|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Province*** | ***Législature*** | ***Session*** | ***Type de discours*** | ***Date du discours*** | ***Locuteur*** | ***Fonction du locuteur*** | ***Parti politique*** |
| Ontario | 36e | 1e | Discours sur la santé | 2 octobre 1996 | Jim Wilson | Minister of Health | Progressive Conservative Party of Ontario |

I'll just take a few minutes to give a few introductory remarks. Mr Chairman, members of the committee, I'm pleased to appear before you again this year to address the Ministry of Health estimates for 1996-97. I'm grateful for the opportunity to discuss the achievements of the government in the area of health care over the past year and the direction we'll be taking for the future.

My focus will be on what has been done, where we are now and where we are going. Let me start by trying to provide some overall perspective.

We are here to look after the best interests of patients; to ensure that our health care system adapts successfully to the changing needs of Ontarians; to ensure that we continue to have the money and resources to do what is necessary. We are here, in short, to ensure that the people of Ontario continue to have a high-quality health care system.

To sustain the quality of that system, I believe it has to change, and it has to change urgently and fundamentally to meet the changing needs of Ontario's population. Physicians, nurses, pharmacists and many others within the health care system are coming to realize the need for change to better meet the needs of patients.

The population is aging, leading a healthier lifestyle and becoming more diverse. Technology has made giant strides in many areas, making new treatments possible and rendering old procedures obsolete.

The difference between the change we are undergoing in health care today and the change that has often characterized government programs in the past is the urgency with which we must move.

I pointed out a year ago when I appeared before you that this does not mean that we need to spend more money on health care in Ontario. It does mean we have to spend it differently.

We have to restructure the entire health care system to be able to invest in new programs and services for patients. For example, just recently I announced $2 million in one-time funding for coronary stents. The use of stents could mean less need for additional procedures, which will lead to savings. We'll be bringing forward a more comprehensive cardiac services plan later this year.

Governments across Canada are facing serious fiscal constraints and must be strategic in allocating financial resources to priority needs. We are aware of this need and we are designing high-quality programs that work.

To give some examples, let me turn now to what has been achieved in the past year.

Our commitment to hold health care spending at $17.4 billion annually remains firm. When this government came to power, we promised we would protect health care spending, and we're doing it in spite of the fact that we're now seeing a reduction of $2.1 billion in transfers from the federal government. Our commitment to health care funding stands despite the federal government's actions.

There have been changes, however, with how money is spent in the health care envelope, consistent with the vision for a new health care system that I presented in my estimates speech in February.

I promised to shift resources to community-based services and away from expensive institutions; to begin to reform primary care so physicians and other health care practitioners can practise to give maximum benefits to patients; to reinvest in priority areas; and to expand treatment programs in cancer care, dialysis, cardiac care, community mental health, long-term care, public health and community health services. This is a vision that emphasizes prevention, early detection and intervention and allows us to reinvest our resources in such critical areas as breast cancer screening.

It's a vision that includes more efficient hospitals with more accessible programs. It's a vision that uses information technology and health information to link our health care system, to measure health outcomes and obtain more accountable spending.

I promised you in February that I would give you concrete examples of the reinvestments we've made as we transform the Ministry of Health and the health care system. This money for reinvestments came from within the budget envelope and has been focused on the needs of patients. I'm proud of the successes of the past year.

We've made a reinvestment of $170 million over this year and next in community-based services such as nursing, personal care, homemaking, meal programs, attendant care services, and therapies such as speech language pathology, physiotherapy and occupational therapy. These services will help avoid any possible gaps at the community level possibly created by hospital restructuring.

Funding has been used for palliative care, supportive housing and aboriginal long-term-care services. This reinvestment, $170 million, will create some 4,400 new front-line jobs and 80,000 more Ontarians will benefit from community-based services.

We invested $25 million into 18 hospitals in high-growth areas to help them deal with the pressures of a growing population on their services.

We streamlined 74 home care and placement coordination programs into 43 community care access centres. Those centres will simplify access to long-term-care services and reduce administration. They will be up and running early in 1997. Most of the boards in the province are now in place.

We are implementing a $23.5-million community investment fund to treat people with severe mental illness and to build up community support, such as a valid option to institutionalization.

We have expanded dialysis services across Ontario, allowing kidney patients to receive treatment closer to home, by reinvesting up to $35 million.

