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**Ontario’s Health Speech: Second session of the 31st legislature, November 14, 1978.**

Hon. Mr. Timbrell:

Mr. Chairman, the members will be pleased to hear that I have a brief statement.

As I said before, I thank you added a couple in the editing and the repetition of that.

 At any rate, within the past year, the spending of the Ministry of Health has been scrutinized in some detail by the members of the Legislature before both the standing committee on social development in the spring and the select committee on health-care costs and financing over the summer and early fall. I really don't think it would he useful to go over again all of the ground which has been so thoroughly covered in the recent past.

 However, by way of introduction to my ministry’s estimates this year, Mr. Chairman, I would like to give you and the committee a broad but brief description of the current changes in our health-care system and touch on some of the more significant developments which are indicative of the approach my ministry is taking to encourage the evolution of the system.

 Last week, as you may know, I spoke to the annual meetings of the Ontario Public Health Association and the Ontario Hospital Association on the same day. I indicated to these two key organizations that essentially the ministry is focusing on three trends.

 First is the process of decentralization, whereby more of the planning and decision-making about the use of health care resources is to be done at the community level.

 Second is the process of public enlightenment, as it were, whereby people are hopefully persuaded to assume more responsibility for their own health, by taking better care of themselves and by dealing with their own minor injuries and illnesses when they can safely do so.

 Third is the process of deinstitutionalization, by which we are placing increasing emphasis on alternatives to the kind of round-the-clock acute care that hospitals provide.

 I also attempted to give both the Ontario Public Health Association and the Ontario Hospital Association an impression of where these changes would take us.

 As I see it, there is a need for greater integration between the hospital sector and the public health sector. In future, I think the concerns that were traditionally those of the hospital sector and other institutions and the concerns of the public health sector will overlap to a much greater degree.

 As we encourage our hospitals to expand such programs as day surgery, day hospitals and outpatient programs, they will be reaching out more and more from the confines of their four walls into the community. I expect the public health sector to reach beyond the boundaries of its traditional territory as well. The old lines of demarcation between hospital and public health programs will become increasingly blurred. Today, distinctions between these sectors have not only lost their value and meaning, but they also stand as impediments to the co-operation so necessary between these two complementary operations.

 I believe that, in the long run, such an evolution is inevitable. It is inevitable because what this province requires is an integrated health system-a partnership among hospitals, independent health professionals and the public heath sector.

 One may well ask, why are these changes necessary? The answer quite simply is to improve health-care delivery in Ontario by making it both more effective and more efficient and by making better use of the health facilities and manpower which are available to the people of the province.

 I would think that it is important to remember that, in the context of the overall transition within the system, we are not simply dealing with a cost-consciousness exercise. Cost certainly is part of the rationale but, as you 'are aware from the many presentations to the select committee, health-care costs are under control in Ontario.

 From 1968 to the fiscal year 1975-76, health expenditures by the provincial government in Ontario increased from three per cent to 4.5 per cent of the gross provincial product. This trend has been turned around. In fiscal 1978-79, we estimate that health expenditures by the provincial government will be about 4.1 per cent of the gross provincial product, the lowest they've been in five years.

 So that there's no confusion, Mr. Chairman, I might just add that from time to time you will see figures from other countries indicating their expenditures as a proportion of gross national product. But in those terms, Canada in 1975 spent 6.9 per cent. That, of course, is much broader than the figures I have just given you, because the figures I have given you are just for the provincial government; they don't include other expenditures by municipal governments and the federal government and private expenditures on pharmaceuticals and the like. As I say, the 1975 figure was 6.9 per cent.

 None the less, these cost-containment measures do not mean that there will be no growth in health-care services. How's that for a double negative?

What they do mean is that growth will be carefully planned and managed to ensure we get the best value for every dollar we do spend in the health system. In any event, as I have said, cost is really only part of the answer. The fact is, there are other good arguments which are equally compelling for redirecting the health system.

 The health-care system is not out of control, but rather out of balance. Services designed to solve one problem have been used to solve others. Money was spent on highly sophisticated facilities when less expensive ones would do just as well. Emphasis was placed on healing sick people when it would have made more sense to keep people healthy. There is very little evidence that the general level of health is increasing nearly as fast as the money being spent on it.

