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| Ontario | 32e | 4e | Discours sur la santé | 29 octobre 1984 | Keith Norton | Minister of Health | Progressive Conservative Party of Ontario |

Mr. Chairman, while the statements are being circulated and before getting into the details of the opening remarks, I would like to express my appreciation to the committee for its co-operation in rearranging the time and the hours of our meetings. We have shifted to switch places with the Ministry of Community and Social Services and, given the other events that are taking place within my party, I might have a little more flexibility in my time later in the fall.

The ministry staff has prepared a number of audio-visual presentations that might be of interest to the members of the committee during the course of the estimates discussions. We will make them available at any point you wish to have them. Immediately following my remarks, a list of them will be circulated to you. If you will then indicate which presentations you wish to see, the staff will make the necessary arrangements.

If you will permit one suggestion, the demonstration of the central bed registry now in operation in Hamilton might prove to be of some interest to the members. The registry has had a major impact on the more effective use of hospital resources in that city, and I will be discussing our plans for implementing central bed registry technology in other Ontario centres later in my remarks.

I am pleased to present the estimates of the Ontario Ministry of Health for the fiscal year 1984-85. The 1984-85 budget of the ministry totals $8.2 billion. That represents 30.6 per cent of the provincial government's total estimated expenditure of $26.8 billion for 1984-85 and is the largest amount allocated to any ministry of the government. The ministry itself employs 10,339 classified personnel. It funds 220 public hospitals, 17 private hospitals, 17 children's and adult rehabilitation centres and 10 provincial psychiatric hospitals.

The major payments that make up the 1984-85 Health estimates are approximately as follows: $2.4 billion to physicians and practitioners; $4 billion to public hospitals; and $1.8 billion for all other expenditures including drug benefits, clinical education and so on.

In the institutional sector, the ministry was funding, as of June 30, 1984, 36,808 acute care hospital beds, 13,030 chronic care hospital beds and 29,187 licensed nursing home beds. In addition, the government funds 12,944 extended care beds in homes for the aged through the Ministry of Community and Social Services.

As an example of the way in which the ministry serves the public, it should be noted that the ministry has 120 offices and facilities, such as laboratories, throughout the province. It funds 38 home care programs, 182 ambulance services and 43 local public health units. It has supported the development of 26 district health councils, which currently serve more than 90 per cent of the population, and the Ontario health insurance plan has 21 office locations which handle two million telephone inquiries a year.

While these few facts and figures give you an idea of the breadth of the health care system, they do not show the continuing pressures on that system which constantly push it to become even larger and to assume even higher costs. If we look at just two areas, we will see the kind of growth pressures I am talking about. For example, hospital funding has increased by $287 million from 1983-84, and OHIP's budget has increased by $269 million from 1983-84. However, in addition to budget increases in those two areas there are many more pressures on the system.

Increasing demands for more community-based services, extended home care programs, health promotion projects, improved care for the elderly, high-technology equipment and community mental health programs all place a stress on the system. It was in response to these kinds of pressures, as well as others, that the Ministry of Health, in consultation with the major provider groups, decided the system should prepare to bring about a process of careful change and evolutionary reform.

The ministry called upon the assistance of the Ontario Council of Health and the district health councils to help in initiating the strategic planning process. I would like now to outline that process and how it is developing.

With the consultative process that began two years ago, the government, the health care provider groups, the institutions and the volunteer organizations and agencies promised to work together to develop a health care system that is both appropriate to and responsive to our changing health care environment.

Last year I asked those who had participated in the consultation process for their ideas about how we might proceed with phase 2. There was widespread support for moving ahead with consultative health care planning, and there was clear unanimity that the ministry should provide leadership in establishing goals and objectives.

I would like now to outline for the committee members our agenda for action, which I am confident will see us successfully through the next 12 months or so.

As a first step, I recently announced the creation of the Ontario Implementation Group on Health Promotion and Disease Prevention, under the chairmanship of Mr. Steve Podborski. Mr. Podborski is eminently qualified to take on that new responsibility. He has twice been named Ontario athlete of the year. A world cup ski champion, he is an officer of the Order of Canada and in 1981 was named chairman of the Canadian Paraplegic Association.

For many years Steve Podborski has also been a strong advocate of more effective health promotion and disease prevention activities. I suppose he is particularly well known for public positions he has taken on this issue.

I will expect this implementation group to advise me and to bring me recommendations for specific programs covering a whole range of promotion and prevention activities, including preventive treatment. Membership will include representation from the district health councils, the scientific community, nutritionists, professionals in physical and health education and in alcohol and drug abuse. I expect all appointments to be completed and ready for announcement very shortly.

To create a support base for the implementation group, I am initiating a restructuring within the ministry organization. The office of health promotion under a senior ministry official will be created and charged with co-ordinating and implementing the promotion/prevention programs across all branches of the ministry.

I have also identified the five key areas that initially will be addressed: improved physical fitness, smoking cessation, alcohol moderation, good nutrition and, finally, increased awareness about personal responsibility for health. I do not mean anyone on the committee to think they are being targeted by these areas I have identified, but I suppose some of us might benefit from a careful review of them.

Several. Many times, as a matter of fact.

That is right. I have always observed that, on most occasions.

That is right. Only once in the past 21 weeks.

New attitudes about health are rapidly gaining ground in today's society. We see a new awareness among growing numbers of people that healthy lifestyles and good health have a direct cause and effect relationship. We are seeing a new concern to seek out those lifestyle choices that promote health. I believe, therefore, we are being offered an opportunity not to be missed. We must seize this time and move with determination, and I am convinced this new initiative on our part is destined to have a good measure of success.

Another action we have under way will have a positive impact on the operation of our public general hospitals. Some members of this committee will know that a computerized central bed registry has been functioning in the city of Hamilton since May 1983. The registry uses one of the computers at the Chedoke-McMaster Hospital, and terminals are located at five general hospitals in Hamilton and at the region's ambulance dispatch centre. With this system, accurate information on the availability of hospital beds and the status of emergency rooms is available 24 hours a day to all participating facilities.

The system links physicians at the base hospital with ambulance personnel to make sure patients are directed without delay to the most appropriate available source of care. For patients who walk into emergency rooms and require admission, if an appropriate bed is not available at the contact hospital an available bed can be located immediately elsewhere.

The Hamilton experience has been an unqualified success for the effective operation of emergency services and for the more effective use of that city's hospital resources. Before the system went into place, for example, there were recurring complaints that the city was underbedded. Today physicians and hospital personnel find they are able to manage effectively with the resources available to them.

