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**Ontario’s Health Speech: Third session of the 32th legislature, December 6, 1983.**

Hon. Mr. Norton:

Thank you very much, Mr. Chairman. Initially, I want to thank my colleagues from the Conservative caucus for the demonstration of support today and the critic for the

 Oh, shucks. I was just going to make that observation. At least, then, I will thank the critic for the third party for his interest in the issues relating to health care in the province. It is unfortunate that the same level of interest is not demonstrated by the official opposition. However, I am sure if these proceedings were in public they would be there protesting an abiding interest in health care and might periodically appear during the next couple of weeks to try to make that point in passing.

Yes. Isn't it a shame?

the past couple of months, and for agreeing to a modest reduction in the number of hours so that we could complete the estimates prior to Christmas.

 It is my pleasure to present for the first time the estimates of the Ministry of Health, these being for the fiscal year 1983-84. Before I present a more detailed report on the activities of the ministry, I would first like to give the committee an idea of the size and complexity of the health care system.

 When I assumed this portfolio just a few months ago, the 1983-84 budget of the Ministry of Health totalled $7.5 billion. That represents 30 per cent of the provincial government's total estimated expenditures of $24.8 billion for the 1983-84 fiscal year. It is the largest amount allocated to any ministry in the government.

 The Ministry of Health itself employs 10,469 classified personnel. It funds 228 public hospitals, 17 private hospitals, 17 children's and adult rehabilitation centres and 10 provincial psychiatric hospitals.

I welcome the member for Renfrew North.

 We have not got around to Marion Hill yet; it is coming.

 The major payments that make up the 1983-84 Health estimates are $2.1 billion to physicians and practitioners, $3.6 billion to public hospitals some in Pembroke-and $1.8 billion for all other expenditures, including drug benefits, clinical education and so on.

 That is right. You will notice that I have been able to make one statement in the House per day since I got back, an indication that there should be an acting minister in motion more frequently to get things rolling.

I would like to thank those people who are here, and the Liberal members of the committee for their flexibility in scheduling the estimates so as to accommodate my schedule, which was somewhat altered during

No. That is coming. You had better warn your brother-in-law or whoever it is.

smoother if you just read what you have in the book and not engage in debate with the member from wherever it is-it always escapes me

 I might just observe that although he has maintained that he voted for me at the nomination meeting, he mentions it much less frequently these days than he has in the past.

We do not have a delegate convention.

In any event, in the institutional sector, as of November 30, 1983, the ministry was funding 36,797 acute care hospital beds, 12,961 chronic care hospital beds, 29,206 licensed nursing home beds and 12,901 extended care beds in homes for the aged.

 As an example of the way in which the ministry serves the public, it should be noted that the ministry has 120 offices and facilities, such as laboratories, throughout the province. It funds 194 ambulance services and 43 local public health units. It has supported the development of 26 district health councils, which now serve more than 90 per cent of the population. The Ontario health insurance plan has 21 office locations, which handle two million telephone inquiries every year.

 While these few facts and figures give you an idea of the breadth of the health care system, they do not show the continuing pressures on the system that constantly push it to assume even larger proportions and, consequently, even higher costs.

 Just two areas will show the kind of growth pressures I am talking about. Hospital funding, for example, has increased from $3.3 billion in 1982-83 to an estimated $3.6 billion this year. OHIP's budget has increased from $2.1 billion in 1982-83 to an estimated $2.4 billion this year.

 In addition to budget increases in those two areas, there are many more pressures on the system. Increasing demands for more community based services, extended home care programs, health promotion projects, improved care for the elderly, high-technology equipment and community mental health programs all place stress on the system. While our population growth will be about 0.6 per cent in 1983-84, we project an increase of about three per cent in the number of physicians in the province. The number of services provided by physicians is expected to rise by about two per cent.

 It was in response to the kinds of pressures I have just outlined and to a number of other issues and concerns as well that the Ministry of Health, in consultation with the major provider groups, decided last year that the system should now prepare to bring about a process of careful change and evolutionary reform.

 To develop a long-term strategic health care policy for the province, the ministry called upon the assistance of the Ontario Council of Health and the district health councils to help in initiating the strategic planning process. I would like now to outline how that process worked.

That is correct. It was initiated by my predecessor and brought to fruitful conclusion following my assumption of office.

 It was decided that the process would have to be a consultative one. It would require the commitment of a large number of people from a wide variety of backgrounds and with different points of view. Indeed, the active participation of those directly involved in the system, both providers and consumers, was seen to be essential. To this end, a series of seven health policy conferences was organized around the province this spring and summer.

 The first, the minister's policy conference, was held in Toronto last April. It was convened by the Ontario Council of Health and involved the participation of 240 people, who were primarily senior representatives of 60 different professional, consumer, government, health care and special interest groups.

 The strategies and action steps that emerged from the minister's policy conference as a means of addressing future needs fell into eight areas in the following priority order:

 First, decentralization was proposed to make the health care system more responsive to local needs. Second, participants gave their support for basic, applied and clinical research and stressed the importance of a province-wide data base.

 Funding and incentives emerged as a means of encouraging innovation and efficiency within the system. Better co-ordination of services was advised, with the Ministry of Health taking the lead role in all health and health-related activities.

 Professional training was discussed from the perspective of fostering a multidisciplinary approach to health care. Participants agreed that public education should be improved with a view to encouraging greater individual responsibility for health and the more appropriate use of services.

 Alternative delivery systems and redefined professional roles were discussed as a means of encouraging a multidisciplinary team approach to health care and a more efficient use of trained personnel.

 Finally, it was felt that effective, co-ordinated and innovative health care planning requires the participation of providers and consumers.

 The eight issues I have just outlined were than taken to the six regional conferences hosted by the district health councils. They were presented as a framework for discussion in an attempt to measure to what extent they reflected the concerns and priorities of people across the province. It should be stressed, however, that conference participants were not restricted to a discussion of only these topics. They were encouraged to raise any issues they felt were appropriate.

