to the vast majority of doctors who have chosen to participate in the plan.

I am prepared to work with the profession to address these issues and develop solutions, but I must call upon the profession to understand the problems that I and my ministry face in managing the health system. For example, I, too, am concerned about the issue of opting out. We have accepted the right of Ontario doctors to opt out of the provincial plan and bill their patients directly.

At present, while close to 15 per cent of physicians practising in the province have opted out, only six per cent of claims are billed on an opted-out basis. I believe that level can be tolerated within the parameters of our commitment to a universal and accessible system.

However, the public is legitimately concerned to find especially high rates of opting out in certain medical specialities and in certain geographical areas. For example, 62 per cent of anaesthetists, 43 per cent of ophthalmologists and 39 per cent of obstetricians and gynaecologists have opted out.

Statistics like these make it easy for some to argue that opting out should be abolished. Frankly, I am frustrated that the medical profession has not helped to defend its right to opt out by assisting in developing some solutions to those particular problems in some communities and in some specialities.

We are also concerned about hospital utilization. Individual doctors have almost exclusive control over admissions, length of stay and the range of diagnostic testing, procedures and nursing care a patient receives. Given that we have a fair ratio of beds to population in this province, I am perplexed by the utilization trends for institutional facilities, as I discussed earlier.

We need answers to some fundamental questions, such as, why do we have chronic care patients staying in acute care beds? Why do we have such a high rate of institutionalization? Why do we have persistent demands for even more chronic and extended care beds?

Since the mid-1970s, almost everyone involved in health care delivery has agreed with the necessity of shifting our focus from the treatment of disease to prevention and health promotion. I have yet to hear what specific action should be taken by the medical profession to encourage their patients to take greater responsibility for their individual health.

So there are genuine frustrations felt by both the government and the profession. I am meeting with medical groups in various parts of the province to begin what I hope will be a new and productive dialogue between the government and the profession. As we communicate more effectively, I believe we will discover a number of shared interests and mutual objectives. I will continue to accept the right of physicians to opt out of OHIP, but I would hope the profession agrees that health care must be premised on real, provable and effective universality and accessibility.

The government and the profession might also consider how conditions affecting the practice of medicine have changed since medicare was established in the late 1960s and the implications of those changes on the system. Since we need to expand our capacity for health promotion, perhaps we need doctors to undertake different types of activities.

Physicians criticize medicare for its assembly-line approach to medicine. Maybe we should examine that argument and what has contributed to it. Perhaps compensation through the OHIP schedule, which is modelled on the Ontario Medical Association fee schedule, should take into consideration the years of experience or particular expertise of individual practitioners. Perhaps the government and the profession should examine the additional requirements of the family physician in the context of a highly urbanized and sometimes impersonal society.

Since physicians wield decisive influence over the utilization of hospitals' resources, the medical profession and the ministry should work together with hospitals to bring better co-ordination to the way we spend our health care dollars. I believe that with co-operation and with good faith on both sides, we will be able to work together to address these and many other issues.

There is one problem that can be solved quickly. Doctors have complained about exclusion from the formulation of health policy. We must respond to that complaint because I agree that the medical profession must clearly be the focal point of any efforts to bring about prudent, evolutionary reform.

Accordingly, the OMA is being invited to participate fully in the policy conference I have arranged for next April. I expect the OMA to make a key contribution to these deliberations.

I also hope physicians will participate in the local consultative conferences to be held by district health councils between June and September of next year. This process will enable all groups within the system, especially nurses and physicians, to present their views and discuss priorities, alternatives and goals.

We have to start by accepting the need for carefully considered change. It can occur with the OMA as an external critic, complaining about changes as they occur, or with the OMA as a major participant, helping to shape the health system in which physicians practise.

 Both the government and the profession must put aside the traditional animosity and mistrust of the past and take the risk of co-operating. I believe we can build a better system by effecting reforms together that will benefit both the public and the profession.

Perhaps this might be an appropriate place to end before I am terminated.