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| ***Province*** | ***Législature*** | ***Session*** | ***Type de discours*** | ***Date du discours*** | ***Locuteur*** | ***Fonction du locuteur*** | ***Parti politique*** |
| Ontario | 31e  | 4e  | Discours sur la santé | 28 Mai 1980 | Dennis Roy Timbrell | Minister of Health | PC |

**Ontario’s Health Speech: Fourth session of the 31st legislature, May 28, 1980.**

Hon. Mr. TimbreIl: I want to thank the last speaker for enumerating a list of initiatives in that part of the province. I would like to think it would be possible to look at most areas Of the province and be able to and I think we could list a variety of similar initiatives enacted on the part of the ministry in the last year.

 I would like to come to that in a little while. It is true that the ministry is by for the largest in the government, but the level of flexibility in the amount Of money we have is very little-in terms Of ability to cease funding One area and changing to another.

 That comes to the basic paint I think the member far Oshawa was trying to make. The most frustrating thing is trying to redirect the health care system; to introduce initiatives and to effect changes; whether it is in the practices of the various disciplines Or would be disciplines, in the operation of the institutional sector or any Other aspect Of the health care system.

 The fact is that built into the basic fabric of the health care system is a whole hast Of interrelated and interdependent lobbies; perhaps special-interest groups is a kinder way to describe them. I couldn't even begin to enumerate them. Whenever we seek to effect change they immediately throw up their own defence mechanisms. The member from Pembroke has seen this in his own community in recent years. The public, the media, and in some cases members of the medical professions have tried to effect change and have run up against peculiar - not in the sense of odd but in the sense of being local -special interests, an of which I think have to be taken account of. I guess on balance, as frustrating as it is I don't know that I have seen an indication from any quarter of a better way to deal with a system like this than the one we have in Ontario.

 The material I gave the member from Pembroke today is a portion of the report I referred to yesterday that was commissioned by, and last year delivered to, the Department of Health, Education and Welfare in Washington. It describes the planning system in Ontario, which is basically a decentralized system.

 Looking at the institutional sector, we have a very small number of staff in the institutional division. As I said yesterday, there is fewer than one person in that division for every hospital in this system.

 We do rely on the health councils, and where they do not exist, the hospital planning councils, and, where they do not exist, groups like the Queen's health sciences complex committee, to do the local planning and all the priority setting and lobbying on behalf of those communities. Beyond that, once the priorities are set and programs are approved, we do rely on the community owned and sponsored hospitals and hospital boards. Most times that works, I think, pretty well.

 Sometimes it does not work; there are hospital boards that either do not understand or will not or cannot accept, because of some other problems of special interest in the community and the hospital, their authority to manage and to direct the hospital. In those cases in which boards do not use the authority available to them, or perhaps succumb to special interests, it as often as not might be the medical advisory committee that is dictating to the board what they feel is in their interests.

 I think that the best role we can play is to act as a rod to the backs of the members of the board so that they…

 I am thinking of the supportive type of rod not the kind you are thinking of.

 Seriously, when you look at the systems that have been developed in other parts of the world-and perhaps one that is dear to the heart of the member for Oshawa is the UK system, in which so much of the authority was, at least in the introduction of the plan, centred in whatever they call their equivalent of our ministry.

 They were not able to respond to local pressures and to local problems. As a consequence, they got themselves in a lot of difficulty to the extent, I think, that in the 30-year history of the National Health Service it has had two, three, or four royal commissions, each refuting the report of the previous one.

 Great. I think it is worthwhile though to keep abreast of the systems that are in place in the rest of the world to avoid their pitfalls. Certainly the biggest pitfall of the UK system, at least initially, was the total centralization of planning without local involvement. They tried to go the other way. In so doing, they set up an elaborate system of area, district and regional health councils that has fallen apart.

 I think we have a good balance between the ministry's role, which I would think you would agree with, of setting overall provincial objectives, guidelines and criteria; and relying on the local health councils, the local hospital boards and the local people to do a great deal of the detailed planning.

 Inevitably you come up against the local interests. With respect, if you think back over the last couple of years as the ministry has tried to shift from acute care to chronic in many communities; as the ministry has tried to push some reluctant hospitals into greater outpatient services, more reliance on day care, surgery and ambulance direct care as opposed to a continuing heavy reliance on inpatient services, we have come up against those special-interest groups.

