|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Province*** | ***Législature*** | ***5Session*** | ***Type de discours*** | ***Date du discours*** | ***Locuteur*** | ***Fonction du locuteur*** | ***Parti politique*** |
| Ontario | 29e | 5e | Discours sur la santé | 2 Juin 1975 | Frank Stuart Miller | Minister of Health | PC |

**Ontario’s health budget: fifth session of the 29th legislature, June 2nd, 1975.**

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

Mr. Chairman. I'd like to open my estimates with a statement that will outline very briefly some major changes that have taken place in our programme during the past year.

I expect the members are familiar with the World Health Organization definition, which says: "Health is not merely the absence of disease or infirmity but a state of complete physical, mental and social well-being,"

That's a definition we accept. Here in Ontario we are fortunate in being able to work from the premise that the well-being and prosperity of the province require every member of the community to be able from birth to old age to live under healthy conditions with the right to prompt and proper treatment for any sickness or injury. To make this possible the provincial government in Ontario takes responsibility for all essential health services, not only for the general community but for the individual resident.

In recent years, as the members will be aware, the rate of increase in health costs has become a matter of considerable and justifiable concern over consequences of disproportionate increase in health costs compared to our rate of economic growth and development. Cost effectiveness has joined humaneness as one of the essentials of our health care system.

Health care in the past decade has undergone considerable change. There was a time not long ago when health care could be defined in terms of the sick-those with pains, ailments and clear manifestations of disease. What we called health care was really sickness care. To a marked degree the health care system in any community revolved about the acute treatment hospital and it was that hospital which somehow had to respond to the immense range of illnesses and discomfort to which the human is liable. But definitions are changing. People's expectations are changing.

This is not to criticize the health care system of the past because, despite its faults, it has given us one of the highest standards of health care in the world. But we will have to look to other ways and other personnel to share the load.

For generations hospitals have been filling in where others should have been active. In our dependence upon the acute care hospital we have only recently begun to develop the alternative care facilities we now see as necessary: Chronic care in nursing homes; ambulatory and outpatient care programmes; home care services; extended care facilities; more effective use of allied health personnel; promotion of more healthful living; and the many new initiatives to which our ministry has been addressing itself.

We're all aware that a prime reason for a large amount of the skewing in our health care system has been the limitations placed on cost sharing under the terms of the federal Hospital Insurance and Diagnostics Services Act and the Medical Care Act. Discussions are taking place with Ottawa, hopefully to arrive at a mare equitable sharing.

Let's not make the mistake Of thinking that by stimulating development of these alternatives the acute care hospital will ever cease to be a major focus Of Our health care system.

In trying to hold down the cost Of acute treatment services, we must continue to take the initiative and introduce measures for greater efficiency and cast reduction.

We are proud Of Our health system in Ontario. But I think it is important for us to recognize that it's as comprehensive as it is because Ontario, economically, is One of the best favoured provinces of a well favoured nation. In other words, I am well aware that-compared with many Other nations of the world-we start with many advantages on our side.

We in the ministry are trying to promote health as something more than the absence of illness or disease. We are making every effort to stimulate people to assume more responsibility far the state of their well-being.

The healthiest people in the world, yet, judging by most conventional parameters, we are far from being the healthiest, thousands of our people continue to die prematurely from diseases and circumstances that are largely available.

The members have knowledge, Mr. Chairman, Of the growing extent and insidious effects Of poor nutrition, poor dental habits, Obesity, indolence and alcohol and Other drug use among Our young people-people who should, physically and emotionally, be Operating in high gear.

And you know very well they are not.

I must admit that I can't look casually at this waste Of human resources and at the ruinous economic spin-offs that impact on our health care system. Consider all the positive things we could do in terms Of dental care, acute care, chronic care, disease screening, Outpatient treatment, ambulatory care, geriatric services, and so on, if we could be diverting, for these purposes, the funds now being absorbed in the care and treatment Of patients with avoidable illnesses.

We squander our health as if it is an unlimited resource.

We can't compel people to change. It is a free society and if the host thinks the highest compliment he can pay his guest is to drink him under the table, then there isn't too much we can do about it except to try to change his behaviour.

Health promotion is an elusive task. We can have all the information it's possible to summon, but unless we get people that respond to that information, to accept its meaning, and to use it to improve the way they live, we are not much further ahead.

