|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Province*** | ***Législature*** | ***Session*** | ***Type de discours*** | ***Date du discours*** | ***Locuteur*** | ***Fonction du locuteur*** | ***Parti politique*** |
| Ontario | 28e | 1e | Discours sur la santé | 24 Avril 1968 | Matthew Dymonf | Minister of Health | PC |

**Ontario’s Health Speech: First session of the 28th legislature, April 24, 1968.**

Hon. M. B. Dymond (Minister of Health):

Mr. Chairman, you will no doubt recall, sir, last year the format of the estimates of my department was changed somewhat. This change in form at reflected the reorganization of the department and the present estimates parallel the format of last year with three exceptions.

There has been added the health insurance registration board represented by a new vote in the estimates, 808. Under this same vote, you will find transferred the estimates far the data processing branch which appeared elsewhere last year. Grants in this year's estimates have been allocated to appropriate sections of the department and this vote has been deleted as such. With these changes, the general format follows the pattern established last year.

Because of the number and diversity of the activities of The Department of Health it is, you will understand, quite impossible to touch an each branch. Attention will be given here to those involved in changing responsibilities, and hon. members will no doubt have many questions pertaining to all matters.

Under vote SOl, departmental administration, will appear 18 items and in this statement I propose to elaborate the programme associated with only a few of these.

The Ontario council of health, which was established last year and which, you will recall, you were advised was to be the senior advisory body to the government of Ontario an health matters, has met in plenary sessions an three occasions and its committees and supporting subcommittees held 70 meetings. Through its committee structure, some 60 persons have been involved in the work of the council and through various subcommittees it is expected that the total number of active participants will alter from time to time, depending upon the need for special or particular study or information.

The involvement of a large number of parsons in this kind of activity has two advantages: it makes effective use of the skills available to government, and results in a substantial number of people acquiring a close and intimate knowledge of provincial programmes, and therefore the objectives of government, through The Department of Health. The primary and mare important committees working in the fallowing fields are: health manpower; education of the health disciplines; regional organization of health services; physical resources; health research; health statistics; library services.

This year we anticipate that each committee will be presenting a substantial report on its activities during the present year, which will provide advice to government an the planning and development of health services in Ontario. We are looking forward with some anticipation, far example, to the report of the committee on health manpower. We expect this to be a major presentation to council at its May meeting and this will provide an analysis of health manpower, which is most important to the work of the other primary committees and the planned development of service, educational and research resources for the health field.

Similarly, we expect the committee an the education of the health disciplines to advise an the location and general arrangements for educational programmes. A common pattern for the regional organization of health services, taking into account other related services, will be proposed. The committee an health research is defining the province’s role in health research. This, it is proposed, will be complementary to arrangements supported by the federal government and voluntary sources. The committee an health statistics will make proposals to close the gaps in our knowledge of essential information on health status and services.

The research and planning branch of the department is a multidiscipline organization which provides primary support and executive assistance to council. This branch has been expanded to keep pace with the very substantial programme which has been undertaken.

Provincial bursaries for medical, dental and other health services personnel have been increased for the next fiscal year by $500,000. This increase, we submit, is necessary to ensure that adequately trained persons are available for new and expanded programmes for health resources in the province. The expansion of our health resources in which the bursary programme plays an important part is tending to reverse the "brain drain" as a substantial number of persons are being attracted from other countries and locations to Ontario. It is most satisfying to find that many are Canadians who, having left Canada, now wish to return.

Funds for health research show an increase in the estimates before you of $1,321,000. A substantial part of these funds is allocated to the foundations and institutes associated with the department, but in addition, money will be available to permit the province to undertake health research in areas which are vital to the development of health services of high quality. Emphasis will be placed on operational research, which is the application of scientific methods of assessment to the administration, organization and procedures in our health arrangements. These studies will be designed to ensure the efficiency and effectiveness of these arrangements consistent with reasonable economy.

In the financial services branch, which is the second vote but is actually a part of general administration, during the latter part of 1967, the branch took the necessary steps for centralization of the accounting functions for the homes for special care programmes. Under the Canada assistance plan, the federal government will subsidize to the extent of 50 per cent, qualified expenditures in respect of persons placed in homes for special care.

At the present time, the accounting functions in connection with the homes for special care programme are still carried out by the business offices of the various Ontario hospitals and hospital schools. However, on April 1, 1968, the present decentralized accounting functions were consolidated into one single operation located in Toronto, and payments to nursing home operators and all others providing services will now be made from the central office.

The advisory services division of Treasury board has commended the establishment of the nucleus of a systems and procedures branch in the financial and administrative services division. Funds for this branch have been provided for in the 1968-69 estimates.

An increase of $1 million is requested in the estimates for home care. You will recall that this is a shared programme with the Ontario hospital services commission and is designed to support the development of comprehensive home care programmes. These arrangements plane an emphasis on the effective use of community resources and play an important role in decreasing the demand for hospital admission. It is our intention to stimulate the development of home care arrangements which have been carefully planned and developed to meet these objectives. More will be said of this under the hospital services vote.

The primary purpose of the local health services branch is to stimulate, guide and assist the progressive development of modern public health services across the province in close correlation with the needs for such services. The branch facilitates the delivery of provincial public health services to local health agencies and residents and provides consultative advice and assistance to local health agencies; promotes liaison and cooperation among agencies whose work affects the health of the public. It assists in the training of health personnel and development of public health research.

A measure of decentralization has been effected in this division during the current year by the establishment of the head office, located in Toronto, and the regional offices, located as follows: Northern-Toronto; southwestern-London; midwestern-Hamilton; central-Toronto; and eastern-Kingston.

The basic staff in the head office and in each regional office comprises consultants in public health in the following areas: dental education, inspection, medical, nursing and supporting staff. The administrative head in each office is respectively the senior medical officer and the regional medical officer.

The local health services branch staff in the five regional offices will be augmented by the addition of engineers, nutritionists and veterinarians as consultants.

The primary objective of the local health services branch in 1967 was amalgamation of local health units and health departments into district units to promote improvement and delivery of modern public health services. Based on exhaustive studies by a task force, it was recommended that the department establish 29 district health units in Ontario. Following review of this proposal by local officials and consideration of their comments, the department announced acceptance of the 29 district health unit boundaries. Fourteen district health units have been established and we anticipate adding at least four districts in the next two 0'1' three months. Fourteen of those district health units have been established and three more will be presently before the Lieutenant-Governor in council for approval. Consultations are going on steadily in respect of the others.

The 1967 Public Health Amendment Act and pursuant regulations provided for the payment of grants for all approved full-time public health services-25 per cent to' single municipal health departments and 50 per cent to municipal health departments farming part of health units. These became effective April 1, 1967. A 75 per cent grant to' establish district health units went into effect January 1, 1968.

Increasing emphasis is being placed on the role of the department in the development of province-wide programmes to insure adequate public health standards throughout Ontario. These programmes will be based on recommendations of task farces and of special committees, same of which had already been formed. All official local health agencies are included.