The ministry will now provide funding to establish similar computer registries in six additional hospital centres throughout Ontario: in Ottawa, Windsor, London, Sudbury, Thunder Bay and Metropolitan Toronto. Each of these cities was selected because it contains three or more hospitals. I have asked that planning begin immediately in five locations, with Thunder Bay to begin its planning during the next fiscal year.

A great deal of co-operation, communication and information sharing is going to be required in setting up a registry and to ensure that agreed upon actions are followed through. I have therefore asked the district health councils to play the co-ordinating role in working with the key players, the hospitals and the doctors.

There is another important initiative that should be mentioned in this context. Recently I announced the creation of a new working committee with the sole task of developing a co-ordinated health data and information base for Ontario. This committee will be headed by Mr. Bill Nichols, the current vice-chairman of the Metropolitan Toronto District Health Council. He will be assisted by members from the Ontario Hospital Association, the Ontario Medical Association and the Registered Nurses Association of Ontario as well as by representatives of other provider groups.

The committee will consult and work with the major suppliers, users and analysts of data. It will identify the types of information needed, the types available and the gaps that now exist. The committee is also charged with proposing to me a mechanism for establishing a co-ordinated data information base appropriate to this province's health care system.

This development is certain, to give the ministry, the hospitals, the district health councils and, indeed, all our health-related institutions and organizations an invaluable tool for the planning, development and allocation of health care services. I also believe that as a direct result of this venture we will see a new spirit of co-operation and consultation flourish within the health care system.

The members of this committee are aware that our province's new Health Protection and Promotion Act, 1983, was proclaimed and came into force on July 1, 1984. I believe it is the most progressive public health legislation in North America, and as such it has great significance for the health and wellbeing of all Ontario residents.

The act focuses on the promotion of healthy lifestyles and the prevention of illness. In this respect it reflects a growing interest on the part of the general public in learning about what contributes to wellbeing and good health. The act and its regulations are designed to help people exercise greater responsibility in personal and family health by providing them with the necessary support services.

One of the distinguishing features of the legislation is that it represents several years of consultation with numerous committees and individuals from local health boards. The universities, the related health care professions, the general public and other ministries were also involved.

The new act clarifies the roles of our province's 43 boards of health and medical officers of health, who are responsible for ensuring the provision of public health services. It eliminates outdated and unnecessary provisions of the old act and has been designed as a concise statute that can be easily understood.

However, what sets the act apart from previous public health legislation is the requirement that throughout the province a basic core of seven standard health services now will be available. The required services are community sanitation, communicable disease control, preventive dentistry, family health, home care, nutrition and health education.

To ensure more effective control of communicable diseases, for example, boards of health now have strengthened responsibilities with respect to immunization. They will make information available about immunization and ensure its provision through regular clinics and family physicians.

Hearing and vision testing and a health assessment is to be made available for each child before or upon entry to school. For our growing elderly population, services will be available to assess their mental and physical wellbeing. Particular attention will be directed to high-risk seniors. Some of these services and programs are already available through some of the 43 boards of health. However, in certain instances, new programs will have to be developed.

While the act establishes standard levels of services for all boards of health, each board is free to introduce additional programs in response to local needs. Thus individual boards will continue to exercise the creativity they have shown in the past, which has been fundamental as input to this legislation.

We can be justly proud of this new Health Protection and Promotion Act. It represents the collective wisdom of Ontario's health professionals, numerous health-related interest groups, members of the general public, ministry personnel and the members of the House. I am confident the Health Protection and Promotion Act will lead to better health and better health protection for all residents of the province.

There have been other equally important developments in the priority area of public health.

I would like now to share with committee members details of our plan to formalize teaching and research within the public health sector through the introduction of teaching health units.

Affiliated with one of the five health sciences centres, a teaching health unit will serve as the public health counterpart to the teaching hospital. Teaching health units will become centres of excellence in public health service, teaching and research.

Through cross-appointments, teaching health units will promote a more positive interaction between professionals from the university setting and those in the field. This arrangement will, I am confident, create role models for the future generation of public health professionals.

Teaching health units will also offer greater exposure to public health concepts and techniques for undergraduate students planning careers in health care or health-related services. Through the program we hope to instil a community health orientation in young physicians, nurses and other practitioners and to embed preventive attitudes throughout the health care system.

The ministry is now proceeding to implement a developmental plan for the formal introduction of teaching health units. The health sciences centres and the associated health units in Ottawa and Hamilton have completed their initial planning and have begun to develop pilot projects. The two health units that will be involved initially are Ottawa-Carleton and HamiltonWentworth.

Reflecting the ministry's commitment to strengthen French-language health services in the province, the Ottawa teaching health unit will become a bilingual centre for the training of public health personnel.

We believe teaching health units will improve the image and substance of public health by reinforcing the teaching and research base for the practice of community medicine, and we fully expect our investment to pay dividends through a higher level of community health across Ontario.

The provision of health care services for the elderly residents of Ontario is one of the major ongoing priorities of my ministry. Our objective here is twofold: first, to maintain the health and preserve the independence of elderly people so they may remain active members of our communities; and second, to provide access to an appropriate range of good institutional care when that becomes necessary.

Home care is an integral part of the continuum of service being provided to many elderly residents, and there are now 38 local home care programs in operation throughout the province. These services are directed at helping patients to attain and maintain their physical capacity for independent living.

In the 1983-84 fiscal year, 121,300 patients were individually assessed for admission to the home care programs.

Home care has two components, acute and chronic. The acute component of care has been available province-wide since 1974. The chronic component, which is of particular benefit to senior citizens and disabled people, was initiated in 1975 through three pilot projects. With the implementation of chronic home care in Metropolitan Toronto this past March, this component is now available province-wide.

It is estimated that about 10,000 patients will be admitted to the chronic home care program during the first full fiscal year of its operation.

The Ontario program in chiropody came in response to our concern about the provision of adequate foot care services throughout the province. It was recognized there was a growing need for foot care expertise associated with the ageing population. It was also recognized that the loss of mobility among elderly people frequently brings about a requirement for institutional care.

It was, therefore, proposed that a chiropody service be established and that clinics be set up in hospitals, nursing homes and public health units throughout the province to meet the needs of local communities. It was further decided that we should train our own Ontario chiropodists in the community colleges. The program was established at George Brown College in 1981 with clinical teaching at the Toronto General Hospital.

Our first group of chiropodists graduated last year and they have been working in hospital clinics in Toronto. These chiropodists are salaried and the service is provided as an insured OHIP service to the patient. The program has been extremely well accepted and we are satisfied that the quality of care being offered is excellent.