The key to successful education far health promotion is attitude. What attitudes do we hold, or do young people hold in respect to health? How valuable is good health?

In Ontario, preventive health programmes have received emphatic support from the ministry. Health protection and health promotion programmes delivered on an organized community basis are efficient ways Of delivering preventive public health services preferably One that involves the health professionals.

To do this, Mr. Chairman, we need a mare equitable distribution Of medical manpower. We also need a better balance between families, physicians, and specialists than we now have. But I believe both Objectives can be obtained without any sudden major upset. Continuity Of health care is absolutely essential and, even though we have to bring about same changes in direction, we'll be taking care not to rock the boat unnecessarily in the process.

Go talk to them in Windsor and see whether I am taking steps before an election that you think I wouldn't. Just ask your comrade On your right-hand side there.

There doesn't seem to be much doubt that the two areas Of health care posing the greatest threat Of runaway costs are first, those created by unrestrained cost increases in the hospital system, and, second, those represented by the uncontrolled size, variety and distribution of health professionals, both in the primary care and secondary care sectors.

As I am sure most members are aware, at the joint meeting of the federal and provincial Health ministers in January in Ottawa I was able to raise and successfully carry the paint that some sensible system must be introduced to handle the uncontrolled immigration of doctors.

In terms of overall medical manpower, Canada already has a higher number of doctors for every thousand of population than most other countries and that's particularly true for Ontario.

Some people interpreted this very necessary action as a move to reduce the number of doctors in practice in the province. Far from it, we expect the total number to show a gradual increase, to maintain the present ratio. That's roughly one to every 575 people.

As a result of the adoption of Ontario's proposal concerning the flow of immigrant physicians, the occupational demand rating used to assess applications for immigration has been reduced to zero for physicians.

This adjustment is an interim measure, of course, pending detailed discussions with each province. Its effect is to require immigrant physicians to show evidence of arranged employment acceptable to the ministry, or to proceed to a destination designated by the ministry as in need of their services, in order to have their application for immigration approved.

Discussions are being held with the federal authorities to make the necessary arrangements so that all job offers to immigrant physicians be referred to the ministry for approval before they are confirmed for immigration. This will enable the ministry to be informed of foreign graduates who wish to enter the province and to determine whether or not Canadian physicians are available to fill vacant positions.

This, of course, is a highly sensitive area, Mr. Chairman. It is our intent to discuss it fully with all professional bodies concerned as it develops.

Finally, Mr. Chairman, I'd like to say a word about this government's new approach to the protection of Ontario workers and residents from occupational and environmental health hazards resulting from industrial activities. Members will recall the recent announcement of the Provincial Secretary for Resources Development of the formation of an advisory council on occupational and environmental health matters. This body will provide the formal mechanism for industry, labour and other interested parties to advise government on health hazards and to recommend new policies and programmes. It will assist government in defining how health safeguards can be engineered into plans at the design stage and it will be a central reference source for public information about all aspects of occupational and environmental health.

Occupational and environmental health, Mr. Chairman, is a field in which the government can never be entirely proactive but in which it should, nevertheless, exercise control. Such an advisory council is a means of recognizing shared involvement, of ensuring that the interests of all concerned are considered when standards and guidelines are questioned and of visibly displaying a mechanism that is kept current on world developments and able to advise the government on these.

The mechanism should be viewed as an active means of reviewing particular concerns raised by any group, including referring studies the government would like to see conducted.

Terms of reference, Mr. Chairman, are being developed by my ministry, at present, and the project is proceeding on schedule. In this, my ministry is working closely with the Ministries of Labour, Natural Resources and the Environment. We expect this to eliminate a good deal of the fragmentation previously evident in this field.

The last thing I want to do, Mr. Chairman, is to leave the impression that the ultimate purpose of changes in direction taking place in the field of health is cost constraint. It goes beyond that.

The need to restrain costs has forced us all to be a lot more imaginative, innovative and productive. As we face constraints, we must be ever more judicious in the use of public funds. There is no way we can avoid seeing the handwriting on the wall. The public is demanding more access to better health care, and it is holding the trustees of the health care system to better account for the use of those funds. And, Mr. Chairman, that is how it should be.