In October, reports of task farces and special committees and other reports were presented at a meeting of medical officers of health and chairmen of boards of health in Niagara Falls. The subjects covered preventive dentistry, tuberculosis control, school health, home care, family planning, health aspects of accidents, community mental health aftercare, immunizing agents, manpower resources, financing and other provincial programmes. The work of these groups has already proven to be of great benefit in the total public health programme.

There is no question that this will become steadily more important since it is becoming very evident that only in preventive health care can be found the most effective control of the rapidly escalating costs of treatment services.

The Air Pollution Control Act, with the exceptions of sections 12 and 13 which deal with automotive exhaust controls, was promulgated on October 26, 1967. On January 2, 1968, a general regulation became effective, the primary function of which is to replace existing municipal air pollution bylaws. Specific regulations, dealing with specific classes of industry or particular subject matter are presently being drafted. The air pollution control service is responsible for the enforcement of the Act and regulations.

TO' carry out its greatly increased responsibilities, the service has been completely reorganized and is being greatly enlarged. The municipally operated air pollution control programme for Metropolitan Toronto was amalgamated with the provincial programme an January 2, 1968, and those far Hamilton, London and Peel county are to be incorporated during the present year. The increase in personnel caused by the integration of existing municipal organizations will bring the total complement for the service for] 967 -68 to 85.

Supporting the service will be a 22-man air pollution laboratory section within the environmental health laboratories service. Work performed by the service during 1967 included approval of control installations for new industrial sources or for existing sources which are altered 0'1' modified; some 262 applications covering 347 major sources were processed. Visits to firms in connection with approvals totalled 323. Other direct measures taken, or underway, for the control of air pollution sources include:

1. Notification to' motor vehicle manufacturers that, starting with the 1969 model year, automobiles must be equipped with exhaust emission controls.

2. Notification to certain industrial sources of air pollution, not previously subject to control, that abatement of their atmospheric emissions must be undertaken now.

3. Asphalt mixing plants in the province have been surveyed and control requirements will be promulgated shortly.

4. A study involving the meat-packing and allied industries is currently underway in the Keele-St. Clair area of Toronto, as the result of which control requirements to reduce odours will be made applicable across the province.

Complaints concerning 181 sources of air pollution were investigated. Assistance was given on 73 requests from municipalities. Financial assistance far support af local air pollution control programmes was given eight municipalities, totalling approximately $150,000.

Air quality monitoring equipment, which will permit the continuous measurement of sulphur dioxide, oxides of nitrogen, hydrocarbons, oxidants, and carbon monoxide, has been purchased by the service. This equipment forms the nucleus around which a province-wide sampling network will be built. A special 300-foot micro-meteorological tower has been erected in Metropolitan Toronto and a portable 100-foot tower purchased for use in specialized locations in the province. It is presently erected at Windsor.

In the vicinity of four new industrial operations where control equipment has been installed, air quality studies which were being carried out before installation are being continued. These studies are being done in Atikokan, Guelph, Lambton county and Port Robinson. Emission surveys and air quality studies have been undertaken at Sault Ste. Marie, Aurora and along the Niagara River. A similar study is scheduled to start in Weiland in the immediate future. A cooperative air pollution monitoring programme is being carried out with the Peel county air pollution control agency.

Other studies are under way in the Grimbsy and Humberstone township areas, and in the Windsor-St. Clair River valley. The latter study is in response to a recent air pollution reference to the international joint commission, with both the federal and Ontario governments participating. The federal role is one of documenting trans-boundary flow. The province is responsible for the documentation of ambient air quality, atmospheric emissions and meteorology. The study will include an investigation of the effects of air pollution on vegetation materials and human health.

In the Sudbury area, available information on vegetation injury and atmospheric levels of sulphur dioxide is being evaluated. The meteorological parameters are being determined so that the necessary equipment can be purchased. An emission survey of atmospheric pollutants will be undertaken during

1968. Fog formation to the west of Copper Cliff is presently being studied.

Seven applications for funds for air pollution research projects, and one for equipment to be used in graduate teaching, were approved, the total financial assistance amounting to approximately $250,000.

Mr. Chairman, ordinarily I could shout him down, but I am afraid that today my throat has got the better of me. However I will sit down until he is finished.

A great deal has been said, Mr. Chairman, about pollution and I think it quite right and reasonable to say more should have been done earlier. There may be some consolation in the knowledge that we are not alone in this respect, by any means. The important thing is that the job is being tackled now, as one hon. member fears by "toothless legislation", and I quote, but in a positive manner.

Because there is much that is yet unknown about air pollution, fear and near hysteria are not uncommon among some likely to be affected, nor should this be surprising. All of us fear the unknown. But panic, sensationalism, misstatement, understatement, snap judgments, instant research and instant experts are not the answer or the solution. In my view, the opinions as expressed, for example, in Modem Power and Engineering of January 1968, give a far better understanding and more objective assessment of what we face and what we are doing.

One hon. member suggested that I refused to admit that I and my department had problems. Never was one so far off the mark. None knows better than we the problems we face, but each is a challenge which cannot be dealt with by turning our back or resigning as another hon. member suggested. There is only one way to deal with our problems, and that is to buckle down to them and seek solutions-controlling their effects as best we can while seeking and finding more permanent solutions.

I said that we did not need instant experts, Mr. Chairman.

What is it the the apostle says in Hebrews? Not easily provoked?

It is encouraging to note that the province has been able to attract engineering staff of high quality to this programme. When The Air Pollution Control Act was presented to the House last year, I indicated to you a five-year programme for the planned development of control arrangements. We intend to adhere to this pattern, but I must emphasize that, if the staff are involved in too many isolated incidents, it will be difficult for them to attain the planned objective.

This is not to suggest that important incidents should be ignored, and matters of this sort will be dealt with on a current basis. However, we are receiving many requests of a minor nature which do dissipate staff effort in a way which could adversely affect an orderly development of the control programme. The department will do its best to handle current situations, but, I repeat, a programme of this magnitude must proceed on an orderly and co-ordinated and planned basis.

The air pollution control service is to be expanded by the addition of 55 staff in our 1968-69 estimates, to bring the complement for this service to 140. The majority of these are required for work in the abatement section and in the approvals and criteria section.

In addition to the services provided locally for Metro Toronto, Hamilton, London and Peel county, regional and district offices will be established at Windsor, Samia, WeIland, Sudbury, and the Lakehead.

A small automotive exhaust control section will also be established during 1968-69. An instrumented meteorological tower is planned for the Guelph-Kitchener area.

Two complete gaseous sampling stations and other specialized monitoring equipment will be put into operation in Metro Toronto, and a mobile sampling unit obtained for surveys in various localities. Three mobile sampling stations are planned for the automotive exhaust control programme. Regulations are being drafted governing the emission of pollutants by incinerators, automobiles, asphalt mixing plants and the rendering and meat-packing industry.