We have dramatically reduced waiting lists for heart surgery by reinvesting up to $16 million in cardiac surgery over two years, resulting in the treatment of 1,435 more patients, which is almost a 20% increase in cardiac surgeries.

We will reinvest $12 million over the next three years in Ontario facilities to treat acquired brain injuries. If you saw your clips today, there are some tremendous success stories with respect to this program. We are repatriating about 75 Ontario residents currently receiving treatment in the United States so they can be closer to home, family and friends.

We have restored out-of-country health coverage for Ontarians to $400 from $100 per day, in keeping with the Canada Health Act. We're one of the only provinces now in Canada that's in full conformity with the Canada Health Act.

We have expanded the Trillium drug program to make it easier for another 140,000 working poor to receive assistance with catastrophic drug costs. We are prepared to reinvest up to $45 million for the drug costs of these people.

With funding of $4.5 million, we are providing a second immunization for school-age children that will virtually eradicate measles in our province over the next two years.

I announced that we will start a new program to immunize seniors and other vulnerable persons against pneumococcal disease -- serious pneumonia -- at a cost of $20 million over three years. We are also immunizing secondary school students who have not been vaccinated against hepatitis B, as well as continuing with our grade 7 hepatitis B immunization. I was at Central Tech earlier this week to launch that province-wide program, at Central Tech high school here in Toronto.

We have introduced community-sponsored contracts to recruit physicians in 21 of the most underserviced northern communities, at a cost of $6.7 million per year. We also created a community development officer for northeastern Ontario and a job registry to bring together physicians and communities looking for physicians.

We have introduced programs in rural medicine and a network to move medical training programs from southern medical schools to the north.

We've introduced a $70-an-hour sessional fee to help with recruitment and retention of physicians and ensure emergency room services in small, rural and northern hospitals, at a cost of $15 million. To date, 69 of the 77 eligible communities are registered and six others are interested. This allows the communities to restore or maintain 24-hour emergency room coverage, something many people in large urban centres take for granted.

In this year's budget, we announced the reinvestment in breast cancer screening and treatment, a well as the treatment of ovarian cancer. October is Breast Cancer Awareness Month and I look forward to announcing further details of our strategy in the coming weeks.

In the budget, we also announced $10 million for a healthy babies program, and another budget initiative at $10 million this year, growing to $20 million in the coming years, is a pre-school speech and language therapy program.

We have enhanced level two paramedic training through the Ontario Pre-Hospital Advanced Life Support project, at a cost of $15.5 million. Soon Ontario can look forward to having paramedics in all of our ambulance crews across the province, as this program moves along.

We will almost triple the number of magnetic resonance imaging units across the province to 35 from 12, at an annual cost of $150,000 per machine, which translates into $3.45 million per year. This will ensure timely access to this technology throughout the province. New units have been announced for Sudbury, St Catharines, Oshawa, Mississauga, Brampton, Barrie, Timmins, Sault Ste Marie, Windsor, Newmarket and Burlington. I should mention that 35 MRIs, when they all come on line, will bring us up to European standards, and we'll be there with some of the best standards in the world. The idea is to have access of one machine for about every 320,000 people, which is an excellent standard and one we will achieve.

We have added an average of 18 new drugs a month to the Ontario Drug Benefit Formulary. We have done this by controlling costs and being the last Canadian province to introduce some form of copayment. This allows us to add new products as they become available. As opposed to the previous government's approach, which was to unilaterally delete some 260 drugs from the formulary, we've added slightly under 260 drugs since coming to office, the first time in many, many years that new drugs have been added to the formulary in such large numbers.

We are creating a $1-million province-wide nursing database. This will provide up-to-date research data to nurses to let them learn about and use the best practices available in nursing today. This information sharing will improve patient care.

Just last Friday in London, I announced $5.8 million in a reinvestment to expand diabetes education programs and services and create four new regional diabetes networks.

On Monday of this week, I announced a $2-million reinvestment in an HIV viral load testing program as part of Ontario's comprehensive response to AIDS.

We are working to create a smart electronic health information network so we can determine how care is being delivered and where money is being spent across our health care system. This will help us reduce unnecessary services, inappropriate medical interventions and insufficient patient follow-ups.