In the coming year we expect that chiropodists will begin locating in other areas of the province so the aim of a provincial chiropody service can be achieved as soon as possible. The Ministry of Colleges and Universities has assisted us in reaching this goal by approving an increase in the class size at George Brown College to 36 from 24, effective this September.

Chiropodists are already providing a significant volume of services in the province, about 50,000 patient visits per year. This program, which is the first of its kind in Canada, is also providing young people in Ontario with an important new opportunity for a health care career.

Over the last few years, there has been a significant increase in the number of chronic care beds. As of June 30 of this year, there were 13,030 chronic care beds, including rehabilitation beds, an increase of 1,152 or almost 10 per cent over the last four years. The ministry has also addressed the need for additional chronic care beds by approving 548 new beds that are currently in various stages of construction.

In addition to new beds for the elderly, the ministry supports the development of geriatric day hospitals, and 21 are now in operation. These facilities offer an innovative alternative in the provision of care to the elderly, since they are able to receive hospital services without the need for admission.

In September the ministry distributed Interim Policy and Guidelines for Geriatric Day Hospitals in Ontario to the district health councils, hospitals planning day hospital programs and those with day hospitals already in operation. This document will assist groups that are planning to develop new geriatric day hospitals and will guide agencies and officials responsible for reviewing such proposals.

Another promising development in meeting the health care needs of elderly residents has been the introduction of geriatric assessment units in the major teaching hospitals. A geriatric assessment unit consists of a number of short -stay beds and a specialized multidiscipline health care team. These geriatric specialists are able to diagnose the complex health problems of elderly people and to prescribe appropriate treatment.

The emphasis is on rehabilitation and returning patients to the community. When institutional care is required, placement is made in accordance with individual needs for nursing and/or medical care. Currently, II units provide 145 geriatric assessment beds in Ontario. Other proposals are now in various stages of development and several areas of the province are proposing regionalized geriatric assessment services to provide coverage throughout local districts.

Over the past year, the ministry has made considerable progress in ensuring that nursing home residents receive the best possible care. We have listened to the suggestions of citizen and advocacy groups, as well as those of the Ontario Nursing Home Association. As part of the joint efforts to improve quality of life standards, both the Ministry of Health and the Ontario Nursing Home Association have encouraged accreditation by the Canadian Council on Hospital Accreditation.

Effective January 1, 1984, voting status in the Ontario Nursing Home Association requires accreditation, or an application for accreditation accepted by the Canadian Council on Hospital Accreditation. Of the 332 nursing homes in the province, 163 are accredited and 71 have been accepted for survey, a total of 234 homes or 70 percent.

In the past year the ministry has intensified the enforcement of nursing home regulations. The 10 additional inspectors announced in the Legislature in December have now been hired and began their assignments in the field this past June.

In addition, the guidelines used by inspectors to examine whether a nursing home is in compliance with the regulations under the act have been fully reviewed and strengthened. These guidelines promote consistency among inspectors in the manner in which the regulations are interpreted.

Our powers to deal with recalcitrant operators have also been strengthened. Effective January I, 1984, a home that is found in non-compliance by an inspector must file a written compliance plan with the Ministry of Health within seven days or be liable to prosecution.

An experienced government prosecutor, Lloyd Budzinski, has been seconded from the Ministry of the Attorney General to assist us with legal actions. Since January this year charges have been laid against 19 nursing homes.

Also effective January I of this year, administrators of nursing homes are required to advise residents of their right to form a residents' council and to provide them with the opportunity to do so. Community and family participation in the councils is permitted at the discretion of the members.

The councils are encouraged to develop their role as an advocacy group, to speak for themselves regarding the resolution of any complaints and to represent the residents in matters affecting their quality of life. Each nursing home becomes a home to its residents, and this provides them with a mechanism for making decisions about their own environment.

Also effective January I, regulations were introduced that provided an extension of a resident's right to retain his or her nursing home bed while temporarily in hospital. The new time limit during which the ministry will continue to pay the government portion of the per diem rate is 14 days, raised from a previous maximum of only 72 hours.

As a result of the passage of the Health Facilities Special Orders Act last June, the ministry is also equipped to act decisively in the event that the health or safety of nursing home residents is threatened. This measure allows the ministry to install interim management while a licence suspension or revocation is being reviewed.

Inspection and enforcement, however, represent only one dimension of our effort to improve the quality of life for nursing home residents.

The recently announced Nursing Home Residents' Complaints Committee under the chairmanship of Dr. Dorothea Crittenden will begin its work in December. This body will advise me and will deal with complaints originated by a nursing home resident, residents' council or a representative which are not covered under the Nursing Homes Act and regulations.

The Nursing Home Residents' Complaints Committee will be composed of five regional sub-committees, each consisting of a vice-chairman and two members, from the northwestern, northeastern, southwestern, southeastern and central areas. As chairman of the committee, Dr. Crittenden will conduct the central region meetings. She will also meet regularly with the regional vice-chairmen to promote consistency and co-operation in the activities of the committee.

I am sure she would be quite happy to do that. I am sure she misses you. She was always rather maternalistic, so I am sure she has a special place for you.

This type of regional approach will help to ensure that committee members are informed about local health care services and facilities and that they have strong links to the community.

As a second initiative affecting quality of life, the ministry will now undertake a thorough review of the role of advisory physicians in nursing homes. In carrying out the review, we will work closely with the Ontario Nursing Home Association and the Ontario Medical Association to develop guidelines for appropriate medical care in nursing homes and to ensure that the high standards for this care are being maintained.

I expect that as a result of this review we will see greater involvement of the advisory physicians in the day-to-day activities of nursing homes. I want to note that, beginning in 1985-86, the ministry will provide financial assistance to nursing homes that have introduced an advisory physician service.

For the third initiative, the Ministry of Health has agreed to provide a grant to the Ontario Association of Residents' Councils. The money will be used to encourage nursing home representation in the association from across the province. It will also be used to help further the association's goals and objectives with regard to nursing home living.

In 1972 extended care became a health insurance benefit in Ontario and the nursing home industry, which had been largely unsupervised, became subject to regulation. Some homes which predate the extension of medicare have been permitted to defer correcting certain structural and environmental shortcomings which affect living conditions in the homes.

This policy was justified for two reasons. First, the province needed the nursing home beds to accommodate the number of senior citizens requiring them. Second, the owners were entitled to a reasonable length of time to gather the financial and other resources necessary for what in some cases would be major reconstruction.