In the less than one year of operation of provincial licensing of nursing homes, very considerable progress has been made. The size of the task can be judged by the simile of comparing 8,000 nursing home beds, to legislating for sixteen 500-bed extended-care hospitals. It is recognized that nursing homes are not hospitals, but, in fact, an alternate place of residence; nevertheless the needs of these residents for supportive care, as well as board and lodging, indicate service requirements not far below other extended care institutions.

In every large enterprise, there are initial problems, and the nursing home programme is no exception. At the outset, it was recognized that a single piece of legislation is not easy to apply to a heterogeneous group of institutions. The variation in servicing and physical plant alone showed wide divergence of function and need, within the frameworks of urban, suburban and rural areas of the province. Moreover, previous local nursing home legislation, or lack of it, together with the salient fact that nursing homes are over 90 per cent privately owned, all contributed to the difficulty of establishing a cohesive, smooth-working programme. Nevertheless, a good beginning has been made, and present indications show that the original forecast namely, that the task might take at least three years, and possibly five years-is strongly supported by the present accumulated information.

Up-grading is being undertaken as a cooperative effort by the medical officers of health and the provincial Department of Health, the former performing the prime inspection service, and the latter giving consultation and supportive help. In this connection, the importance of fire safety must be noted. In drafting the legislation, the advice tendered by the fire marshal for Ontario was accepted, and incorporated in the legislation.

This placed the onus for providing fire safety inspection service on the provincial Department of Health, and the size of this task can be understood when not one home in ten had adequate fire safety equipment. Equipment alone will not provide fire safety; the need for training of nursing home staff is of prime importance, and plans for this education process are being established.

While there have been losses of nursing home beds to the community, these are being offset by new building. At the end of 1967, there were over 1,000 new beds presently building, or being built, in some 35 homes. Since more than half of these beds are in three large projects, the department is studying the optimum size of nursing homes with the result that a provisional figure of 200-bed maximum has been established, in line with homes for the aged practice.

As mentioned previously, attention is being given to the need to provide nursing home patients with structured broad rehabilitation programmes to prevent, insofar as is possible, any feelings of isolation and banishment from the community.

As far the future of nursing home care is concerned, with an aging population -that is, over nine percent aged 65 and over-some 700,000 persons in the province are potential consumers of nursing home services. From this basic figure, we believe a possible needs formula to be two nursing home beds per 1,000 of population. The homes for special care programme continues to make satisfactory progress in placing in nursing and residential homes, category 4 and category 5 patients discharged from Ontario hospitals. By the end of February, 1968, 5,200 nursing care patients, and 1,200 residential home patients have been placed in the community since the inception of the programme.

There have been significant population movements and there were 350 deaths in the past year in this group. Returns to hospital during the year number 160, but most of these are temporary for restabilization. Discharges have increased to '80, but still remain disappointingly low. Many patients improve greatly when discharged and, therefore, more could go to their own homes if relatives felt able to accept them.

In the past six months, we have arranged with The Department of Social and Family Services to identify those homes for special care patients who, by virtue of indigence or other qualification, become eligible for assistance under federal-provincial cost-sharing welfare arrangements. Some 2,000 patients have been so identified to date, and there will, undoubtedly, be more.

I am pleased to report the marked progress made in the re-organization, and in the further advancement, of the provincial mental health programme. The mental health division is responsible for the planning, development and administration of the provincial mental health programme, the objectives of which are:

1. The appropriate distribution of services so that assistance will readily be available.

2. The provision of a full range of diagnostic and treatment services, offering a continuity of care through the use of in-patient, out-patient, and day care programmes, in each area of the province.

3. An adequate volume of services of a high standard.

4. The co-ordination of community, regional and provincial resources to achieve a properly balanced programme of prevention, diagnosis, treatment, and rehabilitation for the mentally ill and the retarded.

In recent years, an increasing number of local agencies have been encouraged to meet the need for additional services, and at the present time, there are approximately 90 facilities offering psychiatric services throughout the province. Included in this number are: 15 provincial hospitals for the mentally ill; nine provincial facilities for the retarded; six community psychiatric hospitals; 41 general hospitals; and eight mental health clinics as well as a number of private hospitals and other types of facilities.

Because of additional resources within the division, it has been possible to initiate a number of new projects, each of which has a direct application to the stated objectives of the mental health programme.

Basic data pertaining to the current bed utilization for the care and treatment of the mentally ill and the retarded has been compiled. 'This information is being utilized in the preparation of master plans for the provision of services throughout the province in relation to anticipated population growth, and in the development of short-term and long-term plans for each of the provincial facilities. In the formulation of these plans, particular attention is given to population distribution, and to the co-ordination of related services.

Closer working relationships have been established within government and with outside bodies. A liaison committee has been established with the senior officers of the mental health and public health divisions to achieve a close collaboration in the further development of the respective programmes. This committee will continue to focus its attention on certain target areas, such as aftercare and school health services, in order to set guidelines for co-ordination of services at local and regional levels.

Closer working relationships have also been established with The Attorney General's Department in respect to the provision of psychiatric services to the courts in the examination of individuals charged with a capital offence.

A liaison committee has been established with the five professional associations identified with the field of mental health. This has provided an opportunity for the senior staff of the division to review the present programme with the representatives of these associations, and enlist their assistance and support in the further development of mental health services in Ontario.

A similar relationship has been established with the five professors and heads of departments of psychiatry at the universities in order to co-ordinate the further development of training programmes in relation to the service programmes.

The professional services branch has been particularly concerned with staff development and recruitment. A new curriculum for training of hospital aides and attendants has been prepared and is in use. Negotiations are being carried on with the college of nurses in order to gain recognition of the training programme so that our graduates will be eligible for registration as nursing assistants.

In-service training programmes for supervisory staff are also being developed. Each of the consultants meets regularly with the heads of the corresponding department in the provincial facilities to promote the further development and application of their professional knowledge and skills.

Extensive advertising and recruitment programmes have been undertaken in Canada, the United States, and the United Kingdom. Continuing correspondence with individuals and contacts with professional groups are maintained in an effort to recruit staff for the programme. The staff of the branch maintain close contacts with the university centres to promote the development of clinical teaching, and to assist in arranging field placements.

The bursary programme for psychiatrists has been revised and extended, and bursary assistance is being provided to other professional groups.

All of these activities have been undertaken in an effort to raise standards of care. New projects to be undertaken in the coming year include studies of patterns of service within the community, in order to find ways of making more effective use of available resources and to direct more attention to preventive programmes. The potential of community colleges and technical institutes for training mental health personnel will be explored, and residency programmes developed in clinical psychology, psychiatric nursing, social work and activity therapies.

It is evident that widespread changes and re-organization are taking place in programmes of treatment and care, in staffing patterns, and in professional education. Every effort is being made to use, and to influence, these trends for the greatest possible benefit for the mentally ill patient and the community.

The hospital management services branch has also undertaken a number of special projects which are related to the administration and management of the provincial facilities in an effort to raise the standards and quality of care in this regard as well.