I am particularly excited about the potential for using information technology to support and improve health care in Ontario. Improved use of information technology to link health care providers will provide better care to patients by measuring what works.

Many actions and activities in Ontario's health care sector support the evolution of the smart system, including:

Working on primary care reform to find ways to keep information flowing to and between primary care physicians so they become more efficient.

Implementing the review of provincial laboratory testing in order to improve the system so that results go to where they are needed and are not unnecessarily repeated.

Hospitals in areas such as Waterloo, Toronto, Thunder Bay and London are developing technology systems that link health care providers to share information. These projects include the electronic transfer of X-rays and test results between hospitals. Another wonderful project I had the pleasure of inaugurating is the Hospital for Sick Children's telemedicine program with Thunder Bay hospitals. This initiative allows children to be examined in Thunder Bay by Toronto specialists, thereby reducing travel costs and stress for patients and their families.

I would now like to move from what we have done to where we are today and talk about how we are addressing some of the major issues facing Ontario. It is important to note that Ontario is the last province to undergo restructuring of our health care system.

Hospital restructuring is of crucial importance to sustaining the quality of our health care system into the 21st century. In April this year, the Health Services Restructuring Commission began its four-year mandate to implement restructuring plans.

Through district health councils, Ontario communities became involved in planning for restructuring under the previous two governments. More than 30 communities, involving 134 hospitals, began major restructuring projects. In total, about 60 restructuring studies of some form or another were launched, at a total cost of $26 million for the previous government.

All projects included extensive consultation with hospitals, the people who work in them and the communities they serve. To give you an idea of the extent of the consultation that has taken place, the "standard" DHC restructuring project includes literally thousands of people providing input. District health councils received hundreds of written submissions and telephone calls. Then there were town hall meetings, meetings with hospital staff, either personally or in groups, meetings with unions, first nations and francophone groups where appropriate -- and I could go on.

The bottom line is that a great deal of work has already been done and we have heard from the communities. If we want to maintain the excellence of our hospital system, we have to restructure it now and not delay important decisions any longer.

We have to do this because between 1989 and 1995 previous governments eliminated more than 8,400 hospital beds -- the equivalent of about 33 midsized hospitals -- but no hospitals were ever closed. The existing infrastructure was left largely intact. The administration is still there. This costs our health care system millions of dollars annually, money that could be spent directly on patients.

Bricks and mortar do not cure patients. High-quality health care professionals and the programs they run cure patients. As I said in the Legislature earlier this week, people, not buildings, cure people. A hospital system that puts patients first and focuses on caring for them is what I think we all want to create.

Duplication, overlap and overcapacity in major service areas have remained untouched. Service inefficiencies continue. At the same time, advances in medical and hospital care, drug therapy and more advanced technology mean shorter stays and a shift to day surgery and ambulatory care.

The government created the Health Services Restructuring Commission at arm's length from government and empowered it to implement local hospital restructuring plans and engineer a reformed hospital system that puts the needs of patients first. There is only one reason that needed restructuring has not happened over the last 10 to 15 years, and that, my colleagues, is politics. It's time we took the politics out of the process. That's why we created the Health Services Restructuring Commission and put it at arm's length from the government.

The commission's job is to provide direction to help transform Ontario's hospital system to provide integrated, quality, front-line patient care. It's no easy task, but I'm confident that when I appear before you next year I'll have a great deal to say about the progress of hospital restructuring.

My confidence stems from knowing the expertise of the people making the decisions. The chair of the commission is Dr Duncan Sinclair, dean of the faculty of medicine at Queen's University. He has participated in many panels -- for many governments of all stripes -- and committees which have provided advice to the health ministry over the years on issues such as cancer care and health human resources, to name but two.

The chief executive officer is Mark Rochon, former CEO of Humber Memorial Hospital.

Dr David Naylor is chief executive officer of Ontario's prestigious and world-renowned Institute of Clinical Evaluative Sciences. Dr Naylor is serving as special adviser to help the commission with its research and analysis.

The commission members include Shelly Jamieson, the executive director of the Ontario Nursing Home Association; Dr Maureen Law, a former deputy minister of the federal Department of Health and Welfare; George Lund, president and CEO of Baton Broadcasting; Hartland MacDougall, deputy chair of London Insurance and founding chair of the St Michael's Hospital Foundation; Daniel Ross, a London lawyer with an extensive health care background including involvement in London's hospital restructuring; and finally, J. Donald Thornton, who brings a 10-year experience as board member of Oshawa General Hospital as well as his experience as an executive at General Motors.

