|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Province*** | ***Législature*** | ***Session*** | ***Type de discours*** | ***Date du discours*** | ***Locuteur*** | ***Fonction du locuteur*** | ***Parti politique*** |
| Ontario | 29e  | 4e  | Discours sur la santé | 30 Mai 1974 | Frank Stuart Miller | Minister of Health | PC |

**Ontario’s Health Speech: Fourth session of the 29th legislature, October 30, 1974.**

Hon. F. S. Miller (Minister of Health):

Mr. Chairman, I would/like to open my estimates with a statement so that I will summarize, in effect, some of the thoughts and some of the changes in our programme in the last while.

 When this province committed itself to administering a basic health-care programme for the population, the resources already in existence and the funds available were sufficient for the system to become, within a few years, comparable to the best in the world. We attained this position with cost a secondary consideration. Now we are in another age. We know the benefit a good, comprehensive system of health care provides and we do not mean to lower the standards of quality that have been set.

 What we can do, and what we are in fact doing, is to apply our acquired experience to see how proper health care can be equally well provided at lower cost by effective teamwork and co-operation, by alternative and innovative treatments, and by concentrated effort on the most urgent problems.

 There is something else we are doing. That is, to give greater emphasis to securing better health for the population of the province by means of practical and intensive campaigns for health promotion and illness prevention.

 It is particularly essential, indeed, that these benefits should be widely recognized and pursued at this time when the cost of health care is a matter for active concern.

 As the House will be aware, health care in the Seventies has been particularly hard hit by the world-wide escalation of costs for all goods and services. This escalation, coupled with the call for more and costlier health services, has kept costs rising continuously.

 A major factor in rising costs is attributable to the substantial salary increases negotiated this summer for certain groups of health workers. Of these, I can say that I am satisfied that increases were necessary, and that I consider the outcome of the negotiations as reasonable to both sides as the situation allowed.

 Unquestionably, however, these settlements will be responsible for peaks in health-care costs increases, both this year and next.

 Long before this occurred, however, it was comparatively easy to recognize that one of the major causes of increasing health costs lay in the established hospital-oriented tradition of health care, for so long accepted by both the public and the medical profession.

 As the House will know, we have achieved some success with the introduction of alternative care programmes, making more extensive use both of home care and extended care in the nursing home system; but I will speak of these later.

 In attempting to identify other individual causes of the increasing costs of health care, it became apparent that some were equally deeply rooted in our conventional health-care system. Others were attributable to the gradually extending boundaries of our definition of health care and, of course, to the simple fact that many people who previously were not seeking professional help are now doing so.

 It's for all those reasons that, as the House will know, every aspect of the existing health-care system is now undergoing careful examination. The view is not only to effect economies, improvements and, hopefully, extensions to the present services, but also to bring all costs under a greater measure of control.

 Revisions of this magnitude, however, require full consultation and prior agreement with all the health professions and health agencies concerned. It is evident that there are major and fundamental issues still needing to be resolved. And the House can have my assurance that my own, and my ministry's sincere and determined efforts are being devoted to bringing about as much agreement and co-operation as possible.

 The consideration that must ultimately override all others, however, is the welfare of the people. Ontario must have a good health-care system, but it must be a system that the province can afford to maintain. This, in effect, means that our paramount consideration is to ensure that growth in total costs are related as far as possible to some logical index, such as the gross provincial product.

 The process of consultation to which I have referred is now in prowess, but I doubt whether a unified plan will take shape before the early part of 1975.

 The estimates that I am now presenting have, accordingly, not been predicated on any advance assumptions of whatever major changes to the system may be effected. But that is not to be interpreted as an indication that substantial changes in emphasis have not already taken place.

 I remarked earlier of our alternative care programmes. In the fiscal year 1973-1974, a total of 33,552 patients were entered into the home-care programme now available in 41 areas of the province in which 99.1 per cent of the population is living. This shows an increase of 24.4 per cent over the number of patients entered into home care in the preceding year. Costs were held to an average net operating expense of only $8.52 a day. This figure, of course, excludes medical expenses and such things as the use of dialysis equipment where needed. The average stay for each entry was just over 24 days.

 The major service provided in home care is nursing. But, beside nursing, people in home care received when they needed them such extra services as physiotherapy, occupational and speech therapy, diagnostic services, dressings, drugs and medical supplies, the loan of a hospital bed and transportation. During 1973-1974, 80 per cent of the admissions in the home care were from hospitals; only 20 per cent of the increase was in place of hospitalization. That, though, was an improvement on the previous year and we are anticipating a further improvement in 1974HJ75. All told, we are looking to a 20 per cent increase in the number of home-care patients during the year, that is to say, a total of more than 40,000, at an average cost of $10.43 per day.

