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| ***Province*** | ***Législature*** | ***Session*** | ***Type de discours*** | ***Date du discours*** | ***Locuteur*** | ***Fonction du locuteur*** | ***Parti politique*** |
| Ontario | 30e | 3e | Discours sur la santé | 22 juin 1976 | Frank Miller | Minister of Health | Progressive Conservative Party of Ontario |

Mr. Chairman, I do appreciate the sincerity of that. I was asked by the House leader if I could, in fact, stand four hours at a time. The answer is yes I can. I will not be present during question period as a result of it, but since you will have me all day on the grill anyway, I think probably you can miss me at question period.

Before I begin my opening statement, I know the Ministry of Health estimates are sometimes difficult for the members to discuss in a sequence that suits them, because they are never quite sure under which vote a particular topic might fall.

Last year, we rushed into trying to get some printed material. This time, I have enough pieces of paper here, which I'd like to distribute, showing the vote and the item so that the members of the opposition parties and our own party will know roughly where a particular topic pops up. I think it would be wise if, in fact, albeit we only have seven hours, we 'try to discuss them item by item in sequence father than doing what we've done in the past and that is cover all topics at one time. I hope and trust then that the items of interest will get the 'time they deserve.

I would like to open my estimates debate with a statement that I hope will put into perspective some significant changes that have recently taken place in our health programmes. I'm sure the members are well aware that since the 1950s there has been a steady escalation in the number of public services provided by government, particularly in the special service areas.

This quite properly was brought about by ever increasing public demand. The public felt that an industrialized, affluent society should provide appropriate hospital, medical and social services. The federal government bowed to this pressure and introduced, first, universal hospital care, and then later a universal medical care scheme, neither of which had any flexibility in meeting varying provincial needs.

As we all so well know, the British North America Act delineates federal and provincial powers. It is the specific responsibility of the provinces to provide for the legislative, regulatory, financial and service components of health care. The federal government through its national taxing Scheme altered this through financial manipulation, which warped the natural evolution of a balanced health care system. The responsibility of providing services has remained with the provinces. But, until now, we have been unable totally to call the shot. This government has fully accepted the responsibility of protecting the public from health hazards, of preventing the outbreak and spread of disease and of providing for care of the sick and the injured.

As health service's dame under the hospital and medical care insurance plans, expectations 'and demands of both the public and of professionals providing health care have increasingly strained our financial resources. The situation became difficult to control and financially intolerable with large wage settlements, rising cost of products and a high rate of inflation. Under the federal shared- cost programme, services tended to gravitate toward hospitals because of the funding scheme and availability of 50-cent dollars from the federal government— that's on a Canada-wide basis. This overburdened the system with expensive, top-heavy hospital facilities offering a variety of services which could have been delivered in a less costly manner if they had been cost-shared.

Even though there was no federal funding, this province took the initiative of introducing insurance coverage for nursing homes. This has added to the rising costs but it was needed to achieve a balance in the system and to lessen the work load of acute treatment facilities while still providing long-term health care for Senior citizens. While this was happening, the economic climate was changing and inflation began taking its toll.

There have been reams of reports and dozens of investigations and task forces looking into health care services and making hundreds of recommendations on the organization of a balanced health care system. We knew something had to be done to rationalize health care and its rapidly increasing cost. The limitations of shared-cost programmes have repeatedly been brought to the attention of the federal government without success in many rounds of our federal-provincial meetings. Federal counter-proposals were found unacceptable to the majority of provinces, because they put them at a financial disadvantage in providing health care.

As members are aware, the first ministers were in Ottawa last week to work out a new basis for shared-cost programmes which will be fairer to all parties. The federal government put forward a proposal of combined tax points and cash which reflects ideas Ontario has put forward over the past decade. This was a positive step toward improving the accountability and flexibility of the partners in Confederation and toward the removal of petty administrative details.

The federal proposal partially transforms conditional federal grants into unconditional form. However, it does not present the comprehensive reform we would like to see in health financing. It deals with only part of the total health programme and leaves out such vital components as psychiatric care and nursing homes. I have to point out, however, that there are a number of details to be worked out and I think it's premature for us to prejudge the package offered. It's a significant step forward in our opinion in any event.

Under the proposal, the federal government has suggested a global health review. Our Premier (Mr. Davis) had said a review was not necessary and that a more constructive approach would be to include all alter- native forms of health care in the present financial base. This would be in keeping with the spirit of the federal proposal and would spare us yet another exhaustive study. I think the Premier's words were that health has been studied, restudied and restudied in the last few years. We have volumes and volumes of studies. The time has come to act.

As members are well aware, we in Ontario are not alone in our attempts to achieve affordable health care. AU jurisdictions across Canada are faced with containing health care costs.

I would like to report on the progress of our constraint programme. Initially, we estimated a total saving of $48.2 million from hospital closures and selected budgetary controls. Breaking this figure down, it meant $37.8 million would have been saved through bed closings and budget controls, and a further $10.4 million through hospital closures. With respect to hospital closures, the members are aware that four hospitals have been affected by the division court decision with respect to closure by the province. The government is respecting that decision while launching an appeal against the decision of the court. Four hospitals have closed.