Ontario also benefits from the experience elsewhere in Canada, because Ontario is not alone when it comes to restructuring of our health care system. As I said, we're behind almost every other province; in fact, I'd say we're behind every other province in Canada.

In Manitoba, the Centre for Health Policy and Evaluation recently published a report evaluating the impact of downsizing the hospital sector on access to quality care in Winnipeg. The report concluded that access to hospital services actually improved by hospital restructuring and that the quality of service levels was unaffected. Nursing care per patient actually went up. The number of hip and knee replacement, cataract and other surgeries went up. Some went up as high as 33%.

They did it by organizing their resources effectively and concentrating on patient needs. The bottom line is that hospitals and caregivers looked beyond the bricks and mortar, beyond protecting their territory. They looked at patient needs and the whole system. As a result, they increased the efficiency with which they deliver care.

Across Canada, from Newfoundland to British Columbia, governments of every stripe and everyone involved in hospitals are meeting this challenge and coming up with improved ways to meet patient needs. Hospital restructuring is one area where we are making long- overdue changes to preserve our health care system and ensure that it puts patients first.

Before I move on to the other area, I wanted to just quote -- because not all members would have seen it -- the Sudbury Star editorial of yesterday:

"Restructuring Plan Makes Sense.

"If the benchmark of the hospital restructuring exercise is to achieve a more efficient and cost-effective hospital system, then the plan unveiled by the Health Services Restructuring Commission yesterday morning would seem to meet those standards.

"If the goal of the restructuring exercise was to improve or maintain the level of patient care provided by Sudbury's hospital system, then it would seem that the plan meets that objective too.

"While there are members of the community who will argue that closing two hospitals in the city will devastate the system, it would appear from the information provided by the commission that it is a sound plan.

"Yesterday the commission announced that it was recommending the closing of both Sudbury General and Sudbury Memorial hospitals in 1999. The services offered by these two facilities would be transferred to Laurentian Hospital.

"To accommodate the new services, Laurentian Hospital will undergo a $68-million expansion. In addition, the commission recommended that another $8 million be spent on new equipment for the hospital. The changes will also result in reduction in the number of beds to 496.

"The commission estimates that the one-hospital system will save the local system about $41 million annually -- about 25% of the current hospital budget.

"There are recommendations for the province to provide funding for community-based care. With the length of hospital stays decreasing and more people receiving care in their homes, it seems reasonable that the number of beds should be reduced. In fact, commission member George Lund noted in a meeting with the Star's editorial board that when the new system is in place there will still be an excess number of beds.

"Naturally, there will be job losses within the hospital sector, but at this point in time it would be irresponsible to estimate the extent of such losses. The commission rightfully noted that there are many factors in determining the extent of job losses. Among these factors is the attrition within the workforce and the transfer of workers from hospitals to community-based services.

"While the decision will have an effect on the local economy, the main focus of any debate regarding the restructuring process must begin and end with the quality of patient care. Will care suffer under the changes recommended by the commission? It is unlikely.

"Simply having all services available at one location makes the proposed system preferable to the one currently in place. Patients will be able to receive surgical, diagnostic and rehabilitative services without leaving the hospital. At the present time, patients and doctors must travel between hospitals to receive or administer care -- hardly a perfect system.

"The commission has crafted a plan that will likely enhance Sudbury's hospital system and its stature as a referral centre for northeastern Ontario. Now it is up to the community to ensure that this lofty stature is attained."

That's the editorial from the Sudbury Star of yesterday.

We're also moving forward in another critical area of health care; namely, our work with doctors to reform primary care. We are making improvements to the system so that the patient gets the best service, not just from physicians, but from the provider that can help the most.

Another goal is to have a better-informed patient, one who is more involved in managing his or her health care.

Recognizing the importance of primary care, I announced on July 18 that Ontario will proceed with province-wide primary health care reform. Key components to be studied and evaluated include comprehensive and continuous care; rostering with a person's provider of choice; population-based funding, reflecting patient complexity; cost-effective use of information technology; and promotion of quality care through ongoing provider education.