 The regional conferences were held in Thunder Bay, Ottawa, London, Waterloo, Toronto and Sudbury. The seven issues that emerged as a priority from those conferences were as follows: health promotion, co-ordination, community-based and alternative delivery services, accessibility, funding and incentives, data and information, and decentralization.

 A comparison of this list with the one that came out of the minister's policy conference in April shows some variance in the ranking. In April, decentralization was the number one issue, for example, but it was number seven at the regional level, where health promotion took the top spot.

 Despite these priority differences, we are now presented with a group of common concerns that were identified by all the policy conferences. We also have the assurance that the conference participants are ready to begin addressing each of these issues.

 Now that the first phase of the process is over, we must keep the momentum going and move to the implementation phase. In the next few weeks a detailed report on all the conference results will be released. I have asked that all participating groups respond in writing to me with their suggestions on how we are now to

move to stage two of the consultation process.

 The Treasurer could write you a good letter on that based on his earlier experience.

 Yes. In fact, I would invite him and all others to make their suggestions.

 Earlier in my remarks I outlined very briefly the demographic, financial and technological pressures that are having an impact on our health care system. All these pressures intersect when it comes to the services provided by our 228 public hospitals, which consume 48 per cent of the total ministry budget. It has therefore been a priority of this ministry to strengthen hospital management by shaping an environment that fosters stability, creativity and effectiveness in hospital administration.

 Last year, as members of the committee will recall, the government allotted additional funds of $110 million to restructure hospital funding arrangements. Prior to this, some hospitals were regularly incurring large deficits, which meant they expected the ministry to fully or partly cover their overruns.

 With the $110 million, we provided all hospitals last year with a budget base calculated according to the amount they actually spent on patient services in the fiscal year 1981-82. The new formula was accepted, and it included adjustments for inflation, increased work loads and annualized programs as well as money for life support programs.

 We expected this initiative would make 1982-83 a turnaround year in hospital financing. We were confident that hospitals would henceforth be able to manage within balanced budgets while also maintaining and enhancing their levels of service. We also made it quite clear that the ministry would no longer absorb hospital deficits.

 I am very pleased to be able to report to this committee that our expectations have been fulfilled. Almost all Ontario hospitals are now operating within their budget allocations.

 We will continue to refine the new funding formula, of course, and to fine-tune it in consultation with the hospitals. But we feel we are clearly on the right track in our effort to stabilize the financial side of hospital operations.

 For 1983-84, the ministry has raised hospital

budgets by an average of 10 per cent over last year. The $3.6 billion total includes $31 million to cover the cost of increased hospital patient loads; $12 million for the growth in the use of life support programs, such as renal dialysis, cardiovascular surgery and cancer chemotherapy; and $6.1 million for new and expanded programs ranging from computerized axial tomography scanners to the operating costs of new hospital wings.

 These increases, coming at a time of fiscal constraint, reflect this government's unswerving commitment to the provision of the resources that hospitals need to maintain high standards of patient care.

 Hospital management has also been reinforced by the business-oriented new development, or BOND, program. Introduced in 1982, the program creates incentives for hospitals to earn revenue and generate economies. Hospitals now retain their net income instead of having to return budget surpluses to the ministry. This arrangement encourages hospital management to adopt more businesslike procedures of flexibility and priority-setting within hospital administration.

 This is just one example of the ways in which hospital management is improving in this province. Ultimately, however, if we are to make further strides, we will have to develop a better system for measuring hospital performance.

 The ministry and the Ontario Hospital Association are now co-operating on a venture to design case mix groupings that will identify differences in the complexity of case loads handled by various hospitals. Clearly, hospitals treating more sophisticated cases and more serious illnesses will face greater costs than those performing less demanding tasks. We are now reviewing proposals for five pilot projects from hospitals which will measure costs and their link to intensity of care and hospital output.

 When we have the results of the approved projects, we hope to introduce hospital performance measures as part of the criteria for awarding growth money. Global funding for hospitals will continue, but we also need to allocate new funds and new programs based on hospitals' work loads and the efficiency of their operations.

 The kind of performance measurement techniques we are looking at will also help us determine where new programs could be located and where they will be managed most effectively. They will also assist hospital managers with internal planning by providing concrete evidence of how well each institution is fulfilling its role in the community.

 As a first step in the process, over the past year the ministry has improved its information base on financing. We are now in a position, for example, to undertake peer group comparisons of hospital departments in such areas as patient admissions, discharges and length of stay and to analyse related costs. These data help us gauge hospital efficiency and can be very helpful in planning.

 The rationalization of the hospital system is perhaps the single greatest organizational challenge we face today. Hospitals can no longer try to be all things to all people. Instead, we have to reach a consensus within each region as to the appropriate roles and service priorities for each institution.

 We have already seen that such a consensus can be reached. In many communities the spirit of co-operation is replacing the old reflexes of competition and rivalry.

 In Guelph, for example, the two hospitals and the district health council are working on a master program for the realignment of services. This program will implement the recommendations of a recent study that suggested one hospital take a surgical direction and the other a medical emphasis.

 In Peterborough, following a facilitator's report made there last year, a joint implementation committee has been formed to smooth the redevelopment of two hospitals. In North Bay, two hospitals have agreed to amalgamate operations in a new facility. The savings in operating costs generated by the amalgamation will be channelled into new and expanded programs.

 However, to meet the needs of all our communities, we must achieve an even greater pooling of clinical resources and specialized skills so that patients have access to the services they need without duplication or costly competition. We are also asking hospitals to reach out into the community more, to give renewed emphasis to outpatient and community-based services.

 The construction at Peel Memorial Hospital in Brampton, for example, will double the space for outpatient services such as emergency mental health care, day surgery, occupational therapy, speech therapy and physiotherapy. The new ambulatory care unit opened at Scarborough General Hospital this August provides expanded emergency and outpatient services.