As a further step in the administrative reorganization of the provincial facilities, specific plans have been made to adopt a cost accounting system on a departmental basis, and to establish mare clearly, defined budget, accounting and cost control systems. By April, 1969, all provincial facilities will operate on the standard cast accounting system used by all general hospitals.

This standardization and uniformity will provide considerably mare information, permit the development of standards applicable to, all mental hospitals and the intelligent use of cost controls and comparisons and, I may add, Mr. Chairman, will prepare us to, fit in to, that day when under the just society, mental hospitals shall be brought within the framework officially of federal-sharing-in-total-hospital-care programmes.

Training and educational programmes have been undertaken for a wide range of hospital employees. Management seminars have been provided far senior administrative staff. Regular in-service training conferences are being held for senior management staff and department heads. Courses are being arranged in collaboration with the provincial institute of trades, and The Departments of Labour and Education for senior food preparation staff and apprenticeship training for butchers, bakers, cooks and other similar vacations. Staff are also, being involved in courses offered by the Ontario, and Canadian hospital associations for food supervisors, housekeepers, medical records technicians and clerks.

The branch has also been assisting the hospitals to prepare far accreditation by the Canadian council on hospital accreditation. One of our provincial hospitals was included in the three mental hospitals surveyed by the council last year, and achieved provisional accreditation. This was the first provincial mental hospital to, be surveyed, and we are very pleased that the Lakeshore psychiatric hospital received this recognition.

I was most proud, Mr. Chairman, to, have the opportunity, in company with one of the hon. members for that area, to, visit the hospital and to officiate on the occasion of the official recognition of this achievement.

During the past year, the mental hospitals branch has been engaged in an extensive review of the clinical services and physical facilities at the 16 provincial hospitals. In carrying out this study, particular attention has been given to the supporting roles and relationships of other agencies and services. Continuing efforts will be made to, achieve better co-ordination and utilization of the resources in the community, and in the region which the hospital serves. Special attention has been given to, the development of services for children in accordance with the government programme. Throughout the system, staffing patterns are being reviewed and studied to, determine the most effective means of raising standards of clinical care. The unification of nursing services has been completed in most hospitals and is in process in the remainder.

During the past year, staff formerly identified with the rehabilitation branch have been integrated into the hospital programmes so that they will work mare closely and effectively with all services in the hospital in assisting patients to return to the community. Industrial therapy programmes have been expanded, and the fun range of programmes related to vocational and recreational activities are being re-organized under one department. A number of improvements have been made in hospital accommodation and facilities. The first phase in the new construction at the hospital in London is nearing completion, and the preliminary plans for the reconstruction of the hospital in Toronto are well advanced. The construction of the new hospital to, serve north-eastern Ontario, is virtually complete and a number of senior staff have been appointed. The new block of retraining apartments at Penetanguishene was officially opened in October. Renovations have been carried out, and are in process in a number of the hospitals. Any major changes to be made in the building at any of the hospitals now, will be based on the master plans under development for that hospital and the region it serves.

Additional programmes for the treatment of alcoholism have been established within the mental hospitals in collaboration with the addiction research foundation, the government’s agency in this area of service. The relationship and continuing liaison with local and provincial educational authorities, Mr. Chairman, is being strengthened to provide the necessary services for patients within the provincial hospitals with particular reference to children and adolescents. Greater involvement and collaboration with public health agencies is evident within the hospitals and in the central administration of the programme. Public health nurses have been appointed to the staff of a number of hospitals to further strengthen the link between the hospitals and the public health services at local and regional levels. The guidelines prepared by the public health and mental health divisions in respect to aftercare have been circulated to, assist those concerned in co-ordinating their efforts in this area of programming.

The activities of the mental retardation branch have been greatly strengthened by the interdepartmental committee on mental retardation and the liaison committee with the Ontario association for the mentally retarded. Out of these co-operative and coordinated efforts, better services are developing and will develop still further. Within the provincial facilities, special attention is given to the multiple-handicapped child and to the seriously retarded, as well as to the needs of families for support and back-up assistance, particularly where children are being managed in their home.

The development of new services and training programmes has been pushed forward vigorously. With the assistance of the Department of Education, the number of teachers working within the facilities has been increased by 26 to a total of 127. Additional classrooms have been provided, and the number of children receiving classroom instruction has been raised by 16 per cent to approximately 1,200. The procedures for assessing the needs of the child and the family situation have been revised so that requests for institutional care can be handled more efficiently. A rating scale has been devised, and is being used to establish the urgency of the need for placement, and to identify those children who require prompt attention. The public health division has been particularly helpful in the development of a programme which makes use of staff of the local public health agency in assessing the family situation.

A new in-service training programme has been prepared for the staff providing day-today care, training and instruction for the retarded, for implementation this year. In the curriculum, emphasis is on child-care and child development principles. Provision has been made in the staffing of the branch for a co-ordinator of in-service training, who will work closely with the facilities in the introduction of the new training programme.

At November 30, 1967, there were 10,535 patients in the 15 provincial hospitals for the mentally ill, in comparison with 11,402 at this same date in 1966. The total population in the residential units of the hospitals has also shown a slight decrease from 2,657 to 2,624. The number of patients admitted during this 12-month interval was increased from 13,377 to 14,765 and the numbers of discharges from 13,604 to 14,979. During 1966, two psychiatric units were added to general hospitals for a total of 63 new psychiatric beds, and a further unit of 44 beds was added during 1967 for a total of such beds to 769. Admissions to these units totalled 8,690 and discharges were 8,645.

Five new out-patient services were opened in general hospitals during 1966, bringing the total number of facilities providing outpatient psychiatric services to 55. The community psychiatric hospitals provided 175 beds in 1965 and 381 in 1966. The number of admissions to these facilities rose from 1,013 to 1,392 and discharges increased from 1,003 to 1,287.

One new community psychiatric hospital was established in 1967 at Hamilton, and the new building for the expanded programme at the C. M. Hincks treatment centre in Toronto was completed. This facility offers extensive out-patient and day care services for children and adolescents, as well as 16 beds for in-patient diagnosis and treatment. The first stage in the construction of the new community psychiatric hospital in Windsor was completed, and the second stage was started. This work will be completed this year and provide 80 adult beds for the care and treatment of the mentally ill. Having completed the new buildings, renovations will be carried out in one of the existing buildings to accommodate the regional centre for children.

The total population of the provincial facilities for the retarded was 6,900 at November 30, 1967, as compared to 6,845 at the same date in 1966. This increase is accounted for by the expansion of programmes in some of the newer facilities, and there has been a reduction in the population at the hospital schools at Orillia and Smiths Falls. The number of admissions increased from 1,083 to 1,309 and discharges from 861 to 1,138 during this interval.

During 1967, the number of beds for the seriously handicapped in privately operated facilities was increased by the opening of a unit at the Ongwanada sanatorium in Kingston, and expansions of the programme at the Brantford and Fort William sanatoria. There are now approximately 550 beds for such children throughout the province, which are maintained by the government.