During the time required for the appeal, the hospitals will, of course, continue to operate financially under the general funding principles of the ministry. Should the appeal fail, the government will consider possible legislative action. To do so now, however, would be to prejudge the appeal process, about which we are hopeful.

Because of the court decision and the adjustments in our control programme, the projected net constraint saving amounts to $23.3 million in total; or $22 million from bed closures and budgetary controls, and about $1.3 million from hospital closures.

In general, hospitals have been very co-operative and have tried to live within the established guidelines. That is not to say that these guidelines were perfect. There is room for improvement and we have been working closely with hospitals in their submissions.

I am also pleased to report that we have been successful in our constraint programme as it related to the closing of psychiatric hospitals and public laboratories. Along with the savings achieved in the public hospital sector, another $3.4 million has been saved by converting the provincial psychiatric hospitals at Goderich and Timmins. A further $375,000 net savings this year will be realized through the closure of four laboratories, even with the expenses attendant on closure.

This government is making a substantial saving, a total in excess of $27 million this year, but what is more important is that these savings will be realized annually, thereby saving Ontario taxpayers many more millions of dollars in the future.

Within the Ministry of Health itself we have made determined efforts to make savings ourselves. In fact, the ministry has reduced its staff by 2,192 persons in the past two years— staff at all levels, including senior management. That's roughly two-thirds of the provincial total. We have consolidated branches and divisions within the ministry to streamline operations and improve management.

Earlier this month, I spoke about the measures we have taken to strengthen this ministry's occupational health protection branch. These measures include changes within the branch organization and management, and the "beefing up" of staff.

At the time of the original statement on occupational and environmental health I indicated there was a shortage of occupational health personnel. I am now pleased to report that my ministry has made an inventory of all occupational health manpower within the province and has contacted all health science centres to encourage them to train occupational health specialists. It is expected that by 1977-1978 there will be a substantial increase in the number being trained.

The "Interministerial Accord on Occupational and Environmental Health" was completed in draft form in October, 1975. Implementation of the accord is being effected through regular meetings of the four deputy ministers and through an interministerial standing committee on occupational and environmental health.

I would now like to discuss the Ontario Health Insurance Plan. During 1975-1976, 8,240,000 Ontario residents were covered under OHIP. There were 50.1 million claims representing a total of $728,3 million. An- other $13.8 million was paid out for non-fee for service payments, which include doctors' salaries, sessional and capitation payments. In total then, the plan paid out $742.1 million. For the record, I would like to note that administrative costs were only 5.06 per cent of the total expenditures which compares favourably with other similar health insurance plans.

Under OHIP we have active committees which review and scrutinize professional activity and billing procedures. These are the medical review committee and the practitioner review committees. The medical re- view committee deals with physicians and the practitioner review committees deal with chiropractors, chiropodists, optometrists and dentists. These committees monitor the professions' billing practices.

I would also like to touch on the drug benefit plan which in 1975 covered one million Ontarians. One million prescriptions a month are filled under the programme which provides drugs to persons over 65 or on family benefit, extended care patients or home care patients, people receiving vocational rehabilitation and indigent diabetics. In September, we will be adding general welfare recipients as well. The average drugs benefit prescription was 68 cents less or 16 per cent lower than the overall average paid by other drug insurance plans, like Blue Cross or Green Shield. The control features of the drug benefit plan were responsible for the savings.

Medical manpower planning is important. The ministry has supported, a careful review of specialty and family-practice manpower needs by the medical profession and medical schools. The rate of physician immigration has now been brought under control in Ontario. Between July 1, 1975, and March 31, 1976, 81 immigrant doctors were admitted, nine with a landed status. This compares to 236 in the first six months of the year. The distribution of physicians is improving. The underserviced area programme has been successful in placing doctors and to a degree dentists and nurses in communities previously with inadequate health care.

With respect to controlling laboratory costs, I indicated several days ago that legislation controlling laboratories, specifically Bill 59, will remain on the order paper but will not go forward this session. We intend thoroughly to review it with a view to amending it. I would like to outline for the House today some of the specific steps this government is presently taking to control the cost of medical laboratory services in this province.

Regulations are being developed under the Public Health Act to control conflicts of interest in the ownership of laboratories. I can say that that legislation or regulation is practised and we are simply awaiting a series of appendices to it to be included in the regulations naming labs by specific location. Regulations under the Health Disciplines Act are also being drafted to eliminate kickbacks. Again, I believe those have been circulated to the various professions in the last few days. In addition, a new laboratory test requisition form is being developed to dis- courage unnecessary utilization of medical laboratories. I can also say that new requisition form clearly states the cost of each laboratory procedure ordered by the doctor so that he will be aware of the cost.

Reimbursement mechanisms for laboratory procedures are currently under consideration. Global budgets, tendering and other mechanisms all have strong points and, unfortunately, weaknesses, all of which we will take into consideration. The methods of reimbursement of both private and hospital labs are under review for obvious reasons. We are faced with rapidly escalating utilization and costs in the private sector, a factor that has been promoted by vigorous and aggressive marketing techniques on the part of private lab owners. Also, current mechanisms must be revised to provide some incentives to hospitals to use their laboratory capacities more fully by doing more of their own out- patient tests.