 Let us be frank about it. There have been occasions when some of our political opponents have taken advantage of that, shall we say, to promote their own interests. I do not decry that. I just wanted to acknowledge that this has happened.

 Let us be honest about it. That is a factor that has to be considered as well, in trying to effect change. No matter what kind of changes you want to talk about, whether it is changes in the relationship of one discipline to another, or changes in the relationship of institutional care versus preventive and community care, you are earning up against some vested interest, be they the boards, the doctors, the unions.

 I was greeted by a group from one of the unions the other night in Cornwall. Their concern is basically not about quality of care but job security, which is a valid concern. But there, where the hospitals are talking about making same changes in the way they provide services, they have come up against that vested interest. I do not use the term "vested interest" in a pejorative sense or a negative sense, but it is one that has to be dealt with by them and by us.

 So change is not going to come overnight. I think though I would have to paint out that change in this province, in the shifting of the system, has probably been faster and more thorough than in just about any other province.

 Far instance, a lat of attention is focused on the fact that in almost every community in the province, except those that have seen huge growth in population, we have over the last number of years closed or phased out acute care beds in the last five years. I think I remember the figures we gave to Mr. Justice Hall, something in the order of 3,500 acute care beds.

 At the same time we have added-and in many cases adding would be by way of conversion, but most of it is straight add-on 6,700 chronic, rehab and extended care beds. So in the five-year period, we all know what has happened to the birth rate, we all know what has begun to happen in the last five or 10 years to the aged people of our demography. We have shifted the system to take account of that.

 In the same period of time, we are now at a point where something like 33 per cent, one third, of all the surgery performed in Ontario is day surgery. That is across the province. You will find hospitals, for instance not too far from you, the Bowmanville Memorial Hospital-I was there last August. They told me mare than half of their surgery is day surgery. People came in in the morning, get prepped, have their operation, rest for a few hours and go home. There are still hospitals in the province where it is down around 10 to 15 per cent and there is still a lot of potential to increase day surgery, thereby reducing pressure on inpatient beds; maybe allow far some conversion for other uses as for chronic care; reduce costs; and reduce inconvenience to the public and patients for those who do not really have to give up two or three days to be in hospital.

 In the same period of time, in shifting proportionately more to the public health sector, we have made a considerable amount of progress in the last couple of years in developing standards for the future for the public health services. You have seen all of the documents that have been prepared to date by public health officials. It has been extensive and wide and very thorough-not just consultation, but involvement by all of the constituent bodies in the public health field in developing the care program proposals which will eventually, within the year, find their way into the new health protection act and the regulations under the health protection act, to bring the public health sector into the next generation.

 I am sure you are aware just how far it has come in a relatively short period of time. Going back 35 years, which is not long, we have gone from 1,000 public health units in Ontario, all with part-time medical officers of health, very few staff, and a fairly limited mandate, to the paint where today we have 44-43 if you will; we have one northern Ontario public health service-health units all with full-time well trained medical officers of health, extensive numbers of public health nurses, inspectors, nutritionists and the like.

 One of the problems you mentioned before when you were asking what has held the public health service book-one of the factors, and this is why I chose to go the route of the core programs with the minimum levels of service, has been the reluctance on the part of some municipal governments to attach the same priority in public health as, not just the ministry, but the local board of health.

 Like you, I was once a municipal alderman. I am sure your municipality was no different from mine. When it came to the first council meeting in January and you sat around divvying up the committee appointments, the first to go were parks and roc and public works, then traffic, so you could make sure the parks, the boulevards, the sewers, the curbs, the streets and the traffic lights and stop signs were looked after in your word.

The last one anybody was interested in, at least in 1969-1972 when I was on the North York council, was the board of health.

 Unfortunately, it is a fact of life that to a municipal politician being on the board of health does not get you re-elected. It is the tangible signs of the parks, the roads, the sewers and so forth that you point to in your re-election brochure and that the ratepayers' group remembers.

 So the introduction of the core programs will go a long way to ensuring that there is a greater uniformity of all aspects of public health services from one part of the province to the other. You only have to look at the per capita spending. I cannot give you the figures for 1980 but as I recall them for 1979, the per capita ranged from about $8 at the low end-was it lower than that?-even lower than that. Well, let us say $8 to about $17 at the upper end of the range per capita spending across the 44 health units.