 In Hamilton, planning is under way for an east end health care facility, which will be a satellite clinic of St. Joseph's Hospital.

 The ministry currently funds 15 children's treatment centres across Ontario which provide rehabilitation and assessment services to physically handicapped children and infants on an outpatient basis. Most of these centres were originally funded by Rotary and other service clubs. They enable children, who in another era would have been consigned to live on the fringes of society, to lead useful and productive lives.

 These initiatives reflect the high priority the ministry places on the development of outpatient and community-based services and reaffirms our determination to provide high quality care in all areas of the province. In future, public hospitals will remain the linchpin of our health care system. In responding to new opportunities for community-based services, their role in the health care system is certain to be enhanced.

 I believe the way a society provides for its elderly is a sign of its fundamental values and principles. This government has always been determined to provide the best possible care to its senior citizens. But as their numbers grow it becomes necessary for both government and society to assume an even greater responsibility for care of the elderly and to prepare now for the tremendous impact this phenomenon will have.

 In Ontario today we have about 900,000 elderly residents. Over the next 20 years, it is expected the growth of this population will outpace all others. By the turn of the century we will have almost 1.4 million seniors in our province, and that represents a 57 per cent increase from the current level. In Ontario people aged 65 and over now make up about

one tenth of our population. They use about one third of our health care resources. As can be seen, when the number of aged citizens expands so too will the demands on the health care system.

 Having said this, I should also say it is a mistake to stereotype the elderly as always being sick, infirm or totally dependent on social

support services. We know that more than half of Ontario's citizens who reach the age of 65 and over are still active in the community.

 Given this situation, I see this government's task as twofold: to support the independence and preserve the health of elderly citizens in their own homes and communities; second, to guarantee a high standard of institutional care for those who need it. In this regard, the ministry has implemented a number of initiatives, some of which I would like to outline today.

 Institutionalization seems to have become all too often an automatic response to caring for the elderly when, in many cases, it appears that such a step need not be taken at all. It has therefore become a priority of this ministry to develop new home care programs for seniors, particularly for the chronically ill who need continuing care. Chronic home care programs are now available province-wide, including in Metro Toronto, to-which the announcement in the House today related.

 That is a little bit of an exaggeration; I just screwed up there a bit. The Metro Toronto program will come into effect on March 1, but the announcement took place today.

 Day hospital programs have also been expanded; there are 18 operating in the province at this time. Through this service, senior citizens can receive physiotherapy and general nursing care and even use the social and recreational facilities of a hospital, without having to be admitted. Through the geriatric assessment program the elderly can get comprehensive medical, psychiatric and social evaluation. These are only two of the many programs and services the ministry has implemented to improve care for the elderly.

 Since we realize, however, that health care for our seniors will necessitate some dramatic and fundamental changes to the health care system in general, we have also been looking at this issue on a much broader scale. The Ottawa-Carleton District Health Council, for example, recently brought Dr. John Dall, a renowned Scottish geriatric expert, to Canada for a one

year study of health care services for the aged.

With his guidance, an innovative program of care was established in that region.

During his year in Canada, Dr. Dall met with

134 representatives of all geriatric fields. Using the information he gained from these consultations, and drawing on his own background and experience, Dr. Dall has designed a program that would ensure the elderly are provided with appropriate care, whether it be in their own homes or in hospital.

 Dr. Dall emphasized the importance of proper assessment in geriatric care, noting that in many cases assessment takes place immediately following a serious and emotionally disturbing incident such as a stroke, when the patient's condition is still unstable. At that time, doctors and family may decide that nursing home care,

for example, is the only solution to the elderly person's predicament. Dr. Dall says if such decisions were delayed until the patient has had a chance to recover properly, it may well turn out that the nursing home care is not needed and that with the help of appropriate support services the patient is fully capable of returning home.

 The ministry has recently funded two projects to establish geriatric assessment centresone in Ottawa and one in Hamilton. Using Dr. Dall's assessment procedures, Ottawa alone was able to significantly reduce the number of elderly waiting for long-term care beds. Dr. Dall points out, however, that if we are to reduce successfully the institutionalization rate for senior citizens, we must have at least four things in place.

 We must have proper geriatric assessment programs, first of all. We must have all of the necessary support programs that allow the elderly to stay in their own homes or with their families. We must change the "custodial" attitudes about seniors that are currently prevalent. Finally, we must develop medical education programs that deal with seniors' special health care needs.

 One of the things my ministry has acknowledged for some time now is the need to develop a better co-ordination of services, especially as

they relate to senior citizens, who often have to deal with a number of different government ministries, agencies and community service groups to get help with their varied needs. In this regard we are developing better communications with the Ministry of Community and Social Services and the Ministry of Municipal Affairs and Housing, for example, and are working diligently to improve the co-ordination of all health-related services.

 We now also have 12 placement co-ordination services operating in the province. Their mandate is to link those in need of long-term care, either with institutional facilities, or with agencies that provide community support services. In Hamilton, the PCS has helped in the development of day care, respite beds and a municipal licence for lodging homes that provides supervisory care to the elderly and chronic psychiatric patients.

 In Thunder Bay, the PCS has eliminated the

duplication of data collected by a variety of institutions and has become a central information source for a number of agencies, facilities, municipalities, the health council and the ministry. It has also been able to ensure appropriate patient transfer between different facilities, in response to changing needs.

 Not all the health care needs of the elderly can be supplied by community services or home care programs, of course. There comes a point at which some senior citizens will benefit from institutional care. Whether the elderly receive care in the community or in the nursing home, however, our objective remains the same-to ensure that appropriate, efficient, humane and responsive care is available to every senior in this province.

 The very best nursing homes in this province and there are many of them - are homes in the very best sense of that word. Their personnel are just as concerned as every member of this committee about the kind of care elderly people receive in the institutional setting. They want to see poor quality services eradicated. They want to see public confidence and trust rebuilt where it has been eroded, and they have been fully behind most of the initiatives we have taken this year to correct the abuses and rectify the problems that we all know exist.