I appointed a steering committee to advise me and to guide primary care reform and to consult with key stakeholders such as nurses and other primary care providers. The committee, which is headed by Dr Wendy Graham of the Ontario Medical Association, will make recommendations to me on potential primary care pilot sites by the end of this year.

The changes we foresee will allow patients to choose the family physician or group of physicians with whom they want to roster and enter a contractual relationship with the physician. Rostering commits the patient and the provider group to each other through a written understanding that sets out where patients will receive their primary care and the obligations of the providers. It's a two-way street.

The benefits of the primary care reform include improved access beyond regular hours, including telephone advice and a 1-800 number for health information and triage; greater coordination of referrals to specialists; patient accountability without sacrificing the freedom to choose their family physician or health care provider of choice; stable and predictable funding for physicians; improved flow of information to support quality care.

I can proudly say that Ontario is taking the lead in Canada in this area. I look forward to discussing how we have established successful pilots when I appear before this committee next year, because we are committed to having the pilots in at least two areas announced at least and hopefully up and running by Christmas.

It goes without saying that physicians are crucial to primary care reform and to the health care system as a whole. As caregivers they play a lead role. Despite media reports and opposition grandstanding to the contrary, our goal is to work cooperatively with the province's physicians.

For more than 10 years, in fact I would argue 15 years, the relationship between various Ontario governments, regardless of political stripe, and physicians has been unsatisfactory to both sides. You can't fix at least 10 years of neglect in a day, but as promised by both myself and the Premier, we will negotiate seriously and in good faith with the Ontario Medical Association, and those negotiations began yesterday. Our negotiating team is well under way in their efforts on our behalf to do everything they can and we can to bridge the gap between government and physicians.

Our short-term goal is to draft a memorandum of understanding to address the issue of additional funding for medical services. Longer term, we want to resolve problems regarding payments to physicians, physician distribution across the province, and other important issues.

The bottom line is the need, which I'm sure physicians share with me, to safeguard access to medical services, and I'm confident that together we will succeed.

Ontario is not alone in dealing with challenges when it comes to physician-government relations. British Columbia signed a new agreement with its physicians last spring. There is a hard cap for the first time on physician payments. Physicians are projected to overspend the amount budgeted, and BC's Medical Services Commission last week announced a 3% holdback. It sounds rather familiar, doesn't it?

Alberta continues to reduce spending on physician services. The physician budget will be reduced by $50 million by the end of 1997-98. We fully preserved our physician budget in this province.

Saskatchewan has been using a utilization commission to reduce the volume of medical services. A utilization formula requires the government and the doctors to share equally the cost of utilization increases of more than 1%, so if use of the system goes up more than 1%, both parties are affected. Negotiations with the Saskatchewan Medical Association begin late this year on a new agreement.

New Brunswick is in the process of ratifying a new agreement with its medical society. For the first time, physicians there will be subject to threshold discounts of $275,000 for general practitioners and $400,000 for specialists.

Nova Scotia signed a new agreement with its physicians last year. It reduced physician expenditures by 1.8% and restricted new billing numbers to places in need. The budget is hard-capped and physicians remain subject to thresholds.

Let me turn now, Mr Chairman -- and I'm concluding very soon -- to my vision of the future of health care in Ontario. The future can be summed up in really three words: integrated health care. Our overriding goal is to provide quality health care at an affordable price. This means putting the patient first. It means shaping the process to serve the needs of quality health care, not the other way around.

Integrated health care provides a coordinated continuum of services to a defined population. Its participating network of organizations agrees to be held clinically and fiscally accountable for the outcomes and the health status of the population it has agreed to serve. Integrated health care brings together assessment, diagnosis, treatment, care, prevention of illness and promotion of healthy lifestyles.

In the past, various stakeholders such as hospitals, doctors, community agencies, pharmacists, drug manufacturers and private health providers, just to name a few, often worked in isolation from each other. What has often been missing is the integration that puts patients first and offers them quality care at every stage of their journey through the health care system. Patients want and need a clearer path from doctors to medicines and therapies, to hospitals, to care in the community, and back again if necessary.

Modern, integrated health care is comparatively new as a concept. Until fairly recently, the traditional government response to new needs in health care was generally to allocate more taxpayers' dollars to solve problems. But this has changed as the growth in health care expenditures started to snowball. They increased faster than inflation and faster than the growth of the population itself -- much faster. Finally, they began to outgrow the ability of governments to finance them.