 Obviously included in that $17 group would be the city of Toronto. You can say the city of Toronto has more restaurants to inspect; they have more problems with new Canadian groups and their health problems; they have more this, more that.

 You can discount all that and still find that there are many areas in the province where the level of public health service is simply not satisfactory. Particularly in parts of eastern Ontario, where the member for Oshawa, the member for Renfrew North, and I hail from, even the existing programs for preventive dental services are not sufficient. In some cases they just do not exist, even though there has been provision to cost-share some of those programs. In other areas, the levels of inspection of restaurants and food preparation facilities are not sufficient, quite frankly.

 At any rate, we are moving in that area. But ensuring the co-operation of the municipalities has been a problem. That is why, for instance, last year when I freed up approximately $2 million to increase the provincial share of the health unit budgets in Metropolitan Toronto by one third, one of the riders to the six councils was that I wanted to see the bulk of that I think the expression I used was the lion's share-used for public health services.

 That happened in all but a couple of the Metro municipalities. Unfortunately, one can point to a couple of municipalities where the bulk of it went into keeping down the mill rate and not into public health services. So it is typical. Your municipality was not one of them.

 East York, but they have their own problems.

 But establishing a ground floor and the new health protection act will help us to overcome those problems where the board of health is not able to convince the municipal council that the council should attach the same high priority to these matters as does the board of health and the ministry. Many times we have found ourselves in the position where we have had our 75 cents in hand to cost-share a program-or 60 cents, or 33 and one-third cents-and the municipality has not been willing to come up with their 25, 40 or 66 and two-thirds cents.

 I should also point out that this year we have identified eight health units we consider to be undernourished. Over and above the 7.6 percent base budget increase, we gave them an additional five per cent.

 Hamilton-Wentworth; Metro Windsor; Oxford; Waterloo; Peel; Brice: Niagara: and Halton.

 It is a judgement call on the part of our staff; these are eight health units that are undernourished and need some beefing up of their programs. We gave them an additional five per cent increase. There again the municipalities are going to have to come across. To the best of my knowledge that has not been a problem as yet.

 When we get into some of the points you were discussing-podiatry, chiropractic, denture therapist, and so forth-there is only so much. If it is possible to think of treatment of health problems as a pie, inevitably, what you come up against is somebody who is always trying to get a slightly bigger piece, which pushes them up against other professions or quasi-professions on both sides.

 The disputes that have gone on between denture therapy and dentistry are classic; also the disputes that have gone on in previous times between dentistry and medicine. Fifty years ago dentistry and medicine were really at war. Over a time that was resolved. With time we can resolve these, but not without a lot of anguish.

 Let us just take the case of podiatry. I went through the history. The fact is we have had a Chiropody Act for nearly 40 years, but in the mid-1950s somehow the board of the day shifted the grounds so that chiropodists could not be registered in Ontario, only American-trained podiatrists.

 Every review done by lay people - I have to emphasize that; not by doctors, not by people with vested interests who are alleged to work within the ministry, or whatever - through the Committee on the Healing Arts, and particularly the task force on health care for the aged of the Ontario Council of Health, has concluded that what we need is chiropody.

 Introducing it is not as easy as that. What it has meant has been a series of discussion papers and allowing time for this sink in. We will be proceeding this year to begin to develop the educational program. As I mentioned yesterday, we are working on the legislation to give effect to this. But we are all against medicine on the one…

 First of all, I think it was very clear in my statement in the House that we do not intend as of a particular date to say, "The existing practice of podiatry under the Chiropody Act and the scope of practice as defined therein will end. We are not saying that.

 We are saying that the podiatrists in the province will be allowed to continue to treat their patients, that people will not be denied access to them. We are not going to change their scope of practice. We made that very clear. The existing scope which is in the Chiropody Act, as it has been defined or clarified by the courts from time to time, will prevail.

That's right.

Until they want to practice.

 Anything within his existing scope, including the use of topical anaesthetics, would continue.

The courts.

 Essentially it will provide a mechanism whereby chiropodists trained outside Canada-primarily UK chiropodists-would once again be allowed to register in Ontario.

Right-in the health unit, and the hospitals.

 Secondly, once the program is funded, Ontario-trained chiropodists would be registered to be employed in Ontario and provide foot care services.