 I suppose in the past the real problem has been that very few of us really understood what makes people healthy. We have laboured under some false assumptions about the way health is maintained. These false assumptions account for a paradox: We need a system that satisfies the public and is efficient by international standards, yet one that is not contributing as much to health as its share of its budget would lead us to expect. Let's look at these assumptions.

First, there is the "modern miracle" theory. This line of reasoning goes something like this: Our life expectancy is much greater today than it was 300 years ago, let us say, and the reason must be the miracle of modern medical technology; therefore, the more we spend on it, the healthier we are going to be.

 I would have to admit that this theory is generally accepted in North American society. It provides the motivation behind our preoccupation with hospitals, doctors, medical training and research. It accounts for the fact that most of our health spending is directed to professionals and' institutions.

 The problem is that the "modern miracle" theory ignores history. The fact is that most of the improvements in mortality rates in the past three centuries occurred before medical advances such as immunization. The most feared diseases, tuberculosis, scarlet fever and smallpox, were already subsiding decades before there was any known cure or preventive procedure.

 Improved sanitation and a better standard of living had a lot to do with that. It is perfectly true that in the 20th century medical technology has saved many lives, but not nearly as many as improved nutrition, hygiene and living conditions. To quote one researcher, Dr. Thomas McKeown of Birmingham University, both behavioural and environmental influences are more significant to health than medical care. In addition, the pattern of illness within our society is changing. Hospitals are designed for crisis cases, such as infectious disease, but these are no longer important causes of death.

 Our aging population now is succumbing to degenerative diseases which are often not curable, and yet these cases too frequently end up in hospitals because that is the only place for them. It is an expensive waste of intensive care for those who don't really benefit from it. It makes no sense to spend continuously more on expensive technology in the expectation that it will lead to improvements in overall public health. The biggest payoff lies elsewhere, and that is why we are de-emphasizing institutional care.

 A second assumption related to the first is that sick people need special care in special places called hospitals. We could call this the intensity theory. Not that patients like going to hospitals, mind you, but too many do assume it is necessary and desirable from a medical point of view. But I would have to say that often it isn't so. It seems hospitals have become the all-purpose solution to every problem, including family disputes.

 An acute-care hospital is no place for chronic ailments, for minor problems, but too often they end up there because there aren't enough alternatives. That is one of the problems of the system. It is a little inflexible, and it is over-invested in acute-care facilities.

 Most diseases heal at least as fast at home, and in recent years we have found that even many heart-attack victims can do as well or better if they go home within a week. Home care is a better way to treat many chronic illnesses, and it is much less costly as well.

 Minor problems can be looked after at a clinic, including surgery that isn't serious enough to warrant putting the patient up for the night.

 These then are some of the alternatives which we are investigating, and in many cases actually investing money in. But public attitudes have to change along with the services and the facilities.

 The third assumption is that health is something to think about when you are ill. We don't consider our physical performance or invest any time in it unless we are flat on our backs. Until we become more sensitive to our physical needs, we are not going to stay healthy.

 In fact, much illness can be avoided. If we could only get people to think about their health when they are healthy and can do something about it we could save our beleaguered taxpayers literally millions of dollars every year.

 The problem is that most of us assume there is a shortcut to health. Unfortunately, there is usually no miracle cure for chronic problems that have developed over decades of unhealthy lifestyle or pure and simple neglect.

Disease is not always a tragic accident that happens to the unlucky; nor is health something administered to a passive patient by superhuman doctors. Health is an attitude of self-respect and intelligent sell-care. It is something most of us can do for ourselves.

 This is the most important change we have to undergo: a change in attitude from passive consumers of health services to active providers of our own health maintenance, especially as we grow older because the greatest successes of traditional medicine are with children. The chronic illnesses of old age are relatively impervious to our medical skills.

 We are adjusting our health-care system to these new realities. I believe the public wants to be involved in its own health. I think the ordinary citizen is interested in becoming an active participant in the health system. Our job, then, is to offer encouragement and sound information on what each of us can do to maximize our potential throughout life.

 As I said, Mr. Chairman, in recent months at these tables we have discussed at great length a number of issues, first in the spring with respect to OHIP and the financing of same, and in the summer and fall we talked about the entire health-care system. In fact we had a very good day on September 15 discussing a whole range of issues. I am sure members will have points they want to raise today. We can cover some old ground if they like, or turn to other areas that are of interest to members of the committee.