 My ministry addressed some problems head

on in June of this year. We introduced amendments to the nursing home regulations that significantly broaden our powers to act when the health, safety or welfare of nursing home

residents might be in jeopardy.

 The new measures allow us to suspend a licence and place a nursing home operation under new management while the suspension or revocation is being reviewed. Prior to the amendment, a licence revocation could be tied up in litigation for months.

 Since July 1, nursing home reports, based on annual relicensing inspections, are being made available to the public as they are completed. The reports contain facts about the home, such as its size, age, accreditation status and so on. They also name the violations listed in the inspection report and note whether or not the operator has taken action to correct them.

 In order to present the residents' view, residents' councils may wish to prepare a profile of the home from their perspective and have these profiles included, along with the inspection reports, as a public document.

 We are currently planning further amendments to the nursing home regulations. One will give all nursing home residents the right to establish and participate in residents' councils. Another provision will protect a resident's place in a home while he or she is in hospital. Current regulations call for the termination of extended care coverage 72 hours after a patient's transfer to hospital. The amendment will extend this period to 14 days.

 Earlier this week I informed the House about new action we will undertake with regard to inspection procedures and the enforcement of the nursing home regulations and standards.

 As some members will recall, nursing home care became an insured benefit under the health insurance program in 1972 and the ministry, accordingly, established an inspection program. At that time there were 22,741 licensed beds in 455 nursing homes across Ontario. Today there are 29,206 beds licensed in 335 nursing homes. In other words, there are more than 6,000 more beds and 120 fewer homes.

 I would point out that someone in the media asked if that meant they were more crowded than they were previously. I suggested that that was not the case. In fact, it represented consolidations and expansions of some existing homes, not necessarily crowding more people into the same space.

 In almost every case, homes closed because they were too small, inefficient or obsolete to meet the ministry's standards which were being enforced with increasing determination. The remaining homes which predate medicare have been brought into compliance with the ministry's structural, fire and safety requirements, but they have been allowed to defer correcting some structural and other environmental shortcomings, which affected the living standards in the homes.

 This policy was justified on the grounds that we needed beds and the owners were entitled to some reasonable time to prepare for the financial and other obligations entailed in what would, in many cases, be major reconstruction. We believe there has now been enough time and have decided that, as a matter of policy, we will

deal with the deferrals over the next two years.

 To achieve this, I have directed staff to review with the individual homes involved, and the nursing home industry as a whole, the means by which our policy can be implemented and to present us with options which the government can consider before the beginning of the next fiscal year in April 1984.

 We plan two other specific actions which I also explained to the House. It was three and a half years ago that Mr. Timbrell announced a restructuring of our nursing home service as part of the institutional operations branch. When it became clear that the 24 inspectors were not enough to provide the level of inspections we required, Mr. Grossman arranged with our colleague, the Minister of Municipal Affairs and Housing to second seven fire inspectors to help us for a period of one year. As well, we were able to divert some additional staff and technical resources from within my ministry, in spite of the staffing constraints which have been in effect during this period.

 In order to deal with the shortcomings, which were previously deferred, and to maintain the intensity of our current inspection program, we decided that we would need some additional staff for inspection purposes immediately. While an assessment is being made of our additional staffing requirements in the longer term, I have authorized the immediate recruitment of some 10 more inspectors for the nursing home service.

 The success of the program, as I indicated to the House, will depend on the degree of compliance that we receive from the nursing home operators in Ontario. However, there are some in spite of the fact that most are very co-operative-who may be reluctant and will, in fact, need to be encouraged by the possibility of more frequent legal action.

 My colleague, the Attorney General, as I again explained to the House, has therefore seconded Lloyd Budzinsky, QC, a senior crown attorney from the central office in Toronto, to the Ministry of Health to work full time and exclusively on prosecutions or revocations which are justified by the non-compliance of any nursing home operators.

 Members may be aware that there are four letters of revocation before the Nursing Home Review Board and 39 charges pending before the courts. I expect that Mr. Budzinsky's demonstrated diligence as a prosecutor will stand us in good stead in the months ahead.

 I am confident that, with the kind of changes that have been outlined, we will go a long way toward protecting the rights of nursing home patients and the quality of care they receive. The ministry is, and will continue to be, in

constant contact with social service agencies, other government ministries, nursing homes and seniors themselves in an effort to ensure that everything that can be done is being done in this priority area of health care services.

As we shift the focus of Ontario's health care system to a greater emphasis on community-based services and health promotion, Ontario's 43 public health units will have an even more important role to play. They are the statutory agencies whose primary concern is disease prevention.

 The Health Protection and Promotion Act, 1983, which received royal assent on February 23, is expected to be proclaimed in the new year. Replacing the old Public Health Act enacted 100 years ago, the new act is designed to prepare public health units to exercise leadership in the new preventive medicine era that has arisen partly as a result of renewed public interest in personal health and fitness.

 At the heart of the act is the establishment, for the first time, of minimum service requirements, or core programs, which must be met by all boards of health in the province.

 The mandatory program package on family health, for example, covers a full cycle of care from birth to death. It includes counselling and family planning services; programs to identify pregnant women in high-risk categories; services for infants, pregnant women and the elderly; preschool and school health services and the collection and analysis of epidemiological data.

 The universal availability of these fundamental programs will ensure that all Ontarians have access to the resources and guidance they need to assume more responsibility for their own health.

 The core requirements of the new act will be implemented in stages, so that those health units needing it will have the time to adjust. Phase one will be introduced in 1984. Subsequent phases will follow over a period of five years or so, depending upon local circumstances and priorities.

 In order to make sure that public health units have the staff that they need to fulfill their new mandate, the ministry has been working with medical schools to realign postgraduate training posts. I am happy to announce that this fall the number of residency positions in community medicine increased by 42 per cent. Last year we had 19 funded residency positions; this year we added another nine, for a total complement of 28.