My ministry will now take action regarding these structural and environmental shortcomings under the recently announced Compliance Plan Review Board.

Under the chairmanship of Mr. Sam Ruth, president of the Baycrest Foundation, the Compliance Plan Review Board will act as an advisory board to consider the specific requirements of each nursing home and to make recommendations to me. Individual nursing home operators will bring any difficulties in achieving compliance to the board for discussion and advice. It may also look at future structural guidelines for nursing homes in Ontario.

I am confident we are taking every necessary step to make nursing homes in this province adaptable and appropriate to the needs of the growing elderly population. Clearly, more work still needs to be done and will be done. My ministry, the nursing home industry and the citizen and advocacy groups must now proceed to accomplish our objectives in a spirit of mutual support and co-operation.

Since the last estimates presentation to this committee several important events have occurred in the planning and development of our province's emergency health services system.

 The implementation of the pilot paramedic program has been one of its proudest achievements. Training of 54 student paramedics began on January 9 of this year at the Toronto Institute of Medical Technology. There have now been nine classes of six students each.

In Toronto, the Toronto General Hospital and Sunnybrook Medical Centre have been designated as base hospitals and the Hospital for Sick Children as an associate. In Hamilton, the McMaster University Medical Centre has been designated as a base hospital with Chedoke Hospital as a backup.

Students successfully completing the paramedic training will be able to perform a number of delegated medical acts associated with the emergency care of heart attack and accident victims. Upon successful completion of the training program, students will then be certified by the Ministry of Health. Detailed evaluations will be carried out on this pilot program, as well as on the program's impact on patient survival.

We expect the experience thus gained will assist in introducing the paramedic concept in several additional Ontario cities over the next few years. In the meantime, the interest generated by this project has provided an opportunity to encourage emergency-related health service actions in a number of communities.

These actions, such as citizen cardiopulmonary resuscitation training and the introduction of telephone number 911, are not only necessary to establish a paramedic program, but they represent major improvements to a community's public safety response capability.

With respect to paramedics in the northern air ambulance services, it has been determined after careful review and evaluation that the education and clinical components of the pilot project for the Thunder Bay and Sudbury ambulance services should be taught in those communities.

Meetings have been held with the Sudbury General Hospital and the McKellar General Hospital to discuss the extension of the Toronto-based program. With the approval of the medical advisory committees, the hospitals have agreed to evaluate their resources and to report back to the ministry regarding their capability to provide the paramedic training program. We expect training will begin before the end of the current fiscal year.

As part of our effort to improve the transfer of patients between hospitals, the ministry has introduced the use of critical care transport units in the province. These vehicles contain highly sophisticated advanced life support equipment and are used in transporting seriously ill and injured patients to major medical centres from community hospitals in the surrounding districts.

The vehicles are staffed by physicians and nurses from the sending hospitals. The first vehicle was stationed in London and has been serving southwestern Ontario since November 1982. A second vehicle was delivered to Kingston and surrounding area in June 1984 and a third was recently announced for Hamilton.

In the Windsor area, significant improvements have also been made to ambulance services. These resulted from an operational review conducted by the ministry and included the addition of 12 ambulance attendants, two assistant managers and two new ambulance stations.

I am not sure. Was their contribution constructive? We can debate that later. Of course, I give you credit, David.

I am sorry. I did not notice he was sitting here.

In 1980 cabinet approved the ministry's plan for the establishment and direct operation of a province-wide central ambulance dispatch services system. We now have 15 CADS centres in operation and plan to have a total of 17 functioning by 1986-87 to complete the provincial network.

The CADS communications centre, through modern communications and electronics technology, is able to receive calls, dispatch ambulances and direct and monitor the delivery of pre-hospital and interhospital emergency care services. A CADS system is also capable of rapidly mobilizing, deploying and co-ordinating ambulance, hospital and other resources to respond to regional emergency situations.

Based on the ministry's experience to date, with the implementation and operation of the existing 15 central ambulance dispatch services, we believe a fully implemented CADS system will help to reduce ambulance costs as well as the response time to emergency calls.

With the implementation of an increasingly complex emergency health services system, a series of information systems capable of meeting all the currently known management information needs is essential. The ministry is taking steps to develop a new management information system for EHS which will take full advantage of modern technology to improve productivity, reduce information costs and provide more and better management information.

At this year's annual district health council conference, the first series of discussion papers for developing a comprehensive EHS system in Ontario was released. The first document reflects my ministry's commitment to provide leadership and guidance to local planners and providers by setting out a coherent set of goals, objectives, priorities and guidelines.

As the documents are released, they will become the subject of a consultative process among the related health service providers, consumers and the ministry. This type of consultation will give all groups concerned the opportunity to comment on the appropriateness of the selected initiatives before they become established policies and programs.

Our provincial EHS advisory committee, which is meeting regularly under the chairmanship of Dr. Arthur Scott, anaesthetist-in-chief, Toronto General Hospital, has examined the role of base hospitals in a comprehensive EHS system, the process for designating them and their operational requirements. The committee has also reviewed the criteria for trauma centres and has provided input into the evaluation of the paramedic pilot project.

The ministry is now satisfied that we have completed the initial steps in EHS systems development. We have built public awareness and consensus, established a working data base and set up inventories of existing resources. The ministry believes EHS planners, providers and consumers are ready to proceed to the next phase, which involves the development of the detailed action.

A recently published report on the financial health of Canadian hospitals indicates that hospitals in Ontario are in an extremely good position compared to those in other provinces, and are in an exceptionally good position compared to those in the United States.

Several measures of financial status were used in this study, including liquidity, profitability and a composite measure called overall financial viability. On the liquidity measure Ontario and Saskatchewan set the most favourable pattern, and on the profitability measure Ontario and Manitoba had the best values. On the composite measure Ontario and Saskatchewan had the best values, reflecting a stable financial situation.

Hospitals in Ontario received an average increase of eight per cent in provincial funding grants in 1984-85. The increases were based on a funding formula with the following components: a general increase of five per cent; an additional one per cent increase for hospitals with fewer than 50 acute care beds or a ministry allocation less than $2.85 million; an adjustment for the cost of new programs or services approved by the ministry and begun during 1983-84 and those approved to begin in 1984-85; a provision to recognize growth in patient care activity; and finally, an adjustment to fund work load increases associated with high-technology life support programs.