 We will not be saying to the podiatrists whatever number it is, 84 or 87; I have heard both numbers-who are really registered as chiropodists under the existing legislation, "Pack your bags," Or, "Here is a new scope of practice limiting you to something less than the service you have been providing to your patients."

That's right.

That is one issue we are considering, and I will be interested in the views of the members of the committee whether we should provide a date after which no new ones, other than those Canadians or landed immigrants who are enrolled in courses of podiatry, could be registered, or leave it totally open.

 We have discussed this with the podiatrists. After our last meeting I invited their comments on the question of grandfathering -how they would prefer to see it done. I am sure you have seen a copy of the letter I got back were very much on their minds; which is understandable, I suppose, with the investments they have made.

 We have One profession against another. Certainly the whole business of the use of the word "doctor" is like a red flag with podiatrists, and also with chiropractors. Our position is very clear. We have no intention of ever letting either use the term "doctor," unless there are lower criteria for its use in Ontario than I think are generally supported.

 Oh, they do. They do extensively. I walk into meetings and they say, "This is Doctor Smith," and I say, "Hello, Mr. Smith"; "this is Doctor Jones," "Hello, Mr. Jones." This goes on all the time.

 I must tell you, at the time of the earlier discussions my thinking was very much along the lines of grandfathering it at a particular date-no new ones after that. I have listened to their arguments and have read their briefs, and I am leaning more to recommending that there be no cut-off date; that we provide, in effect, for its continuance-but putting in place some competition.

 In a number of the discussions it has, as you say, come down to economics. Several years ago, the then president of the podiatry association said, "Take us out of OHIP if you want." I don't believe he really thought that one through, but he really wanted me to delist him from OHIP. I have no intention of doing that.

 On another occasion recently, admittedly when my thinking was along the lines of a cut-off date, it came down to, "We won't be able to sell our practices." So economics and their own personal financial considerations.

 There have been discussions with chiropractic for some four years about developing new legislation. Currently there is in fairly wide distribution a draft bill which represents their desires. It includes the use of the term "doctor," and they know my position on that. It includes a scope of practice to which we have not agreed. We have told them we think it is broader than it should be if it is to reflect the training what should be the practice of chiropractic. In short, we have not been able to agree on legislation.

 We will be meeting with representatives of chiropractic in the very near future. I will be putting it to them that I would like to see this cleared up. I am prepared to indicate that my parliamentary assistant and all of our staff will be directed by me to give it one last push to try to come to some agreement on legislation that we could bring to the House.

 Failing that, we either drop it and come back to chiropractic later-because there are others waiting, such as physiotherapy; the occupational therapists would like their legislation cleared up-or perhaps it is something they would like to put to a select committee or some other process.

 They are pushing up against medicine and against physiotherapy. Both medicine and physiotherapy have concerns about the draft bill which is in circulation. I know the usual view of the representatives of chiropractic is that it is all a medical plot; that the physicians are the big enemies. There have been opinions expressed by physiotherapists, by some chiropractors, the straight manipulators-is that the proper term?

So it is not an easy Mea.

Well, if that's agreeable, we will just turn the whole matter over to the chairman. He can write the legislation and it will all be done.

 The point has to be made that when you are talking about the introduction of alternatives and changes in the system it is obviously easier to introduce alternatives and make the biggest and most significant shifts where you have shortages or lack of services, or wherever you are talking about a new service.

 We have had the greatest success, for instance, in introducing the use of nurse practitioners in the north, particularly through our northern Ontario public health service and in the health service organizations, such as the one in Burlington or in Flemingdon or in Sault Ste. Marie. I think they use them in Oshawa at the Glazier Medical Centre; I am not sure.

 The introduction of chronic care has been most successful in the areas where there have been shortages of other forms of care. It is not in competition; it is filling a void.

 The changes in hospitals have come about because of the pressure put on the existing beds by the traditional practices of medicine and because we have said: "We are not going to keep adding where we don't think it should be added. You are going to have to look at these other areas." They have done so, and so you have ended up with hospitals with only about 50 per cent day surgery with no negative effect on health, but in fact a positive effect.

 We are going to be dealing with HSOs in public accounts on June 5.

 I can give you the list - I think we have given it to public accounts - of their budgets and which ones, are on the new payment mechanism, which ones are going to go on it and which ones will be health centres, such as a couple in Ottawa. I would be glad to get that for you.