As early as 1987, reports to the Ontario Premier's Council were pointing out that the money was drying up. New areas, they said, would have to be funded by reallocation of existing resources. This reallocation could be done without sacrificing quality care.

More than once in the 1980s, the Premier's Council said that health care in Ontario did not need the infusion of more public or private money. Some reallocation took place in the early 1990s, for example, with the beginning of reductions in Ontario's high rates of hospitalization and the closing of the beds that simply weren't being used. The move to reallocation became a major policy priority last year when the government protected health care funding and announced major reallocations within the envelope, and I've talked about a lot of those reallocations or reinvestments.

The next step, which is only now beginning, is to change not just where the money goes, but the entire process of how it's used. The thrust of this new policy is that money flows with the patient, not the provider. We call it patient-based budgeting or patient-directed care; there's a whole pile of terms out there. But the idea is that you break down the silos and the dollars go with the patient who needs the care. Every other interest is secondary to the patient's interest. When the best interests of the patient dictate more outpatient medication and shorter hospitalization, that's where the money will go.

Make no mistake. Integrating the health care system in this way will be a profound change, and merely talking about it in Ontario has stirred up a great deal of reaction from a lot of people. But as we've said, Ontario is not alone. In fact, we're one of the last in Canada to make needed changes, and certainly one of the last in North America to make needed changes.

There will also be change in how the Ministry of Health does business, in how hospitals are managed, in how physicians and other care providers do their job, in the level of understanding of patients, in how drugs are dispensed and paid for.

As I've said, we don't really need to spend more money on health care in this province. In fact, we spend up there at a per capita basis with the best in the world. We do need to spend it better, though, and we have to shift the way we target expenditures to take account of broad medical, social and demographic developments which are transforming the face of Ontario.

Government has no way of achieving this unilaterally. Integrated health care can only be achieved by the efforts of all participants and stakeholders in the health care system working together as a team.

I didn't know I had a time limit. You didn't tell me at the beginning.

Haut du formulaire

Bas du formulaire

Thank you, Mr Chairman. This brings me to the reasons that integrated health care has become a central part of the Ontario government's new approach to health care reform. The goal is to create an efficient system that puts patients first by providing quality care and by ensuring Ontario taxpayers get value for the money spent. A lack of integration again means that hospitals in the same neighbourhood often offer the same services. Tests are ordered time and time again because information does not travel with the patients as they make their way through the system. Patients are X-rayed two or three times, at great cost both financially and to their health. We often hear these stories when we're back home in our ridings about the repeated tests or the repeated X-rays.

We cannot afford to carry on doing things the same old way. The entire health care system needs to catch up to clinical advances to make sure that quality care remains available. Integration is the key, perhaps the only way to free up the funds for new drugs, for new technology such as MRIs, or new medical procedures.

Integrated health care is beginning to be seriously examined by health managers, providers, policy analysts and academics. Even more significantly, they are increasingly working jointly rather than in isolation.

Government can't do this alone, but it does have a major role. We have made major changes, including redefining the role of the Ministry of Health. We have a detailed business plan which explicitly aims to achieve seamless and accountable health care and an equitable distribution of resources across the province.

As I have explained -- and I'm almost finished -- we are making a concerted effort to shift money into community based services and to front-line, patient-focused services that may be delivered in new ways. But in the last resort, we have to do more if we want to achieve a high-quality health care system which is not only patient-centred but also highly effective and affordable.

We want to move towards integrating assessment, diagnosis, treatment, care, illness prevention and health promotion. That's our vision of integrated health care, Ontario style.

That vision is shared by organizations such as the Ontario Nurses' Association, who recently came out with a very similar plan and an almost exact vision for health care in Ontario as we articulated earlier this year in the ministry's business plan. They call it integrated delivery systems. Starting now, we're going to start calling it integrated delivery systems so that the language is the same and that ONA understands that we have the same vision of health care.

I don't want to put a deadline on it, but I can promise that my report back to you this time next year -- and I don't keep saying, Mr Chairman, with all due respect to members, that I'm necessarily going to be the Minister of Health next year. But if I am the Minister of Health next year and I'm the one reporting to you, I hope that I'll be reporting considerable progress to you along all of the lines that I've mentioned in my remarks, and I thank all of the members quite sincerely for their patience.