 Similarly, in our extended-care programme for patients requiring nursing-home care, the net total of nursing-home beds available increased by approximately 4.3 per cent during the fiscal year 1973-1974 to a figure of 23,479. During the year, our policy of continuously upgrading the quality of the nursing homes was continued. In consequence, 43 existing homes were closed and 13 new homes of larger capacity were licensed in the same period.

 Additional beds were also approved in existing licensed nursing homes. By the end of September, 1974, the figure was up to 24,601 available beds and by March, 1975, we anticipate a further 750 to 790 beds will be added; Where they are adequate and appropriate to a patient's actual needs, the home-care programme, the extended-care programme and, of course, the ambulatory-care programmes, operated by our hospitals and outpatient treatment all afford treatment at a fraction of the cost of inpatient hospital care. Inpatient hospital care, which has always represented something more than 50 per cent of our total health costs, will necessarily remain a basic need in those instances of acute or chronic sickness or injury demanding a high intensity of care.

 Because of the factors causing the cost of inpatient care to show a disproportionate increase-more people per thousand of population being admitted, more technicians per hospital, more doctors per patient and higher wages and salaries-it is clearly necessary to hold the overall cost of hospital care, in relation to the total health costs, at its lowest practical level. I can, however, assure the House that this is not a matter on which there is any real contention between the Ministry of Health and the hospitals. Although the ways and means of achieving the objective can be a matter for discussion, the demands of the overall situation are fully understood on both sides.

 Many hospitals, indeed, have taken the initiative in introducing measures promoting greater efficiency and cost reductions by commonsense agreement among themselves. In Kingston, for example, there are two fine hospitals-the Kingston General and the Hotel Dieu-working very closely together for the good of the community. During the course of this year, it was agreed between them that all obstetrics should be undertaken at the Kingston General. A little while later, a new bum unit that had been ordered for Kingston General became available and, because of the rearrangement in progress, they were unable to accommodate it. But the transfer had left space available in the Hotel Dieu and they accordingly have now installed the bum unit originally intended for Kingston General. Equally significant, in Smiths Falls, where there have been two separate, self-contained hospitals, St. Francis General and the Smiths Falls Public Hospital, soon-as a result of the generous-minded attitude of both hospital boards-there will be one new entity administering both hospital areas, but with no un~ necessary duplication of services.

 I can give you other examples. In Peterborough, for instance, where, as a result of agreement reached between St. Joseph's Hospital and the Peterborough Civic Hospital, all obstetrics are now being undertaken in the Peterborough Civic, with consequently greater efficiency and economy. Similarly, in North Bay, St. Joseph's General and the North Bay Civic Hospital have a sharing of many common services, and now have only one amalgamated obstetrical unit and only one laboratory.

 Similarly, too, in Guelph and in Chatham and in Sudbury-in all three cities-co-operation between the hospitals in the community has allowed one or more services to be concentrated in only one hospital.

 I give these only as examples of what is already in operation. Discussions on similar lines are taking place between neighbouring hospitals across the province.

 It would be understating the benefits obtained by the many instances where an amalgamated service is now being provided to a community, however, if I left the impression that we are only gaining the advantage of financial savings made possible by avoiding duplication. It goes beyond that. By encouraging specialization, and by providing increased usage of a service provided by one staff, improvements in the quality of care can also be achieved.

 In speaking of our hospitals, I might add that apart from the chronic and psychiatric hospitals, I expect all public, private and federal hospitals in Ontario will be enrolled with the Hospital Medical Records Institute known as HMRI-which is operated as a joint arm of the Ontario Medical Association andthe Ontario Hospital Association.

 The HMRI service collects and collates statistical data from every hospital, and each month prepares a set of analysis reports for each hospital. I am pleased to report that as a result of a service agreement just concluded, copies of all this data will be provided quarterly to the ministry from the beginning of 1975. This will meet a major ministry requirement for accurate, current statistical information, and will undoubtedly assist in the integration of all our services.

 In the field of total health-care delivery, other significant developments are taking place in the area of mental health. Including one centre for emotionally disturbed children, Ontario now operates 15 psychiatric hospitals. There is, I'm pleased to say, a continued decline both in the length of. stay and in the proportion of patients admitted on an involuntary basis.