 The new Health Protection and Promotion Act also recognizes that public health units must relate to occupational and environmental health. Sections 11, 12 and 13 create the legislative grounds for the close working relationship that must exist between the Health, Environment and Labour ministries.

 When a medical officer of health receives a complaint about an occupational or environmental health hazard, for example, the new act says that he or she must notify whichever ministry has primary responsibility for the matter, and that any investigation must be conducted in consultation with that ministry.

 Under the act, every medical officer of health has a duty to keep informed about occupational and environmental health, and the three ministries, as well as the municipalities, are obliged to provide him or her with information requested in those areas unless they are prohibited by law from doing so.

 Finally, the act empowers a medical officer of health or a public health inspector to order a person to take, or refrain from taking, any action so that a health hazard may be eliminated or mitigated.

 These sections make it quite clear that all ministries of the government-and particularly Health, Labour and Environment-will work together and will share expertise and knowledge on environmental and occupational health.

 A new statutory post created by the act is that of chief medical officer of health, a position recently filled by Dr. David Korn. As a consulting epidemiologist with the World Health Organization in the mid-1970s, Dr. Korn was honoured for his work on the global smallpox eradication program. In his new post, Dr. Korn will serve as the communications link between the province's boards of health, their medical officers and the ministry.

 In order to strengthen the education and research base for health protection and promotion activities, we are developing the concept of "teaching" health units. As the public health counterpart to teaching hospitals, a unit would be affiliated with one of the five health sciences centres. It would build public health expertise and would create a role model that would influence new generations of health professionals. We are now reviewing several applications from health units and health sciences centres wanting to implement the teaching health unit concept.

 A range of continuing education courses is now available to public health practitioners. Inspectors now have the opportunity to enrol in a four-year degree program, for example, which expands on their two-year qualifying course. The third year can be completed through part time study and candidates receive up to two thirds of their normal salary to complete their remaining year on campus. Three quarters of this support is funded by the Ministry of Health and the rest by the local board.

 Similar assistance for public health nurses has been available for some time, and support is available for business managers to obtain master's degrees or the equivalent in public health administration or related fields. Medical officers of health are likewise offered continuing education programs to upgrade their business management skills.

 The core programs of the Health Protection and Promotion Act now being extended province-wide were designed and developed by public health personnel. It is to them that our appreciation must go for what I believe will be sound and innovative programs. We will continue to tap their creativity and knowledge as we progress, and continue to ask for their help in translating the ideals of health protection and promotion into tangible commitments and effective services.

 Mental health has been a priority issue with this ministry for some time. I want to pay tribute to my predecessor once removed for his outstanding personal commitment to mental health and for playing a very prominent role in involving the ministry more aggressively in pursuing the interests of those who are suffering from mental illness.

 In the past two years I believe we have made rapid progress in revitalizing mental health services and in initiating some profound changes. I assure this committee we will continue to give mental health issues our earnest consideration.

 We currently spend more than $346.3 million on mental health care in Ontario. This figure does not include fees paid to general practitioners in the mental health field, nor, I should add, the operations of psychiatric units in our public general hospitals. We have 10 provincial psychiatric hospitals. We fund 60 psychiatric units in general hospitals. As of April 1983, we were supporting 200 community-based adult mental health and addiction programs.

 Our emphasis in the mental health area has been on the need to seek a better balance between the services provided by the established institutional sector and the new range of community-based programs. This has been a positive step, but for it to function properly it relies upon the positioning of adequate support services so that patients are not returned to a community that is unable to cope with them.

 This August I announced additional commitments of $5.7 million to finance 54 new community mental health and addiction programs. This new money brings to $38 million the amount we are now spending annually on 254 such programs.

 The new initiatives include the establishment of five women's mental health programs. In Ottawa, the funds provide for a women's detoxication centre. In Toronto, a program known as sistering operates a referral service for socially-abused women who have chronic psychiatric problems and regularly move from hostel to hostel.

 In northern Ontario, our mental health services will be increased in sparsely-populated areas. There will be a counselling program in Sioux Lookout, for example, and a psychiatric outpatient centre in Timmins.

 I would like to say that I am greatly heartened by the growing mental health outreach role being taken by our public hospitals. Peterborough Civic Hospital will soon begin two new programs for former patients, a schizophrenia clinic and a complementary volunteer program that will provide one-to-one support and guidance for its patients.

 Sarnia General Hospital will be offering a psychogeriatric consultation service, and Greater Niagara General will be establishing the first mental health day care centre in the Niagara region.

 In March of this year the ministry supported a new model of aftercare in the Parkdale area of Toronto where a sizeable number of former psychiatric patients tend to live. Operated by Archway, a satellite clinic of the Queen Street Mental Health Centre, the program matches

clients with whatever services they requirewelfare, housing, employment and so on.

 These are just some of the projects the ministry has funded in the mental health area with the co-operation of volunteer and community agencies. They provide an alternative to institutionalization but, more importantly, as community-based services they help thousands of people regain their self-confidence, build basic skills, get access to employment and housing and, in short, return to life in the community.

 The success of these initiatives, however, ultimately rests in the hands of the community, which must be willing to provide the kind of caring, compassionate and understanding support that ex-psychiatric patients need.

 To accomplish the goal of increased awareness and knowledge, the ministry has made available to the Ontario division of the Canadian Mental Health Association $1.5 million to prepare and deliver a major public education program.

 The Canadian Mental Health Association campaign will attempt to eradicate some of the myths that still surround mental illness. While the public's attitude to mental health has undergone some positive changes in recent years, many of the old attitudes and prejudices still remain.

 The project will communicate the hopeful realities of those patients who, through the help of their community, have been able to achieve a fuller life. It will also show ways in which the community can participate in helping those who have been mentally ill.

 The ministry has also taken action to link our psychiatric hospitals with the communities they serve. Eight of the 10 public institutions have appointed community advisory boards which report directly to the minister.