By the end of 1967, 5,745 persons had been discharged from our mental hospitals to homes for special care. This substantial movement of patients, with careful placements in selected homes, was achieved in a period of three years. It represents an important development of community services to provide a level of care required by a substantial number of persons who can be discharged from hospital and returned to a community setting. The province expects to make substantial claims against the Canada assistance plan for the support of this programme.

Significant advances have been made in the recruitment of professional and other staff to the provincial facilities during the past year. The advertising campaigns, recruitment efforts by staff, the introduction of contract employment, a new class series for psychiatrists, improved salaries, as well as the general recognition of the advancement of the programme in this province have all contributed to this change.

Full-time medical staff has increased to 206 at January 1, 1968. The number of psychologists and psychometrists has increased to 100, and social workers to 174. Occupational therapists and OT assistants had increased to 252. Ward staff increased by approximately 400.

The total allocation of positions for the hospitals for the mentally ill for the fiscal year 1967-68 was increased to 10,353 and for the facilities for the retarded to 4,474. The number of full-time staff employed within the mental hospitals at January 1, 1968, was 9,833 and in the facilities for the retarded, 4,236. In addition to the full-time staff, a number of professional staff are employed on a part-time basis.

At January 1, 1968, there were 107 psychiatrists enrolled in post-graduate training programmes at universities in Ontario. The number of trainees has been increased from 90 in the previous year. Bursary assistance is being provided to 50 psychiatrists in training, and an additional 21 are on the staff of the mental health division having been selected as career-line trainees.

The number of students enrolled in the occupational therapy assistants course was increased from 44 to 71 last year. Five hundred and thirty-one hospital aids in attendance completed their training in 1967. In addition to the bursaries provided for psychiatrists, bursaries were granted to four psychologists, 39 social workers, 11 nurses, one speech therapist and one teacher during 1967.

An increasing number of clinical studies and research projects are being carried on within the provincial facilities. All moneys from the federal and provincial governments for project research are administered by the Ontario mental health foundation. During the past five years that the foundation has taken the responsibility for co-ordinating and developing research activities, the number of projects supported through the foundation increased from 13 to 73 and the moneys provided for this purpose from $85,000 to $782,000. The chairman of the Ontario mental health foundation has just recently advised me that no project was rejected because of lack of funds.

Mr. Chairman, may I remind the hon. member again that he blamed me personally and I simply…

I do not think he would grasp the force of this, but I trust my staff and they know they must assume responsibilities. They do what they believe in their professional judgment is best for their patients. The medical director whose hospital achieved accreditation, a very much sought after achievement in the hospital field, is one of the most highly regarded men in our whole profession, and the hon. member's statement is a scurrilous attack on the professional reputation of a respected colleague.

Only one thing can flow from a review of this or like cases in this House. The persons involved here, Mr. and Mrs. Uberlah, are bound to be hurt. I have no desire to do this. I repeat, I respect and trust the good judgment of my staff in such matters. At no time am I consulted on such questions; I am advised, after the fact. I have not, in nearly ten years, had reason to change this procedure.

I might add that the decision to increase the per diem rates had been reached and was being processed before the hon. member wrote to me about it. In the case of emotionally: disturbed children, Mr. Chairman, the five departments identified with the government programme are proceeding with implementation of the programme described in the white paper tabled in the Legislature a year ago. These efforts are co-ordinated by an interdepartmental committee of senior technical officers representing each of the departments concerned. There has been continuing liaison with many groups identified with services for children at the local level, in order to review the programme and provide the guidance and direction required for co-ordinated action on a broad basis. These involvements have been productive in identifying problem areas, gaps and overlapping of efforts to provide services, and in enlisting the support and co-operation of those who work in this field.

The development of the regional centres is proceeding as quickly as facilities and staff can be provided.

Ottawa: This city has been providing an out-patient and day care programme for same time. An 18-bed in-patient unit was opened in July last year pending" the construction of a new children's centre.

Kingston: An out-patient service has been in operation for many years. A 16-bed inpatient unit was opened in May of last year in a separate building completely renovated for this purpose.

Toronto: A new out-patient service has been established at Thistletown, a master plan prepared and submitted to increase the capacity of the Thistletown facilities to 160 beds. Renovations to the former Toronto psychiatric hospital are nearing completion and will enable the mental retardation centre to expand their programme to provide a total of 55 beds and an enlarged out-patient and day care service.

Hamilton: An out-patient and day care programme has been established as the first stage in the development of the regional centre and additional space made available to expand these services. Preliminary plans have been prepared for the construction of the new buildings.

London: Beds have been provided for 50 emotionally disturbed children and adolescents at CPRI. Approval has been given for the construction of three new cottages which will provide an additional 36 beds, and plans are now being prepared.

Windsor: An out-patient service is being provided at the community psychiatric hospital and the construction of the new community psychiatric hospital is nearing completion. It will not be possible to establish the in-patient unit until the new addition to the general hospital has been completed, but I reiterate for emphasis, Mr. Chairman, an out-patient service is now being provided..

Sudbury: Out-patient services are being provided and an in-patient unit is under development.

Port Arthur: Out-patient services are being provided and the in-patient service in the diagnostic and assessment unit will be expanded as soon as additional professional staff are available.

Special liaison personnel have been assigned to the eight regional centres by each of the departments. Of the 32 such positions, only four assignments remain to be made. These vacancies are due to the fact that staff with the necessary qualifications are not available, and the positions will be filled as soon as possible. . At the present time the regional centres provide approximately 450 beds. The present plans call for an expansion of these facilities to 850 beds. Since several of the expansion programmes involve new construction, it will take some time to reach this objective.

Additional services primarily for adolescents, and representing approximately 400 beds, have been identified for development in Ontario hospitals and community psychiatric hospitals. Some of these programmes are already in operation, for example at the Lakeshore psychiatric hospital and the Ontario Hospital, Hamilton. A task force of child psychiatrists has been established to assist those responsible for these programmes in development of their clinical services as quickly as possible.

An expert and technical committee has been established in relation to each of the eight regional centres. These committees consist of the regional medical officer of health who is the chairman, the director of the regional centre, and the four special liaison officers assigned to the regional centre by the other department of government. The purpose and fonction of the committees is to provide expert and technical advice and assistance to communities in the development of co-ordinated programmes for children. A number of communities have requested such assistance, and have been advised of the resources available to them through the expert and technical committees. The local medical officer of health is a key person in the co-ordination of mental health services for children, as in other aspects of local health services.

Priority has been given to programmes for children in supporting the development and expansion of mental health services in the community. A new diagnostic and assessment centre has been established in Ottawa. An out-patient service opened in Niagara Falls. A new pilot project directed to primary prevention was undertaken in the Muskoka region. The children's clinic reopened in Oshawa. The clinic in Hamilton expanded. The new C. M. Hincks treatment centre opened in Toronto, as already stated. The diagnostic and assessment service at the Metropolitan Toronto juvenile and family court was re-organized and placed under the direction and supervision of the Clarke institute of psychiatry.

While we are sensitive to the present need for residential placements we are even more anxious to provide facilities for early diagnosis and treatment for these children in an effort to avoid the necessity of removing them from their home and community for a lengthy period of residential care.