 The overall reduction in the resident population of the psychiatric hospitals is still more dramatic. From the peak of 15,700 patients in 1960, the total dropped to 7,800 in 1972, and today is 5,940. In other words, a reduction of about 62 per cent in 14 years.

 The present trend is, of course, to the use of existing community facilities for hospitalization. Today, 56 of our general hospitals have psychiatric departments. More than 65 per cent of patients admitted to a psychiatric facility are now treated in one of these general hospitals, probably in. their own community.

 Obviously, with these resources, a much better distribution of services has been achieved. Every population centre of 30,000 or more throughout the province, in fact, now has a psychiatric facility.

 But perhaps one of the most striking statistics of all relates to the increasing number of patients served on an outpatient basis. The figure in 1960 was 19,000. The comparable figure for the 12-month period ended March 31 of this year was 195,000; an increase of more than 10 to 1.

 I have not referred to the treatment of retardation, since all members will recall that in April, 1974, mental retardation services were transferred to the Ministry of Community and Social Services. I will turn now to the particular needs of children with mental or emotional disorders.

 Prior to 1971, when the Children's Mental Health Centres Act went into effect, these needs received relatively less attention than those of adults. There is now full recognition of the fact that attention to mental or emotional disorders in the earlier years is, in actual fact, of considerable importance.

 The following summary of facts clearly indicates the extent of progress in this area since that date:

 Government expenditures on children's mental health services have more than doubled since October of 1971. In terms of new approved programmes they will have more than tripled by the end of 1974.

 Licensed children's mental health centres (residential type) have increased in number from 20 to 29 and by the end of 1974 will be providing approximately 33 per cent more beds than were available in 1971.

 "Special units" for children and adolescents in psychiatric hospitals now provide 177 beds as opposed to 103 in October of 1971.

 Residential services in six regional children's centres have been increased from 162 beds in 1971 to the current levels.

 Daycare programmes in regional children's centres are now reaching 231 children, as compared to 129 in 1971.

 Outpatient services for children and families have been greatly increased in many existing children's mental health facilities since 1971, and 24 general hospital psychiatric clinics will continue to receive special grant assistance to develop such services in 19741975.

 Inequities in the geographic distribution of mental health services for children throughout the province are gradually being resolved by major increases in programme development in the Ottawa region, and by innovative planning now being undertaken in the northwest.

 Finally, a programme which is one of the most promising and imaginative concepts to be tried in this field is just now taking shape. This is known as the four-phased service system, and is particularly directed to the needs of severely disturbed adolescents.

 The four phases comprise an assessment centre, facilities for closed, or institutional, treatment, a rural community programme and an urban community programme.

 The young person enters the system at the assessment centre, essentially a short-term service heavily staffed with experienced people from various disciplines.

 From this first phase, the adolescent could then go into any of the other three phases.

 The system allows free movement of adolescents from one phase to another in accordance with their needs and abilities, including back-tracking as well as moving ahead. There is also provision for a central tracing mechanism which would follow the youth through treatment.

 This four-phase system-which is designed to be introduced in a variety of different geographic areas-makes use of all existing services required, but introduces new facilities as well.

 This is bold, new and challenging work. You could say that we are setting out to find ways to provide treatment for so-called "untreatable" adolescents.

 We do not expect overnight success. But though there will be setbacks and difficulties, we believe it holds considerable promise. We anticipate that approved programmes within this four-phased service system will provide residential treatment for a first group of something over 200 teenagers during the coming fiscal year.

 Another of the province's health services I want to mention is the Ontario Ambulance Service. As members are all probably aware, this service-an integration of about: 200 different services, privately operated, hospital operated, volunteer, municipal and ministry operated-Functions province-wide, and in its scope and degree of automation is unique in North America, perhaps in the world.. We can take considerable pride in the interest it has aroused and the way in which its planning is now the subject of study by other jurisdictions.

 It is still our objective to continuously upgrade both the responsiveness and quality of the service provided. A casualty care programme of four-week intensive basic training courses for ambulance attendants was first started at Base Borden in 1967, and some 2,100 out of a workforce of 2,600 full-time employees have successfully completed this training.

 In 1972 a new, expanded two-semester course was introduced at Humber College, and this is now being implemented at three additional community colleges. By September of 1975, the course-offered both as full-time and part-time programmes-is expected to be provided in a total of 10 community colleges.

 At a future date, all new entrants into the ambulance system will undergo this training.

 Our people will also be working with the community colleges to develop equivalent package courses for use off campus, perhaps in the ambulance unit quarters, so as to offer the same degree of training to existing personnel through the Minister of Colleges and Universities.