I might add to my reference to the situation in the United States: 1 was recently at a meeting where it was indicated that over the past slightly more than a year there have been 150 hospital bankruptcies in the United States, with a further 1,000 bankruptcies projected before the end of this decade. Looking at the difficulties we face in terms of funding pressures in this province, we have a lot to be grateful for when we look at the experience in other jurisdictions, not only in the US but even elsewhere in Canada.

Not necessarily; it says more about the way in which the funding is provided. That does not necessarily mean it makes a distinction between private or public management.

Capital expenditure on hospital construction and renovation has been restrained in recent years. The ministry is pleased to announce, however, that the approved allocation has been increased to approximately $140 million this current fiscal year from $120 million last year.

The Simcoe Hall Children's Treatment Centre in Oshawa was replaced and the new facility opened in 1983 at a project cost of $2.3 million, as did the replacement facility for the Chesley and District Memorial Hospital with a project cost of $2 million. In May 1984, a replacement hospital for the Hawkesbury and District General Hospital opened at a cost of $16.6 million. In Owen Sound, construction has begun on a replacement hospital, the Grey Bruce District Health Centre. Estimated project cost is $53.4 million.

Direct ministry support for each of these capital projects is approximately two thirds of the total project cost, with each hospital providing the balance of the funding.

The following hospitals are under construction and will open towards the end of this fiscal year or in 1985-86: Attawapiskat at Moosonee, London Parkwood, Baycrest, Salvation Army Grace, and Credit Valley in Mississauga.

Some of the new programs include the opening of 11 critical care beds in London; the opening of 22 chronic care beds and ambulatory care programs at the Willet Hospital in Paris; 38 chronic care beds in the Hamilton Civic; a day surgery and endoscopy suite at the Belleville General and an 18-bed geriatric assessment unit at the Ottawa Civic Hospital.

There has been an increase of 172 acute care beds since March 1983 and 525 beds under construction.

The BOND program, or the business-oriented new development program, was developed to encourage hospitals to become more businesslike in their operations. BOND encourages hospitals to exercise greater control over their own affairs and offers opportunities through incentives to hospitals to use public funds more effectively.

While BOND has been and will remain essentially a business or a financial plan, it can also have a definite impact on patient care. First, hospital managers now have a much greater incentive to seek out new and improved ways to rationalize patient care services within a hospital centre or within a planning area.

Second, the accumulated and retained surpluses now available to hospitals can be reinvested back into new programs-into enhancement of existing programs, for example, into staff improvements, technological improvements and other measures that can directly benefit the quality of patient care.

Based on our experience, it is clear that many hospitals have taken advantage of incentives, most hospitals have shown improved employee productivity and the number of hospitals in the province with operating deficits has declined dramatically.

In association with the -Ontario Hospital Association and the Ontario Council of Administrators of Teaching Hospitals, the ministry is seeking a meaningful way to measure how hospitals do their jobs and how effectively they meet the needs of their communities. Consistent with this concern, the ministry has made a grant of $250,000 to both Kingston General and London's University Hospital to research and develop new ways of measuring hospital performance.

The two research projects will examine how the treatment of specific types of illness and injury affects the use and the cost of hospital resources. These two projects will be monitored by a steering committee made up of representatives from the ministry, the Ontario Hospital Association and the Ontario Council of Administrators of Teaching Hospitals, and by individual hospitals throughout the province. The steering committee will make other hospitals aware of the projects' techniques and the results as they progress and will offer help to those institutions that might wish to apply them to their own management practices.

We expect the two pilot projects in case mix management will be completed in mid-1985.

In April of this year, a regional sexual assault centre was opened at Women's College Hospital in Toronto, the first of as many as five such centres that will be established within the next two years. Located on the ground floor of the hospital, the centre is open 24 hours a day to provide immediate and sympathetic care for sexually assaulted victims. This and other proposed centres will treat patients who come in on their own, as well as those referred by neighbouring hospitals or police and social agencies.

The Metropolitan Toronto District Health Council, in consultation with area hospitals, will be asked to designate the location of other centres in Metropolitan Toronto. The ministries of the Attorney General and the Solicitor General and the Provincial Secretariat for Justice will then collaborate on the establishment and operation of these centres. The establishment of this type of treatment centre has been identified as a top priority by the ministry's advisory committee on women's health issues.

In May 1981 Dr. Gil Heseltine of the University of Western Ontario was contracted by the Ministry of Health to review and assess the current mental health services in Ontario and to recommend policy directions for their future development and delivery. His review included hospitals, community programs and agencies, and our relationships with other ministries such as Community and Social Services and the Attorney General.

In November 1982, Dr. Heseltine submitted his interim discussion paper, Blueprint for Change: The Next Ten Years. In early 1983 he travelled throughout the province to present his findings and to receive feedback on his interim document. Meetings were attended by representatives from a wide variety of interested groups, such as the district health councils, public hospitals, the Ontario Public Service Employees' Union and local branches of the Canadian Mental Health Association.

Following this consultation process, Dr. Heseltine's final discussion paper, Towards a Blueprint for Change: A Mental Health Policy and Program Perspective, was submitted to me in December 1983. This document covers a wide range of topics, including the distribution of mental health services, planning and co-ordination and continuity of care. Dr. Heseltine also discusses specific services such as child and adolescent programs, rehabilitation and maintenance, forensic services and psychogeriatric care.

This latest document has been distributed to other provincial ministries as well as the Ministry of Health and to groups with a special interest in mental health. Our intention is to obtain as much comprehensive feedback as we can. Ministry of Health staff are now reviewing and consolidating all the responses to the document. These views and opinions, along with Dr. Heseltine's recommendations, will be given full consideration in planning for the future development of mental health services in the province.

The community mental health services program funds community-based programs for people needing mental health or alcohol and drug addiction services. Currently, 256 programs are being funded for a total allocation of $47.5 million. These programs are designed to reduce the frequency and duration of admission to psychiatric facilities, to provide treatment to the patient in the home and the community and to reduce the risk of mental disorders in high-risk groups.

Drug and alcohol addiction programs were brought under the administrative umbrella of the community mental health services program in the spring of 1983. Of the 256 programs currently funded by the Ministry of Health, 50 are for addiction services such as detoxification centres, assessment and referral services, and residential and outpatient treatment programs. All programs accepted for funding have been subject to the advice of the district health councils or, where a district health council does not exist, any other recognized health care planning body designated by the ministry.

On February 14, 1984, I announced the appointment of Windsor lawyer Charles J. Clark, QC, to head a review to examine the current practice of electro-convulsive therapy and to recommend guidelines for its use. Subsequently, 15 members of the committee were appointed representing a cross-section of disciplines, including psychiatry, psychology, bioethics, law, hospital administration and lay representation. The members of the committee act as an advisory board to the chairman, who will be responsible for formulating the recommendations and producing the final report.