 Of the two remaining hospitals, we expect that Penetanguishene will have a board appointed early in the coming year. Queen Street Mental Health Centre will also have a board, once the reorganization now under way there is completed.

 The boards' mandate is to assist in providing effective and efficient patient care by increasing regional involvement in the management of these facilities. They have been created to promote greater community awareness of the nature of psychiatric hospital care, and to bring to the hospitals and their patients the many benefits of community skills.

 In response to the issue of patient rights, this past year patient advocates were appointed to each of our 10 provincial psychiatric facilities. The advocates come from a variety of backgrounds, including law, nursing, social work and the clergy.

 Advocates listen to concerns which patients and their families have about treatment, restrictions, privileges, legal issues and so on. Advocates can speak on the patients' behalf, provide patients with information on their rights and refer them to community support groups.

 The patient advocate program is designed to foster communication and understanding between the staff of the psychiatric facility and the patient. Advocates are independent of the hospitals and report to the deputy minister through the patient advocate co-ordinator.

 To assist with the implementation of the patient advocate concept, we have appointed an advisory committee on psychiatric patients' rights. The nine-member committee includes providers and consumers of mental health care, as well as lay and legal advocates. The group will serve as a forum for discussion and will make recommendations on program content and delivery methods.

 At the ministry's request, district health councils have also embarked on an extensive review of mental health services in their territories, ranging from institutional care, housing and counselling to aftercare programs.

 All of the programs I have outlined so far are an attempt to achieve a single aim. That is, we aim to have a system so co-ordinated and comprehensive that patients enter it in their own community at the time most appropriate to their condition and receive the treatment they need. Then they return to normal life having moved smoothly through the various stages of assessment, treatment, recovery and rehabilitation.

 We were given the preliminary outline for such a system by Dr. Gil Heseltine, in a discussion document released earlier this year. Dr. Heseltine is chief of psychiatry at University

Hospital in London and chairman of the psychiatry department of the University of Western

Ontario. He was appointed by the ministry in 1981 to assess mental health services in the province and to recommend future policy directions. In carrying out this assignment, Dr. Heseltine has consulted extensively with the provincial mental health community.

 His interim discussion paper presented a model of community mental health services linking three levels of care: inpatient hospital care, outpatient support programs managed by hospitals, and the broad range of social services offered by community agencies.

 I am now looking forward to Dr. Heseltine's final discussion paper which is expected very shortly; in fact, it may well be available prior to the conclusion of these estimates. It will provide more depth on the proposed organizational structure for the mental health care system and will cover issues not addressed in the interim paper.

 As the honourable members can see, we are entering an exciting and challenging stage in the evolution of care for the mentally ill, but we cannot rest here. We must create a system which guarantees equal access to the level of mental health care which best meets everyone's needs.

 Members of the committee may recall that last year the Ministry of Health recognized both community health centres and health service organizations as legitimate and permanent elements within our province's health care system. Health service organizations provide primary care to their patients with a particular emphasis on continuity of care, health maintenance and the co-ordination of other health-related services.

 Membership in a health service organization comprises community residents who have voluntarily signed on to the HSO roster.

 Community health centres provide their members with medical and nursing care in a setting which frequently includes other health and social service components, such as family counselling and nutritional guidance. They are funded

on a global budget basis. We have a total of 10 community health centres operating in the province at present. Nine of these are community sponsored and one is physician sponsored.

 We are now considering funding alternatives to support the further development of CHCs within the province. We are considering moving to negotiated funding for each centre, based on the demonstrated need and demand for health care services within an identified population group and the specific approved program objectives of the CHC.

More than 250 copies of the discussion paper

on guidelines for the establishment of community health centres have been distributed to a cross-section of health care providers and advisory bodies. In response, major submissions have been received from more than 40 organizations. In the meantime ministry staff have continued to meet with interested community and physician groups and, as a result, several new initiatives have already been undertaken.

 In July of this year the ministry funded a detailed needs assessment for the Parkdale Community Health Centre committee. The needs assessment was completed in early September and a proposal to establish a CHC in South Parkdale submitted in late September. The Parkdale committee's proposal is now with the Metropolitan Toronto District Health Council, whose response is expected soon.

 A proposal to establish a new CHC in Hamilton has been developed by the McMaster department of community medicine, endorsed by Hamilton-Wentworth DHC and submitted to the ministry. The Hamilton proposal, which contains a major teaching element, is under review by several areas of the ministry. A final response will be available before the end of the year.

 Ministry negotiations with the family practice section of the Sunnybrook Medical Centre have just been completed and the province's 18th health service organization will now be located at that hospital. Physicians in other group practices are now conducting preliminary discussions with the ministry regarding new HSO developments.

 As we consider these program developments, I believe we must also consider whether the basic concept that lies at the root of these service alternatives is relevant to the health

service requirements of a far greater portion of our population. I would suggest, for example, that the concept underlying community health centres can have tremendous relevance to the

aged and to our increasing efforts to ensure that greater numbers of senior citizens are able to lead independent, healthy lives within their own communities. The concept also has relevance to children's health and to the importance of health promotion among the young.

 If we look at the principles upon which CHSs and HSOs are based - at the ease with which they can support multidisciplinary approaches; at their community involvement in service definition and service delivery; at their focus on identifying populations at risk and on reaching out to them- I think we can see a broader application of the CHC and HSO concept in our health services system.

 This will be one of the key issues to be addressed by a new ministry-appointed task force on primary care. The committee will be

charged with identifying the primary care needs that currently exist in the province, and with making recommendations to me about how

provider groups and services might be more effectively structured to meet our requirements.

 I plan to announce the appointees to the task force on primary care early in the new year.

 In a province the size of Ontario it takes a great deal of planning and local co-operation to design and implement an emergency health services system to serve all our citizens. I am pleased to report, however, that we are well on our way to seeing a comprehensive emergency health services system become a reality in this province.