 At this point, I would like to refer to OHIP claim statistics for the fiscal year 1973-1974, and briefly discuss how and why we have estimated these will change in the year 1974-1975.

 The total number of claims handled was over 40 million, amounting to an average of 533 claims for every 100 insured persons in the province. It a1so represents 976 actual services provided for each 100 persons. In other words, slightly less than two services for each claim card.

 We are estimating that the overall cost of OHFP claim payments in 1974-1975, amounting to some $635 million, will show an increase of 10.9 per cent over the 1973-1974 year. Of this, 5.3 per cent is attributable to price increase; 3.9 per cent comes from increased utilization; and the remaining 1.7 per cent because of population increase.

 I have been speaking of resources to deal with the treatment of illness and injury, which we can think of as the negative aspects of health. But as I said earlier, the more positive aspect, health promotion, is now taking an increasingly important part in our scheme of things. The Ministry of Health is playing an active part in this, both in the planning of educational: programmes, and in the provision of services in co-operation with the public health units and the hospitals.

 There are, for instance, 18 ministry teams now actively working on projects as various as family planning, occupational health services, audio-metric testing, preventive dental care, housing guidelines, nutritional guidelines, distribution of pasteurized milk, nutritional services for the elderly and an especially important one, physical fitness.

 The ministry, in addition to handling written, telephone and in-person inquiries on every aspect of health care, is responsible fur conducting a vigorous public information programme using displays, audio-visual presentation, newspapers, film, TV, and supporting print material.

 A ministry-sponsored column of reliable health information called "Today's Health," is appearing in 177 weekly newspapers. Some 10,000 pamphlet display racks, called Health Information Centres, have been distributed across the province in hospitals, doctors' and dentists' offices, public health offices, business and industrial health centres, community information centres and the like-and these are proving helpful.

A continuous supply of new pamphlets is being made available each month. Subjects already: covered include smoking, heart diseases, fitness, immunization and poisons in the home, and among those that win be shortly issued wilt be pamphlets on colds and the flu and nutrition.

 The programme I would single out fur special mention is the intensive campaign we are waging-with the fullest co-operation from hospital's and public health units-against venereal disease. I single it out, not because we can claim any victories-unfortunately the figures show we are not even stemming the tide sufficiently-but I mention it because it is a campaign needing wholehearted support and the widest publicity.

 The irony of the situation is that we have ample facilities to diagnose and successfully treat all venereal disease. There are skilled and understanding and dedicated teams standing ready and provision has boon made for complete confidentiality being preserved. We provide a source of comprehensive, easily understandable, person-to-person information.

 There is, indeed, a 24-hour recorded telephone information service available in Metro Toronto. I would suggest to my hon. colleagues they listen carefully to the number in case they need it.

 Did the member for York-Forest Hill wake up?

Oh, now.

 If the member forOttawa East is it? Or Ottawa Centre?

 Yes, Ottawa East. If he will listen, the number to call any time one needs it is 965-3333.

 Somebody said it is the gift that keeps on giving.

 I'm sorry, I'll return to my normal petulant posture.

 Last year there was considerable public interest in community health projects, followed by a period of time in which they seem to have rather dropped out of the news. Quite recently, they have become again a matter of particular interest. I can, however, assure the House that my ministry's interest in all the possibilities of community health services has consistently been maintained. Twenty-three community health projects are at this time operational across the province and others are now in the developmental stage. I would restate the opinion that, while the existence of a community health service does not, in itself, provide a panacea to all the problems of health care, it does represent a progressive approach to many of them. The basic idea-and I'd remind you that community health service is a concept capable of many interpretations without any rigidly fixed pattern-deserves, and is receiving, active attention.

 We have what is termed a project development and implementation group established to handle high-priority projects as assigned. The group is responsible for the planning, development and implementation of a project up to the point where it becomes operational. As a matter of general policy, the project team deals with all initiatives which arise and develop spontaneously, whether professionally or community sponsored.

 All projects start with what presently exists, that is to say, the approach is evolutionary. Several different models of community health services are being supported, depending on the characteristics of the community initiating group. The number of models will probably gradually decrease as unproductive features are identified. A strong emphasis on flexibility is maintained so that the province does not necessarily lock into one or more rigid models. Our approach will permit change where the climate is right. It encourages and supports progressive change which is initiated at the so-called grassroots. Many areas in the health care system are ready and eager for change. I, accordingly, consider Ontario will achieve more by an evolutionary than by a massive approach which might meet, strong resistance in the existing systems.