An advertisement stating the terms of reference of the review committee was widely published in both French and English newspapers throughout the province. The ad asked organizations and individuals with an interest in this matter to make their written submissions to the committee by November 15.

The Oak Ridge division of the Penetanguishene Mental Health Centre is the only maximum-security psychiatric treatment unit in Ontario. Approximately half the patients at the Oak Ridge division have been referred there by the courts. Some have been found not guilty of a crime by reason of insanity; some have been found unfit to stand trial. The courts also send patients to the Oak Ridge division on warrants of remand for assessment at the forensic unit.

The balance of the patient population is referred from the 10 regional provincial psychiatric hospitals or from the general hospital psychiatric units. Like other programs of the Penetanguishene Mental Health Centre, the focus of the Oak Ridge division is on active treatment.

In order to test the effectiveness of current treatment programs, a seven-member committee chaired by Dr. S. J. Hucker, chief of forensic service at the Clarke Institute of Psychiatry, has been appointed to conduct an independent review of the Oak Ridge division. This review, now under way, is examining existing programs and the suitability of a maximum-security environment for patients. The committee will also outline the elements of an appropriate program evaluation process. I expect the review committee to submit its findings and recommendations to me early in the new year.

We have eight community advisory boards appointed to psychiatric hospitals in the province. Reporting directly to me, the boards' mandate includes the promotion of community understanding and awareness of mental health issues and assisting the hospitals in identifying and responding to the needs of their communities. At present, boards are in place at the psychiatric hospitals in Brockville, Hamilton, Kingston, Lakehead, London, North Bay, St. Thomas and Whitby.

Appointment of a board for the Queen Street Mental Health Centre was deferred pending the implementation of that hospital's 1981 organizational review. This has now been completed, and the process of seeking nominations for the community advisory board has been initiated by my staff. Similarly, I expect we will soon be announcing the appointments to the community advisory board for the Penetanguishene Mental Health Centre.

For some time now the ministry has been working to obtain university affiliations for all provincial psychiatric hospitals. I am convinced this would enhance the teaching and research component in our psychiatric facilities and attract additional qualified psychiatrists to work in the hospital setting.

At present, four of the provincial psychiatric hospitals have formal university affiliations. The most recent agreement between Brockville Psychiatric Hospital and the University of Ottawa was signed on September 20 of this year. Negotiations for the remaining hospitals are continuing and will receive priority attention.

In 1983, the ministry provided a $1.5-million grant to the Ontario division of the Canadian Mental Health Association to develop a major educational program. The focus was to promote greater awareness among the Ontario public about the needs of people who are struggling with mental illness, to educate citizens about the facts of mental illness and to counter the many myths and misconceptions that unfortunately still exist.

The public awareness and information program has consisted of staff training seminars, the preparation and distribution of brochures, and television and newspaper advertising campaigns.

 I am pleased that the ministry was able to provide additional funding of $586,000 in June 1984 for implementation of phase 2 of this important public education program.

The development of more community-based health care services has been a planned evolution within the Ontario health care system. To further this development, this year we released the guidelines and submission procedures for community health centres at the district health council annual conference.

CHCs are eligible to receive funding to provide identified primary care and treatment services to specific population groups. Ten existing CHCs are now in the process of negotiating program-based budgets with my ministry.

Two new community health centres have recently received budget approval from the ministry. They have been given the necessary pre-operational funding prior to beginning the provision of patient services later this fall. Our two newest additions are the Parkdale Community Health Centre in Toronto and the Merrickville District Medical Centre. Several other CHC proposals are also under development, including prospective organizations in Hamilton and Ottawa.

A different type of opportunity for those interested in developing alternative models for the provision of health care is found in health service organizations. Eighteen HSOs are now operating in Ontario and each has developed a roster of patients who agree to use the health service organization for their primary care needs. Payment is based on a monthly capitation basis in lieu of fee-for-service payments.

No, not decapitation; that is only if there is an overpayment, then we have to decapitate.

It is worth noting that the majority of health service organizations show a lower hospital utilization rate among their patients than exists among the general populace.

HSOs that are able to demonstrate this less acute hospitalization pattern receive an additional incentive payment from the ministry to develop noninstitutional-based services.

Like community health centres, health service organizations are no longer considered to be experimental but are recognized as legitimate and important alternatives to our more traditional models of providing health care services in Ontario.

The provision of health support services in the school setting will be an important aspect of implementing the Education Act of 1980. The ministries of Education, Community and Social Services, and Health have agreed upon a responsiblity model that includes my ministry's responsibilities in the areas of service delivery training, and direction and consultation.

Due to the experience of the home care program and its availability province-wide, for example, this program is particularly suited to assume responsibility for providing health services in the school setting. However, where services are already being provided by the crippled children's centres and rehabilitation centres, such service delivery will continue.

The target date for implementation for Bill 82 is September 1985. Regional workshops have been held across the province for all home care program staff and the appropriate service agencies. Regional meetings with school boards are now in progress in association with the Ministry of Community and Social Services and the Ministry of Education, and a tri-ministry committee has been formed to effect implementation.

The ministry continues to expand and improve primary health services for residents of northern Ontario. We are particularly committed to enhancing programs which bring such services to them. This approach has practical long-term benefits. It emphasizes, not undermines, the need for continuing development of medical capabilities in the north. The underserviced area program has played a key role in providing primary health care services across northern Ontario.

A very successful year for the recruitment of psychiatrists for Ontario has also been achieved and 43 are now on site. An extensive advertising campaign was carried out in British and American medical journals. Recruitment posters were sent to all university medical schools in Canada, Britain, Ireland and the United States. Ministry staff also attended several national and international psychiatric meetings. It was because of these strong recruitment campaign efforts that we achieved such a positive measure of success.

Our five Ontario medical schools encourage training experiences for students in urban and rural northern centres. Since 1972, my ministry has funded the northern Ontario medical program, which provides a training experience in the northwestern areas, from Marathon in the east to Kenora in the west, for undergraduate and postgraduate students.

The 1983-84 academic year saw 125 trainees select a rotational training opportunity under this program, the highest number since its inception. Of 210 doctors, more than 25 per cent subsequently established practice in northern Ontario.

There are a number of other northern training programs, including the eastern Ontario medical program. Here, the ministry funds rotational training experiences in Sudbury for francophone medical students from the University of Ottawa.