The number of child care workers in training at the Thistletown hospital has been increased to 130 and additional space provided for this function. Additional training programmes have been established at CPRI in London, the Lakeshore psychiatric hospital, and in Ottawa. Two community colleges are now providing courses for child care workers. A committee has been established in collaboration with The Department of Education to co-ordinate the further development of training centres for child care workers and to relate the training programmes to the standards established at Thistletown and adhered to by all provincial facilities offering such courses of instruction.

Standards for accreditation have been prepared and were distributed in November. Because of the need for residential placements, first attention was directed to those facilities offering treatment services by a local agency under schedule 4 of The Children's Institutions Act. Copies of the standards and the accreditation manual have been provided to other facilities on request. Five facilities have been inspected and one more inspection has been arranged. In several instances we are waiting for the facility to complete and return the survey manual. Those facilities which achieve full or provisional accreditation as a treatment centre will come under the jurisdiction of The Department of Health and will be listed under schedule 4 of The Mental Health Act. Under the provisions of this Act and regulations financial assistance will be provided to the facility to cover the net allowance operating costs so that an individual parent or guardian will not be required to pay for the services provided to his or her child.

The other departments participating in the programme are developing similar methods for establishing appropriate standards for those facilities operating under their jurisdiction and comparable financial arrangements.

All the regulations required to bring the new Mental Health Act into force have been made, filed and published. Much discussion has been had with various groups who will be using the provisions of the new Act to help them become familiar with the changes that are being introduced. These discussions have been valuable and have met with favourable response.

It had been hoped that the new Act would have been operative by this time, but the preparation of regulations and the printing of the new forms to be used have been very large tasks. It was deemed better to take the time necessary to familiarize everyone concerned with the regulations, and with our aims and objectives, rather than to rush the legislation into operation before this had been done. As soon as the required forms are available, and they are now available, sample kits will go forward to all who are likely to be using them. Every effort will be made to insure that doctors, hospitals and any others relevant are fully familiar with every aspect of the new Act. We anticipate this can be accomplished by June 1, and we would look to the proclamation of the Act and its becoming effective on that date.

Many improvements and procedural changes occurred in the administration of the medical services insurance plan during 1967 and these will continue to be reflected in the fiscal year 1968-69. The highlights of these achievements were reflected particularly in the following areas.

As a result of OMSIP, just over 95 per cent of Ontario's population as of December 31, 1966, is believed to enjoy medical services insurance coverage. OMSIP's enrolment continued to grow and, by the end of 1967, an estimated 2,000,000 people, or almost 30 per cent of Ontario's population were covered under the plan. Of this total, just over 50 per cent were in receipt of some form of premium assistance.

The breakdown of OMSIP's coverage is as

follows:

Social assistance recipients and eligible dependents .................... Fully assisted .............................. Partially assisted ........................ Full premium paying..............

-----

Total 2,000,000

Temporary assistance-llO,OOO-persons receiving temporary premium assistance, but whose regular contract would be included in the full-premium-paying or partially assisted categories.

The completion of the transfer of PSI paydirect subscribers to OMSIP was realized by the end of 1967. 108,000 former PSI paydirect contract holders are now covered by OMSIP, effective January 1, 1968. As of January 1, 1968, OMSIP offers group medical insurance coverage through the health insurance registration board. Many groups previously too small to qualify for coverage by private companies are eligible under this new provision. The minimum size of groups is six persons, much smaller than usually required for group coverage by private companies. And there is provision for "collectors' groups", an innovation for medical insurance in this province.

The latest figures recorded on the computer

subscriber file indicate:

Groups 130

Persons covered 5,500

An extension of benefits is being proposed

in an amendment to The Medical Services Insurance Act to include refraction services provided by optometrists as well as by physicians. It will be proposed that the section of the Act dealing with "examination of the eyes by refraction" be deleted and ocularvisual assessments when carried out by optometrists or non-specialist physicians will be included in the extended programme.

Steady improvement in the claims payment operation was made during 1967. New systems were introduced, including a method of cyclical payment to physicians. Staff was rigorously trained and re-trained. The processing time for an average claim was reduced to approximately three weeks. But unusual claims are still difficult to handle and are inevitably delayed.

The number of claims received, processed

and paid by OMSIP in 1967 is as follows:

Total claims submitted in

1967 4,251,945

Total claims processed in

1967 ,.................

Total claims paid in 1967 ........ Total claims returned for insufficient information 89,675

An active information campaign was conducted in 1967 to inform physicians and subscribers as to the basic requirements of accurate claims filing. This campaign included direct-mailing to all subscribers, which tied in with television, radio, and newspaper advertisements. The proportions of payment of claims is as follows:

Claims paid directly to the

physician 80 per cent

Claims paid to the subscriber,

submitted by the doctor on

a claim card 7 per cent

Claims paid to the subscriber,

submitted by the subscriber

as a letterhead account 13 per cent

The hon. leader of the Opposition suggested the two health insurance programmes be brought together. You see, sir, that this is an excellent suggestion. You will recall when at the last session of the Legislature, the health insurance registration board was established, it was for this purpose. If you will permit me to quote a statement at that time:

It will permit a maximum integration of hospital and medical services insurance, and establish a mechanism which can be extended to other health insurance arrangements sponsored by government.

At the same time, it envisages the retention of the services and programme components in the Ontario hospital services commission and the medical services insurance division.

This is required for many reasons but the fundamental principle set forth in the first sentence is not offended or transgressed in any way. It is the intention of government to integrate these programmes as quickly and fully as possible.

The health insurance registration board acts as insurer for both the medical services insurance plan and the Ontario hospital services commission. Under the terms of The Health Insurance Registration Board Act, 1967, it has the function and power:

a. To establish and administer a system to provide for the enrolment and entitlement of persons to coverage for insured services under The Hospital Services Insurance Act and The Medical Services Insurance Act, 1965, including the collection of premiums and the determination of eligibility.

b. To maintain a central registry and records for insured persons under The Hospital

Services Commission Act and The Medical Services Insurance Act, 1965.

The board began to function in this capacity at the beginning of 1968, and is the prime interface with the public on health insurance matters. This integration of the insurance aspects of the two programmes is leading to a more effective management of health insurance arrangements in the province, and provides a vehicle which can be used for any extension of health insurance in the future.

At the same time, it recognizes that the Ontario hospital services commission has an important programme in the development and the maintenance of a hospital system for the province. Similarly, medical services insurance is concerned with personal health care arrangements and, in this way, both agencies have important programmes to manage.

As mentioned at the start of this presentation, the health data centre has been placed with the board, as the computer requirements for the two operational programmes constitute a substantial part of the work of such a centre. However, it should be recognized that the health data centre has a two-fold responsibility. An information system must be provided which serves the functions of enrolment, eligibility, billing and claims payment for health insurance and, at the same time, collects meaningful data which can be utilized in an evaluation of the health insurance programme. Second, systems engineering, programme design and data processing must be made available to assist other organizations within the department such as air pollution control, research and planning branch, mental health division, Ontario provincial laboratories, general and psychiatric hospitals and others concerned with the total spectrum of health services in the province. This health data centre will be the focal point for a health statistical system, and through the development of this system, Ontario plans to have one of the most advanced health information centres in the world.