 I referred earlier to the comprehensive review of the province's health care system now being conducted. Obviously, the question of medical manpower, principally the family physician and specialist, is one of the central issues. We have to pay particular attention to ensuring adequate, but not surplus numbers, both, overall and in, respect of individual, specialties, and we have, to make sure that comprehensive health, care of acceptable, quality accessible to every individual in the province.

 The House will be aware that in recent years the one, factor, the one wild card, I'd call it-that, has made it extremely difficult to introduce an orderly system has been the extremely large proportion of new registrants who, have taken their training outside Ontario. In 1973, for example, fewer than 45 per cent of new registrants graduated from Ontario medical schools. Many of the others were, specialists in one discipline or another, but we have no way of knowing in advance what their specialty will prove to be. Accordingly, even though the medical schools in Ontario might be training new doctors in what appears to be a reasonable proportion of family physicians and specialists, the final mix could still be wholly disproportionate to our needs, This is a problem causing concern, of course, in other Canadian provinces and, to a large extent, it has federal implications in respect of immigration policy.

 As I have just said, we want the quantity, mix and distribution of' medical manpower to be adequate but not excessive for the province's needs. It is also our intention to expand the proportion of doctors entering the system from the province's own medical schools. That policy is now being implemented at the five health sciences centres, where a commitment has also been given that 50 per cent of the students will be trained to enter family practice. We still cannot be satisfied with the distribution of medical manpower in the province. This remains uneven, and ease of access to, health practitioners still varies considerably from one area to another.

 I'm pleased to report, though, that our programme for underserviced areas is making progress. Out of 150 areas officially designated as underserviced, only 41 are still without, physicians. Three more doctors have now been approved and are awaiting location. A total of 50 physicians are now practising in the designated areas on a guaranteed contract basis, 120 more are practising on the grant system provided, and I'm pleased to say that a further 41 physicians, who originally started practice in the underserviced areas either on contract or grant, are still in practice but no longer require support.

 A further 12 areas have been designated as being in need of nursing services, and suitable applicants are being sought,

 There are also areas underserviced by dentists, to whom the same programme applies, although the areas are not in all cases identical. Under the programme, out, of a total, of 99 positions to be filled only 36 positions are still open. Four more dentists have lately been approved so when they have been located only' 32 positions will remain to be filled. .

 At this point I'd like to refer to the drug benefit plan introduced at the beginning of September. The 548,000 Ontario residents who, became eligible for this benefit are in three categories: first, people aged 65 or over who receive any portion of the guaranteed income supplement to the old-age security pension; second, recipients of the Ontario Guaranteed Annual Income Supplement, the GAINS plan; and third, recipients of the provincial family benefits allowance.

 Before September, many needy people in these three categories who have greater than average need for drugs but much lower than average incomes were not getting prescriptions filled because of the expense. More than 1,200 drugs are listed in the formulary from which the drug benefit can be dispensed. All drugs meet the strict standard of the drug quality and therapeutics committee of Ontario. Prescriptions do not need to be rewritten every month. Most can be written for three months, some for six months.

 In other words, a benefit intended to provide assistance to more than half a million people in need of it in an orderly and reasonably uncomplicated manner is actually working out pretty well.

 I have given several examples earlier of actions taken to introduce economies and provide more effective cost control, all in the light of our acquired. experience. Another instance occurs with laboratory services in the private sector. Budgetary control and our public accountability exist in the hospitals and public health lab facilities. Until recently, however, this did not apply to the private sector. Under a new system introduced last May called LMS, a uniform method of costing has now been introduced. LMS stands for the three identifiable components of clinical or laboratory services-namely labour, material and supervision. The establishment of this unit price in relation to amounts payable under the old 1971 schedule has effectively de-escalated rising costs and provides a firm basis' on which all future negotiations can be conducted.

 We have also now instituted, in co-operation with the Ontario Medical Association, a new laboratory proficiency testing programme designed to maintain quality control of laboratory operating functions. The LMS system I mentioned will be one control mechanism in this programme.

 There is One aspect of the estimates themselves on which I should comment in conclusion.. Members will note that this. year the estimates have been differently arranged. They now give a better presentation of expenditures for operating costs and of grants provided to health agencies. We are, in fact, gradually changing to a more rational, logical and understandable presentation of estimates.

 I recognize that even the changes already effected may make a direct comparison difficult between this and the previous year's figures, since at first sight there may appear to be decreases which have not in fact taken place. I will, however, do my best to clarify any difficulties you experience and to provide detailed information on all specific costs.