When emergency dictates that patients must be transported to major medical centres, air ambulance services are utilized. The system which serves northern Ontario residents is unparalleled in Canada. Last year alone, our five air ambulances flew almost 2,500 critically ill or injured patients from outlying areas to major medical centres.

There are several other developments in northern health care services that I want to mention at this point. First, a new general hospital is to be built in North Bay, amalgamating the Civic and St. Joseph's General Hospitals, and the North Bay Psychiatric Hospital will be redeveloped. The new amalgamated hospital will be built at an estimated cost of $65 million. Its construction will bring the total number of general hospital beds in the North Bay area to 396 from 364. At present, St. Joseph's has 171 beds and the Civic has 193.

In addition, a comprehensive mental health study will examine needs and services across northeastern Ontario. The study will review inpatient and outpatient services, as well as community-based mental health programs for the areas of North Bay, Sudbury, Sault Ste. Marie and Timmins.

A steering committee will be appointed to establish the study's terms of reference, and the ministry will ask for input from district health councils in northeastern Ontario, as well as from the community advisory board of North Bay Psychiatric Hospital. Once those are complete, there will be a call for tenders. The study, to be conducted by outside consultants, is expected to be completed by the end of 1985.

Second, I want to inform the members of this committee that the ministry has accepted the recommendation of the interim board of Timmins District Hospital to build a new facility for that region. Previous studies under the direction of the Cochrane District Health Council have recommended 306 beds for the Timmins Hospital Centre. This represents an increase of 57 beds over the 249 that are currently available at St. Mary's General Hospital and Porcupine General Hospital.

We are now approving the hiring of hospital planning consultants so that we may move ahead with developing the functional program for the new hospital. This study will determine the scope of services to be provided at the new hospital, the work load anticipated and the staffing and the space that will be required. I expect the consultants will be hired within the next few weeks. I also expect the architects will be chosen in the spring of 1985, when the functional program has been completed.

Finally, I am pleased to say that a new cancer treatment centre will be constructed at Laurentian Hospital in Sudbury. In developing the centre, both Laurentian and my ministry worked closely with the Ontario Cancer Treatment and Research Foundation, the Princess Margaret Hospital in Toronto and the Ontario Cancer Institute. Laurentian's cancer planning committee played an invaluable role, with broad representation from the whole Sudbury community. It was a genuine community effort. I want to thank the members for their fine work and planning for this new development. I am confident its presence will bring considerable support, care and reassurance to cancer patients and their families in northeastern Ontario.

In January 1984 the ministry began a study of French-language patient services in nine of our province's public general hospitals. The private consultants who conducted the study also provided the hospitals with an implementation/work plan. This plan was designed to assist the institutions in delivering necessary health care services to francophone patients.

To date, seven hospitals have approved the program and are in the process of ensuring that all departments have the required francophone components. This will complete phase 1 of the study. The executive directors of the hospitals will be provided with advice and guidance to ensure that the objectives of the work plan are being met and that the tasks assigned to various hospital departments are being carried out. This will conclude phase 2 of the study.

Similar studies will be conducted during 1985 and 1986 in some 20 other public general hospitals.

The ministry is also proceeding with a francophone services study in two psychiatric hospitals. Brockville Psychiatric Hospital and North Bay Psychiatric Hospital have been chosen. These studies will begin in November and should be completed early in 1985.

On May 1, 1984, the ministry and the Ontario Medical Association announced that standards and technology had been developed to allow more medical practitioners to submit OHIP claims by an automated billing process. This step is the most recent in a series of changes that are gradually moving OHIP away from employing a manually operated card input system. Almost 72 million medical claims a year are processed by OHIP. That works out to about 10 claims per second, on average, for each working day.

Various branches of the ministry collaborated on this project, enabling OHIP to be ready when the first doctor submitted a computer-produced claim. OHIP district offices around the province offer specification manuals and technical advice to any doctor or software supplier who requests information. Advantages of the new technology for OHIP include enhancement of confidentiality and fewer errors.

Doctors are able to submit their billings on a weekly rather than a monthly basis. This distributes OHIP's work load more evenly, smoothing out the significant operating peaks and valleys in claims processing. Also, claims that are rejected because of missing information, for example, can be reported more quickly, allowing practitioners to resubmit their claims and receive payment without delay.

The province's district health councils are essential players in planning and co-ordinating the development of health care services in local communities and regions. During the past year, the range of their activities has expanded and they have taken on a major role as partners with my ministry in defining the future shape of our health care system.

For example, 16 councils have established committees to develop health promotion and disease prevention programs in their communities and eight have already completed studies in this area. Most district health councils have also established emergency services planning committees, and all have nominated representatives to the six area committees on emergency care.

Other developments this year include the establishment of a steering committee to assess local support for a council in the district of Parry Sound and Muskoka and the startup of the Simcoe District Health Council. I will receive the report of the Parry Sound- Muskoka committee in the spring of 1985, and this will help us determine whether a council will be created in that area.

The county of Simcoe council, which was established late last year, is now well on its way. It has organized its own planning committee structures, hired staff and begun work on a comprehensive health needs study of the county.

The delivery of French-language health care services to Franco-Ontarians continues to be a priority. Three district health councils-Thunder Bay, Cochrane and Seaway Valley-are now mounting studies to determine the current availability of services in both official languages in their communities. The studies will identify if and where gaps exist and recommend appropriate solutions. Similar studies will be extended to other designated bilingual areas of the province in the near future.

In addition to all these initiatives, councils have continued their long-standing commitment to planning long-term care and mental health care services, to reviewing plans for new and expanded hospital and community-based health care programs and to promoting the rationalization of our health care system. Councils also received funding for 48 new special projects last year. These projects produce the background and information that is needed to substantiate DHC recommendations for new and expanded health care services in their regions.

We now have 26 district health councils active throughout the province serving the health care needs of approximately 92 per cent of the population. I want to point out that DHC membership is made up 40 per cent of health care consumers, 40 per cent of provider groups and 20 per cent of local government representatives.

No; actually, the recommendations do not even come forward from such sources. I have no way of knowing what the political affiliation is any of them; the recommendations come forward from the councils.

The councils represent a truly innovative approach to decentralized planning and developing of health care services appropriate to the regions and districts of our province.

The development of a health system appropriate to the Ontario environment requires a strong research component, one that is of high scientific quality and, equally important, is responsive to the service priorities of this province.

The Health Research and Development Council of Ontario was established in 1983 to provide advice from an independent external body closely tied to the research community. The chairman of the new council, Dr. H. Garfield Kelly, former vice-principal of health sciences at Queen's University in Kingston, was appointed by me in April 1984. The council now has 16 members, who have been selected from across the province.