One of the advantages of the health insurance registration board is that the pattern for handling enquiries from the public is being dealt with in an efficient and expeditious manner. This was one of the major problem areas associated with the development of OMSIP-and those who were in this House at the time OHSC came into operation will remember we had the same problems with it-and the new set-up is demonstrating a greatly improved ability in this regard. As an indication of the magnitude of the problem, the health insurance registration board receives 7,500 written, and 11,000 telephone inquiries each week. Answers are required for all of these and a substantial proportion require investigation before the answer can be provided. We are trying to ensure in the future that inquiries will be answered within one week or, where investigation is involved, a definitive reply will be provided in three weeks. This is a difficult objective to achieve, but I am assured by my staff that it will be accomplished in most instances.

The story of Ontario hospital insurance, since it was launched on January 1, 1959, is one of increasing service and peace of mind for the people of Ontario, but it is also one of rising costs and greater use of hospital services. Never, in the history of the province, has necessary hospital care been as readily available to the people from the standpoint of finance. In just over nine years, millions of patients have received benefits amounting to over $2.5 billion.

A number of factors have combined to greatly increase the cost of the plan and the upward trend is expected to continue for a number of years to come. The main items bringing about the increases are:

1. The increased costs to hospitals for salaries, wages, and practically everything else they must buy;

2. The availability of more hospital beds and greater use of hospitals by the general public;

3. Improved medical techniques requiring more complex hospital diagnostic and treatment services; and

4. The increased number of insured persons and a broadening of the range of services insured under the plan.

Along with the higher costs, however, has come a better hospital product. The rapid progress medical science is making has added to the cost, but it has also enhanced the patient's prospects for recovery to good health. Modern hospitals now offer their patients the lifesaving benefits of such scientific advances as: intensive care and special coronary care units; kidney dialysis machines; sophisticated X-ray; laboratory and electronic equipment; and many other wonder-working facilities. These have made modern hospital care very much superior to the kind of care that was available a decade or two ago.

In its first nine years of operation, the total cost of the Ontario hospital insurance plan increased from $223 million in 1959 to an estimated $612 million in 1967. The cost forecast for 1968 is $744 million. On the average, OHSC administration accounts for less than 2 per cent of the total cost of the plan. About 75 per cent of commission payments to hospitals cover the salaries, wages and fringe benefits received by hospital employees.

In 1959, the average cost to the commission for each day of insured care in general hospitals was $16.16. The estimated daily cost in 1967 is $32.81, a little more than double the 1959 cost. The cost per day in 1968 is expected to average $37.35, and if the present trend continues, the cost in 1970 will be over $46 a day.

The estimated number of persons insured at December 31, 1967, was 7,149,000 which represented approximately 99.2 per cent of the eligible population of Ontario-based on population estimates of the Dominion bureau of statistics at June 1, 1967, and adjusted for growth to the year end.

As is well known, the insurance plan in Ontario is financed by premiums and contributions from the federal and provincial governments. Of the total estimated cost of some $612 million in 1967, $190 million was provided by the provincial government-approximately one third of the total-$157 million was provided through premiums, and $226 million was provided by the federal government. The remaining $39 million is accounted for by additional capital construction support provided by the government of Ontario.

There is still existing much misunderstanding concerning the cost of care in mental and tuberculosis hospitals. From the beginning of the plan in Ontario, this has been an integral part of our programme, and since the federal government has steadfastly refused to recognize this and to participate in it, as legitimate hospital care costs, the government of Ontario has financed it wholly out of provincial moneys.

I must re-emphasize that this is an integral part of the hospital care insurance programme in Ontario, and no matter whether it had been done prior to the inception of the plan or not, it is still an important phase of our operation. I would point out there were other services provided out of provincial funds prior to the inception of the hospital programme-these, too, have been included in the plan and accepted as part of the provincial contribution.

The cost of hospital services covered by OHSC, the special grants, mental and tuberculosis care in 1968, will reach approximately $744 million, of which the province of Ontario will assume liability for approximately $250 million.

The provincial government has, since 1947, been paying grants towards the cost of public hospital construction and renovation programmes. To the end of 1968, the amount paid in these grants will be approximately $222 million, and as an additional spur to hospital construction, a further estimated $100 million will also have been provided hospitals in the form of low cost loans to help them finance their capital programmes. This is in keeping with the province's policy of financial assistance to hospital boards to the extent of two thirds of the approved cost of construction and equipping new and renovation projects. The federal government has contributed $96 million for capital purposes to hospitals in Ontario in the period 1947 to 1967.

Increasing costs for hospital care are not new, nor are they confined to the province of Ontario. Ever since World War II, the science of medicine has been introducing many important discoveries and improvements, and as the economy in Canada and the United States has taken an upward trend, hospitals have had to cope with greater costs.

It was anticipated that, by this time, there would be a "levelling off" in the rate of salary increases but the general inflationary trend in the province's economy has resulted in a continuing sharp annual increase in hospital pay rates. In addition, the greater complexity of hospital service has made it necessary for hospitals to employ more staff per day of patient care than in the past. Public hospitals now have 18 per cent more staff on a day of care basis than they had in 1959.

Prior to this, hospitals employees had very few of the fringe benefits to which they were entitled and which were enjoyed by other persons employed throughout the province. Today, they have an industry-wide contributory pension plan, a group life insurance plan and the majority of hospitals pay two-thirds of their hospital and medical insurance premiums. These fringe benefits amounted to an estimated $18 million last year as compared with $3.3 million in 1959.

Non-salary items-the food, drugs, medical and office supplies, light, heat, power, and so on-that a hospital uses in the treatment of patients and in its administration, also cost more year-by-year. These items account for some 25 per cent of insured hospital operating costs.

Between 1959 and 1967, the number of hospital beds in Ontario increased from 35,870 to 46,880. This brought the number of beds per thousand to 6.5 at the end of 1967. The availability of more beds on a per capita basis has contributed to an increase in the number of days of hospital care used annually by each 1,000 insured residents. Whereas in 1959, insured persons used 1,767 days of care, the same number used an estimated 1,987 hospital days in 1967. Each day-per-thousand increase at 1968 costs, adds approximately $260,000 to the cost of the insurance plan.

The bed situation in Toronto is now greatly improved. At December 31, 1967, there were 13,483 beds. It is expected that by the end of this calendar year, there will be 14,766 beds. It is most encouraging to have reported to me by the Metropolitan Toronto hospital planning council, and I quote:

There are sufficient active treatment beds available or in approved planning stages to meet the needs in Metropolitan Toronto for the next seven to nine years.

Indication that the hospital is becoming more and more the centre of community health is found in the fact that the number of out-patient visits and treatments recorded in 1967 was an estimated 87 per cent greater than the number recorded in 1963.