 For planning purposes, we have divided the province into six areas to ensure a logical and uniform approach to developing emergency health services. Each area will have an EHS committee drawn from the district health councils. Already, EHS subcommittees have been established in 16 of our 26 district health councils. We expect to have the full complement of subcommittees in position within the next year.

 While our planning phase is well under way, the ministry has also undertaken two important initiatives this year. The first is the establishment of a special provincial advisory group of emergency care experts to help communities move swiftly towards an integrated EHS system. The chairman is Dr. Arthur Scott, anaesthetistin-chief of the Toronto General Hospital.

 The second major initiative is the launching of Ontario's long-awaited paramedic program. Paramedics, as you know, are ambulance attendants trained in advanced life-support techniques for accident and cardiac victims. The first group of S4 ambulance attendants will begin training early in January. Upon successful completion of their course they will man ambulances in Toronto and Hamilton, and air ambulances in Sudbury and Thunder Bay. The cost of this pilot project is nearly $1 million.

 Once the pilot project is completed, the paramedic training program will be made available to attendants in other communities where necessary support services are in place. Communities will be expected to have a tiered response capability which will include: cardiopulmonary resuscitation or CPR training for firemen, police and the general public; a central emergency number, such as the 911 number; a central ambulance dispatch; a base hospital open 24 hours for emergency procedures; and an integrated hospital system.

 We also realize that for the system to work, more physicians must be trained in specialist emergency medicine. The ministry now is funding residency posts for 33 doctors in this field.

 We are continually expanding the number of pickup and delivery points for our helicopter ambulance system. We now have 31 licensed day-night heliports serving 46 hospitals. We expect to have another eight heliports completed this year to service an additional 10 hospitals.

 The ministry is also studying better ways of transporting patients between hospitals. In the

past hospitals were designed to provide a wide range of care services to cope with all types of

demand within their catchment area. Today, with our vastly improved transportation network and with quick, safe methods of patient transfer becoming available, the roles of certain hospitals and the range of services they provide must be reassessed.

 To get a clear picture of current emergency care resources in Ontario, we recently completed a survey of emergency departments across the province with the co-operation of the Ontario Hospital Association, the Ontario Medical Association, the Registered Nurses Association of Ontario and the emergency nurses association. The emergency health services division of the ministry is now in the process of establishing a hospital emergency resource inventory as a first step in the categorization process.

 The inventory, now stored in computers, will be presented to the emergency health services advisory committee. It will establish criteria for each category of hospital in the proposed system.

 Perhaps I ought to go back and emphasize that I am not talking about the computer establishing the criteria but rather the committee establishing the criteria, based upon the data from the computer.

 The ministry also recognizes that a good ambulance communications network is an essential component for any comprehensive emergency services program.

 For some time now we have been able to co-ordinate all long-distance air and land ambulance patient transfers in the province through our centralized ambulance dispatch service at Oak Ridges. The ministry is now developing a central ambulance dispatching capability to co-ordinate local patient transfers.

 These integrated systems are bringing in sophisticated communications service to the areas they serve. When our program is complete they will ultimately replace more than 200 separate and distinct dispatching services. We have central ambulance dispatch in 14 areas of Ontario at present. We expect to be operating in all parts of the province by the end of fiscal year 1986-87.

 I would like to stress the urgency for legislation that will enable the further development of an integrated and comprehensive emergency health system, including the implementation of province-wide paramedic programs. The ministry is now working on a new Emergency Health Services Act. I expect a draft policy paper will be presented to cabinet early next year.

 I am confident that with all the initiatives we now have under way, and with the co-operation of the hospitals and health care professionals, we will reach each of the objectives that have been set for comprehensive emergency services in Ontario.

 I would now like to turn to a brief review of some of the activities that have taken place in the management of the Ontario health insurance plan. A major event of 1983-and not only for the minister himself-was the successful completion of the OHIP move to Kingston with no downtime and no interruption of service.

 I was not able to be there; I was in the hospital. However, I did hear a tape of the ceremonies and was quite pleased with the way it came off. I probably got more applause by being absent, actuaIly. Everybody was feeling very sympathetic at that point.

 The move was the culmination of seven years of planning. I would like to pay tribute to the planning staff and personnel who met the organizational chaIlenge. The relocation of the OHIP office was the cornerstone of a series of initiatives announced in 1977 to decentralize government operations into eastern Ontario. Because this was such a massive undertaking, the move was phased over a period of two and a half years.

 I want to stress at this point that the reason I mention this is not to gloat or anything like that, but rather to emphasize the massiveness of the undertaking and the organizational success that it represents as probably the largest single move in terms of distance and personnel ever undertaken by perhaps any government in the country - I am not sure of that, but certainly in Ontario.

 The first Ontario health insurance plan position was relocated to Kingston in 1981. By the faIl of 1982, the majority of the employees were there. They were initiaIly spread throughout six temporary locations, awaiting the completion

of the new five-storey headquarters building. The first 150 personnel moved into the partly completed building on Easter weekend in April of this year and the last of them moved in on September 26.

 Approximately 500 staff members were hired from Kingston and surrounding communities. As a major employer in the community, with a payroll of $13.5 million annually, the omp move has consequently made a significant economic impact on this region of the province, as was the intention of the decentralization initiative.

 Kingston's MacDonald-Cartier Building, where OHIP is headquartered, was constructed at a cost of $23 million and is a model of energy efficiency. It has a computerized system to control lighting and heating, a sophisticated telephone and security system, and provides easy access for the physicaIly handicapped.

 We are not the only tenants. The building also contains provincial courts and the Ministry of Government Services' regional computer centre.

 The centre has now replaced the Leaside data centre in Toronto as the site for computer services supporting OHIP and the drug benefit program operations. More important, the new computer centre, with its vastly upgraded technology, gives us the opportunity to make significant improvements in our processing capabilities.

 I should point out that moving the Leaside computer centre on Thanksgiving Day weekend was a major logistical feat. Beginning at the close of business on Friday of the holiday weekend, 33,000 tapes containing OHIP and drug benefit records were readied for shipment. They were loaded on to four semi-trailers that proceeded in convoy to Kingston, protected by eight security officers of the Ontario Provincial Police.