The council is to provide me with advice on matters of health research policy, health research priorities and the principles of health research program design. To do this, the council has established close relationships with the granting agencies of the federal government and of the private sector to ensure the best focus for our own provincial research funding.

The council will also provide advice on the appropriate use of the knowledge gained from research in our health service activities. This is a most important aspect of the council's work. It is one of our priorities to ensure that research findings are disseminated and applied in a prompt and orderly way throughout the health care system.

The ministry also provides support to health research in Ontario through unsolicited research grants, corporate grants and contracts, health care research units, contributions to statutory foundations and by administering the ministry's allocation from the Provincial lottery.

The ministry administers directly two grants programs that fund the operating costs of specific research projects and one program that provides support to research personnel. Submissions for funds to carry out research projects or to support research personnel are made in open competitions at prescribed times during the year. Applications are initiated by individuals in the health research community rather than being solicited by the ministry.

Projects supported through this program-that is, corporate grants and contracts-are various. Some are unsolicited research studies of interest to the ministry which do not fit the terms of reference of the unsolicited grants programs. Other projects are initiated in response to research concerns that have been identified within the ministry.

Through the program of health care research units, the ministry supports a research unit at each of the five health sciences centres. These units offer consultation services on health research methodology. They conduct health research projects and provide opportunities for graduate training in research.

Through the unsolicited grants program-corporate grants and contracts and the health care research units-$5.8 million has been granted to 100 research projects and nearly $3 million has been awarded to 99 health researchers.

In 1984-85 the ministry has contributed $8.6 million to the research programs of three statutory foundations-the Addiction Research Foundation, the Ontario Cancer Treatment and Research Foundation and the Ontario Mental Health Foundation-as well as the Ontario Heart Foundation.

In recent years we have seen the rapid development of new and improved health technologies. Computerized axial tomography, positron emission tomography and magnetic resonance imaging are just three developments I might mention. The orderly introduction of these technologies within our health care system requires that they be placed where the expertise they require can be effectively used and where good patient access can be provided.

It is a priority of this ministry to develop appropriate standards and guidelines for the use of this new high-technology equipment as well as for the various new techniques and procedures.

We have, therefore, established a number of committees with specified areas of study which will serve as expert advisory panels to me. Three of these committees are the Advisory Committee on the Clinical Applications of Magnetic Resonance Imaging, the Task Force on Kidney Donations and the Committee on Renal Disease.

To assist and evaluate some of the newer technologies, the ministry has also provided grants to specific hospitals to purchase equipment such as a YAG laser, the latest technology in eye surgery. A grant of $100,000 to acquire a Y AG laser has been made to the Toronto General Hospital's department of ophthalmology with several conditions. These conditions are that the machine function as a provincial resource shared by researchers and physicians from other parts of the city and province; that other hospitals agree not to purchase a unit until completion of a provincial evaluation; and, finally, that a research protocol for the evaluation of the unit be submitted by the hospital to be approved by the ministry.

The evaluation will incorporate guidelines for the provision, distribution and operation of future YAG lasers in Ontario.

Committee members will recall that last year I discussed the formation of the health professions legislation review, which was initiated under my predecessor. This is the first major review of the legislation governing the health professions since 1970. It is designed to review those groups that require regulation and to update the regulating mechanisms. Our health care system continues to change and we must ensure that it continues to be appropriately and effectively regulated.

There are more than 200,000 members of the various health care disciplines in Ontario. Currently, about 170,000 are regulated by the self-governing bodies. I am pleased to report that there has been extensive participation by many groups during the review's first year and that the review is making substantial progress.

The review team, consisting of co-ordinator Alan Schwartz and his colleagues James Fisher, Morrey Ewing and Ms. Daphne Wagner of Canada Consulting Group, has received the support and co-operation of all those involved. At last count, 135 briefs had been submitted.

The review is an open process and all participants may have access to all submissions. Mr. Schwartz has encouraged participants to enter into dialogue with each other about matters of mutual interest, especially in areas where there may be disagreement.

The review is now in the process of completing its survey of how health professions are governed in other provinces, the United States and Europe-a total of 70 jurisdictions.

The survey discovered that only four other jurisdictions have attempted a systematic approach to this topic, with the Ontario review representing the most sophisticated attempt to date. Many of the jurisdictions surveyed expressed great interest in the outcome of our review and have asked to be informed about its results. I expect the report of the survey will be released in the next few months.

The review team plans to circulate a discussion paper on the various alternative legislative structures that could be used to regulate the health professions, and on alternative due process procedures that might be employed by governing bodies in dealing with complaints, discipline and registration matters.

By early 1986, I expect the review will be substantially complete and its recommendations ready for submission.

I am pleased to report that the affirmative action program undertaken by the ministry has had a marked measure of success. Thirty-one job areas in the ministry in which women historically have been underrepresented have seen significant change.

Results for 1983-84 show that women continue to move into management and other positions, including information systems, ambulance officers and machine operators. Of particular significance has been the hiring of female attendants at the maximum security unit at Penetanguishene Mental Health Centre.

Within the ministry in the past year, 364 women undertook career development assignments. Our affirmative action program provides a series of microtechnology workshops for women in clerical positions, for example, and an introduction to microcomputers for senior professional and managerial staff.

In line with the government's determination to extend affirmative action to publicly-funded groups, the Ministry of Health has held discussions with the Ontario Hospital Association regarding women employees in public hospitals. In conjunction with the Ontario women's directorate, the ministry plans to offer some new incentive funding, and I will be reporting results of these actions in the Legislature. In November, we will also be addressing these issues with the Ontario Hospital Association.

That concludes my presentation to the estimates committee. I look forward to having an opportunity to discuss with the committee members some of the topics I have raised. I might say that I had much more extensive opening remarks, but I felt that in recognition of the reduced number of hours we have this year, I would cut the opening statement to half or less.

In Ontario, we are accustomed to describing our health care system as one of the best, most efficient and most comprehensive to be found anywhere in the world. I suggest that is a tribute to the importance and priority given to health care by our provincial government.

It is a situation that exists because of the talent and ability of our health care providers, because of the hard work and effort of volunteer health care groups, and because of the expertise and dedication in our health care institutions.

In this province we have committed ourselves to providing health care services in a form and manner that will bring the greatest benefit to the greatest number of people. It is my conviction that we must all work together in a spirit of true co-operation to see that commitment is maintained and enhanced.