While many out-patient services are of a relatively minor nature in hospitals where adequate facilities are available, it is often possible to provide treatment on an outpatient basis which would otherwise require admission as an in-patient. This contributes to a more efficient use of hospital beds.

Much of the increase in the use of hospital out-patient facilities can be attributed to the widening group of services provided as benefits under the plan over the years, as well as another growing trend to turn to the hospital for treatment in an emergency health situation.

Much study is being given constantly to ways and means of controlling steadily rising costs. Since a large part of the hospital costs is absorbed in staff salaries and wages, relatively little remains in the controllable bracket. Certain indicators, however, are coming out of our studies, which suggest that there are possible avenues of savings. Among these are:

Over the past few years, the commission has been developing and promoting the concept of regionalization of hospital services. The main objectives of this programme are:

a. To meet hospital needs of the community as a whole by making necessary beds and services available to provide high quality care where it is needed;

b. To eliminate unnecessary duplication of beds and services;

c. To permit maximum utilization of professional and technical personnel; and

d. To achieve these with the greatest economy of financial resources.

Thus, in any good system of regional planning for the province as a whole, it is necessary to develop a framework into which existing rural, urban, and metropolitan patterns of hospitalization can fit themselves. Only in this way, will it be possible to develop a cohesive unit and deal with the requests quickly and thoroughly.

Central heating will be utilized wherever possible.

The two central laundries in Toronto will be ready to operate this year. Completion date for the Booth Avenue laucory limited is July 1, 1968. It will initially serve five hospitals downtown.

The Centennial hospital laundry services incorporated has a completion date of May 30, 1968. This will serve ten hospitals, in the periphery of Metropolitan Toronto. In certain other areas of the province, central laundries are being planned, or are under construction, to serve the hospitals in a more efficient and less costly manner.

Our proposal to seek negotiated prices for drugs used in hospitals, and related institutions, should provide quite substantial savings and will, we hope, give us some experience to seek similar economies in other fields where central purchasing would be possible.

A pilot project has been authorized which can be developed into the first central computer facilities for hospitals in Ontario. The hospital for sick children has been approved as the initial site for developing systems, locating the computer equipment and training technical personnel.

As the various hospital applications are automated and the systems become operational, the computer programmes will be ready for use in other central computer installations which may be established in various centres throughout the province. In this way, development, programming, and operational costs can be kept to a minimum with eventual benefits to a maximum number of hospitals.

Out-patient services have, over the years been extended to cover follow-up treatment of fractures; hospital services for procedures which normally would make it necessary for the patient to be admitted; physiotherapy, occupational therapy and speech therapy and radiotherapy.

Out-of-hospital benefits cover prescribed physiotherapy as a course of treatment in privately owned facilities and organized home care. Organized home care plans are now functioning in nine centres across the province; approval or approval-in-principle has been given to three more, and a further six programmes are actively engaged in organizational planning. In this fiscal year, the cost of functioning home care plans is estimated at $1.7 million and this is borne on a 50-50 basis by OHSC and The Department of Health. Private physiotherapy services currently cost the plan about $2.5 million a year.

The OHSC plans as of July 1, 1968, will include, as insured hospital services, a number of out-patient services not presently covered by the hospital plan. This extension will close the gap between the commission's present out-patient benefits and those services which are normally covered by OMSIP, and related contracts. These will include the use of a substantial list of care facilities and special equipment available at the hospitals which may be utilized by physicians for necessary treatment on an out-patient basis. It is anticipated that this important addition to the hospital insurance programme will contribute to a more effective use of the specialized facilities in the modem hospitals of our province, as patients will no longer have to occupy bed facilities to obtain these services through their insurance programmes.

Residents of the province holding hospital insurance coverage through the hospital programme of the OHSC, and the Ontario medical insurance plan should not, after July 1, 1968, be required to make a payment at the time service is provided at the hospital, for facilities of the hospital deemed necessary by their physicians for their treatment.

Diagnostic radiological examinations and clinical laboratory tests-other than as now covered under emergency benefits and in follow-up treatment of fractures-which are listed as OMSIP insured benefits, will not be covered by the hospital plan: neither will the plan pay for drugs taken home by the patient. It is expected that the cost to the commission for the additional insured services, on an out-patient basis, will be around $7 million in the first year.

Also effective July 1, 1968, responsibility for administering ambulance services in the province will be transferred from The Department of Health to the Ontario hospital services commission. The emergency health services of the department, which has been developing and administering the programme since passage of the present Ambulance Services Act, will be transferred to the commission which will take responsibility for all the programmes of the emergency health service. After July 1, municipal contributions to the support of ambulance operations will no longer be required.

Since this now will be an insured service, the financing of essential ambulance services will be channelled through the Ontario hospital services commission through direct agreements with ambulance operators, similar to those which are currently in effect between the Minister of Health and operators as part of county and district programmes. Support arrangements will be limited to essential ambulance services.

As in the case of hospital charges, the Ontario hospital services commission rate board will be deeply involved in the determination of charges for ambulance services. A patient-participation fee will be established. This will amount to about 25 per cent of the scheduled rate for the particular service supplied, up to a stated maximum, so that no insured person will be required to pay any more than this maximum amount for long distance travel by ambulance.

Ambulance services will be closely identified with the hospital system, and an organized pattern will be developed to ensure an efficient, effective and economic service. The first year's ambulance service cost to the commission will be about $9 million.

For the first time in our history, the number of nurses newly registered in Ontario during 1967 exceeded 5,000 in number. Newly registered nursing assistants numbered 1,790. There were 54,500 registered nurses in the province in 1967, and 14,011 registered nursing assistants. For the 38,313 rated beds in public general hospitals, there were 35,440 nursing care staff.

In the matter of salaries, between 30 to 35 per cent of the total cost of hospital services in Ontario is paid to personnel in the nursing department. This is half of the total salary and wage bill for hospitals.

The salary ranges for registered nurses in hospitals have again substantially increased from 1967-1968. Since the inception of the plan, the basic rate paid to registered general duty nurses has increased $210 per month, or 89 per cent and the 1968 minimum is $445 per month. Under the 1968 schedule of rates, a newly graduated and registered nurse is paid $5,340 a year, which rises in five years to a maximum of $6,420. This compares with the minimum in 1961 for a general duty staff nurse of $3,420 per annum and the maximum in the same year, $3,900 per year.

In addition, as was announced last year, encouragement has been given to nurses to obtain higher standing at the present, particularly in university preparation. In recognition of the completion of the Canadian hospital association course in nursing administration, they allow an additional salary up to $15 per month.

In recognition of the university diploma course of eight months' duration up to $25 per month. In recognition of the baccalaureate degree in nursing up to $50 per month. In recognition of the master's degree in nursing, up to $80 per month.

And we are very busily engaged at the present time, through the subcommittee of the Ontario council of health, in devising a plan whereby we will encourage nurses who are particularly interested and clinically oriented to attain ever expanding education in the various clinical specialties.

Thank you.