Our effort in the first instance will be geared toward the limitation of growth of medical laboratory workload while encouraging shift in volumes to the hospital labs. Sixteen regional advisory laboratory commit- tees are studying available spare capacity in hospital and public health laboratory services to assess the possibilities of increasing their share of outpatient testing. The committee his developing proposals for a regional laboratory system which will make maximum use of resources, eliminate duplication of services and equipment and make labs more cost-effective.

I have outlined a few of the areas of cur- rent interest in the Ministry of Health and its historical financial perspective. We've had our difficulties in aligning health care service to meet the legitimate needs of our citizens, but on the whole we've had a positive response both from the public at large and those who provide health care services. Everyone recognizes the need for eliminating unnecessary costs.

We have one of the best health care systems in the world and we should be proud of it. We are in a new era of challenge and change that can ensure a reasonable, affordable and rational health care system without sacrificing quality. This government has taken effective bold steps in this regard.

Apart from the prepared statement, I wanted to refer, if I may, to the Browndale situation and the request that the auditors' study be summarized in this House, since this is my last opportunity to do so. While I haven't got a prepared statement, I'd like to sketch out the information given to me.

I might indulge the interest of the leader of the Liberal Party because I'm going to talk about Browndale right now and I thought perhaps he might want to hear it. As you know, the internal auditors of the Ministry of Health have looked into the Browndale situation; at the same time, I understand the Attorney General is looking at certain aspects of the Browndale operation, I can't speak for those things taking place in his ministry because I'm not aware of them in detail. However, I can summarize our ministry's findings. I'm going to read parts of the report to me.

Our auditors found three areas in question when they looked through Browndale's expenditures and accounting methods. The first was the overcounting of children days. As I'm sure you know, they are paid on a certain per diem per child in care. Browndale has overcounted the number of patient days by 145 in 1974 and 161 in 1975. These were included in the days they reported to us and they were paid at the approved per diem rates. Overpayment amounts to $8,700 in

1974 and $10,600 in 1975, for a total of $19,300. As this is an incorrect count of days, we have requested the money back from Browndale and I understand it will be paid.

I'll digress a second to point out they were counting the day of arrival and the day of departure in their days and that is not according to regulations. You count either the one or the other but not both.

The second issue was expenditures on houses in Don Vale. The auditors found that in 1974, Browndale Ontario had entered into a lease for 10 houses in the Don Vale area. These houses were on Winchester St., Sumach St. and Gerrard St. A number of expenditures were made for rent, taxes, furniture and equipment and property improvement. These totalled $368,810 on the 10 homes. Browndale Ontario paid for these expenditures out of the funds which were flowed to them on the per diem rate; they weren't extra moneys given to them.

At this point, our ministry questioned whether that was the appropriate use of the per diem money. Now, as you know, if a person is paid money on a per diem there is no specific requirement that it go for a particular part of the programme. Our auditor stated to Mrs. Brown that he did not consider this to be an allowable cost under the regulations, and that a refund should be made to the ministry. Mrs. Brown has stated to us that she's consulted her lawyer, and that, in his opinion, the amount paid' on a per diem basis was a global amount as the price for their services and that Browndale had discretion as to how it should be used for the programme.

This may well be the correct assessment, but this is under discussion right now. I would have to point out to the House that there is no question our ministry encouraged Brown- dale to believe that some of those homes would be licensed two years ago, because it was part of our urban re-entry programme and we felt homes had to be provided for children who were otherwise in areas like Haliburton, closer to their homes and more adaptable to the city environment.

The purpose, as you know, of the four- phase programme is perhaps to get children out into the country for a while who need' to be stabilized, but before they can return to their parents they often require some time in residence in a city environment. I can safely say though that the reaction of the community of Don Vale, through the Don Vale residents association and ratepayers association, was such that this ministry did not move forward with the licensing of those homes.

The last issue that the auditor referred to was the question of the management contract with Browndale National, and the possible duplication of payments by Blrowndale Ontario. I believe, in the Browndale budget, something in the order of $900,000 in a year is paid from Browndale Ontario to Browndale National for training services' and for professional help. Our concern was that, in fact, that money may have been transferred with- out services being given in return. This was the point on which we were waiting for extra information.

We requested details from Browndale Ontario as to the names of the people on the payroll of Browndale National and Brown- dale Ontario during the periods in question. That information was given to us last week, partially by Browndale National, partially by Browndale Ontario. I can say a quick perusal of it would seem to indicate that there was no incorrect billing. I'm going to reserve final judgement, since the last papers just arrived Friday morning, until the auditors have had more opportunity to review carefully the exact names and, if possible, the salaries attached to them so that we're satisfied on that.

Browndale remains at a per diem rate in the range of $65.94 per child per day. The highest rate that we pay to similar organizations is $84.29 a day; the lowest rate we pay is to Youthdale at $36.28 a day, and Browndale is just about in the middle of that system. Of the $65.94 paid per day, $61.45 is for residential care, the balance is for outpatient care.