 That is a press release I hadn't thought of. We will get to that.

 I remind you that a year ago, when we were beginning to introduce the new formula, which Ray Berry was responsible for developing, there was a great deal of apprehension. You were visited as I am sure the member from Pembroke, Mr. Conway, was visited - I certainly was - by representatives from a whole host of HSOs, saying, "This is bad." Because it was change again. To them, anything different from what they had become used to, albeit in some cases for as little as three or four years, was a threat. But finally those people, particularly the ones in the Sault and Flemingdon and the Caroline Medical Group and the Glazier Medical Centre, and so forth, found that the new funding formula is, in fact, a very good formula for providing them with the opportunities to get into these alternatives.

 I guess that depends on the individual HSO. I will get you the information.

 There are going to be some 12 or 13 that we will not classify as HSOs, that are not in fact viable as HSOs, but which we will classify and will fund as health clinics - an essentially line-by-line budget - or such organizations, for instance, as York Community Services.

 Yes. I will get you copies of it.

 The issue with the denture therapists, when it first came up in 1973, was resolved in 1974 on the basis that denture therapists would be allowed to make complete dentures, upper and/or lower, as long as no live teeth were involved.

 As far as the provision of partial dentures was concerned, they would have to do that under the supervision of a dentist. That has worked in many cases, and in others it hasn't worked at all.

 Perhaps because of philosophical objections on either side-it is cut both ways-some dentists have not been prepared to admit that denture therapists even exist, let alone that they should be supervised. Some denture therapists have never accepted that there should be any restriction. There have also been situations in which one may operate in a town where there is no dentist. Then there is a problem in being supervised by the dentist who lives in the next town. There is also the problem of physical limitation.

 We tried for two years to get the denture therapists and the dentists to arrive at a meeting of minds to resolve the philosophical problems. The practical problem of geography and distance, and so forth, could have been resolved if we had been able to resolve the philosophical problems to give total effect to what is in the legislation. We didn't succeed.

 I felt that the best way to resolve the matter was in a public forum - that forum being the Ontario Council of Health - to examine the issue and determine what is in the best public interest.

 Most of the correspondence I get, and I'm sure most of what you get, deals with the question of cost. If cost was the only consideration it would have been allowed for at the time of the passage of the legislation in 1974; that is, the making of partials without supervision. Cost is a very much less important factor with partial dentures, I submit, than with full dentures, when you are talking about working around, clipping on to and perhaps disturbing remaining live teeth.

I think the public interest would be better served by an impartial review of the level of capability of those who are at present licensed in the province as denture therapists, in order to advise whether it would be in the public's best interest that they be allowed to do this on their own, or whether they should be under some form of supervision.

 I was speaking with the acting chairman of the council of health within the last few days. She tells me that a sociologist and a lawyer have been lined up to sit on the task force and that they are looking for a chairman. I know the concern has been expressed that if there is a dentist on the task force there should be a denture therapist. There won't be either, so they will be free from any allegations of bias pro or anti dentistry or pro or anti denture therapy. I'm sorry I can't give you any names, but as soon as we get them from Sister Margaret we will do that.

 About the question of out-of-province claims, I will leave that until we get to the DHIP vote, if I may, and we can have the general manager of OHIP here.

 I think in the letter to your colleague about her claim, the general manager did try honestly to say that we have some problems of which he is aware - he has been on the job now for about six months - and which he is working hard to overcome. It is a large operation, and I can't recall the breakdown. I think it's $17 million in hospital claims in the United States, but I can't recall the amount in medical and other claims. It is a problem which he is working to resolve.

 On the question of the nursing home regulations, when we get into the institutional budget you may want to be more specific about which ones are of concern to you. I may say we purposely involved a wide range of bodies in the preparation of it; the medical association, the nursing home association, but just as importantly, the Senior Citizens Advisory Council, in reviewing the proposed changes in the regulations, particularly the Senior Citizens Advisory Council to give the senior citizens' point of view since most of our residents in nursing homes are over 65.

 The residents' councils you referred to, along with the process of accreditation, are two particular things we have urged on the nursing home association and the industry in the last few years, which challenges they have willingly picked up and run with. We are up to about 20 nursing homes now, that have become accredited through the Canadian Council on Hospital Accreditation and I can't recall the number of homes that have instituted residence councils, but it is growing all the time.