 I am pleased to say to all of you that this

complex effort was carried off without incident. We would have been in an absolute disaster if anything had happened to the tapes; we might have lost all our information about OHIP. The data centre was able to shut down on Friday evening in Toronto and reopen on Tuesday morning in Kingston, without any interruption

in service, thank God. The next group of OHIP payments to cover 15,000 doctors and approximately 1,800 pharmacies was made on schedule.

 I believe that all of those associated with the data centre move deserve to be commended for the facility with which the OHIP move was carried out.

 Now that the move has been completed, we are planning to initiate major administrative improvements to address the challenges facing the operation of the health insurance plan. With a work-load growth projected to almost double in the next 10 years, it will be increasingly difficult for the staff to maintain operations at the current level, unless we plan now to meet the pressures that the increased work load will bring.

 When I tell you that currently over 100 million health care and drug benefit claims are processed each year, along with 10 million billings for premiums and the issuing of over five million cheques, you get some idea of the dimension of the challenge that I am talking about. We are therefore placing a major emphasis on the re-evaluation and redesign of existing programs, policies and practices. We now have under way two major projects which address the redesign of the enrolment and claims systems.

 We expect, for example, that in time we will be able to meet the requests of many physicians to submit their claims by computer rather than on claim cards. One of the obvious difficulties in designing such a system is that not all computers speak the same language. OHIP must first establish uniform standards of technology to ensure that a physician's computer billing equipment is compatible with the OHIP requirements.

 To complement the major systems redesign, we are undertaking a number of other administrative and fiscal initiatives. These include improved management capability, regulatory reform, office automation and streamlining our direct dealings with the public.

 The Ontario health insurance plan has just met a very great challenge in planning for and implementing the move to Kingston. I believe OHIP is now positioned to design the new innovative systems and procedures that can only enhance its future service to the public.

 Mr. Chairman, earlier in my remarks I discussed the need for rationalization of hospital services in the context of building up a comprehensive emergency health services system in the

province. There is a second impetus behind the need for rationalization, the burgeoning growth of medical high technology, which is expensive and requires skilled, specially-trained personnel for its effective use.

 Computerized axial tomography scanners are a perfect illustration. They cost over $1 million to buy and install and about $300,000 a year to operate, of which $150,000 is paid by the Ministry of Health.

 We therefore work to manage the placement of this key and valuable diagnostic equipment in designated regional referral hospitals. This ensures good patient access to the technology and a sufficient case mix that both professionals and technicians can maintain and upgrade the required skills. It also means that the equipment will be used in a cost-effective way.

 We have now authorized funding for 32 CAT scanners and approved the installation of three nuclear magnetic resonance machines in this province. Another type of diagnostic scanner, positive emission tomography, looms on the horizon and other developments will undoubtedly follow.

 We have already seen three generations of CAT scanners in the past seven years, and the use of nuclear magnetic resonance in diagnosis is still very much in the development stage. Its benefits in comparison with other systems is really yet to be clearly established.

 But it is not only medical hardware that is evolving rapidly. There is dramatic progress in surgical techniques. In the past few years cardiovascular procedures have increased sharply and major advances are imminent in organ transplants, not only involving donor organs such as heart, lungs, liver and kidney, but also mechanical organs such as the artificial heart and pancreas.

 In recent years the ministry's financial commitment to these life-support programs represents new additional costs of between $10 million and $15 million each year, over and above the base funding in this area.

 The ministry is developing management strategies to cope with these trends to ensure they proceed in a reasonable way, because we are concerned that high technology developments could threaten to consume a disproportionate share of our health care dollars.

 In terms of both quality care and finances, we

cannot afford the luxury of hospitals competing for status and prestige by seeking to acquire the latest technology or offering the most advanced procedures in all service areas. This would only distort our capability to provide other important types of patient care, notably primary care, and would result in technology being placed in the hands of inadequately trained personnel.

 It is therefore imperative that we carefully manage the growth of health care high technology if we are to provide good patient care, the most effective placement of equipment and receive the greatest value for our financial investment.

 The ministry recently created an advisory committee on high technology to help us to oversee the introduction of the new devices, procedures and techniques. This committee will keep the Minister of Health abreast of the latest developments in medical technology and will make policy recommendations for the proper

application of these new devices in this province. This committee will be assisted in its work by a series of expert advisory committees in special fields such as cardiovascular surgery, kidney dialysis and transplant and nuclear magnetic resonance.

 The committee on the nuclear magnetic

resonator, for example, will be responsible for the evaluation of the NMR in the clinical setting and make recommendations on how it is to be used and where.

 A recently appointed task force will seek to develop ways of increasing kidney donations for transplant. The task force will advise the ministry on how to raise awareness of the importance of these donations, not only among the public, but among physicians and health care providers as well.

 A separate committee specifically to review and co-ordinate treatment of renal disease has also been appointed. It consists of the leading medical specialists in kidney disease representing all of the medical teaching centres in Ontario.

 We are also taking steps to make health research more pertinent to our requirements in Ontario. We want health research to be clearly focused on our health care needs. In March the ministry established the Health Research and Development Council of Ontario to create a co-operative relationship between the research community and the Ministry of Health,

 The council will advise the minister on the allocation of Health ministry expenditures in support of health research projects. In the past year the ministry has committed some $22 million for health research programs, These funds were distributed directly through awards to foundations and through ministry-administered grants,

 The council will establish priorities for health research that will enable us to address the more tangible and immediate problems facing us in the operation of health care services in Ontario,

 Let me recount some of the research facilities

launched this year.

 In September there was a ground-breaking

ceremony for the new, 513-million, Max Bell research centre at Toronto General Hospital. The wing will provide for major research programs in the areas of nutrition, cardiovascular surgery, thoracic surgery, reproductive biology and oncology.

 In October a similar ceremony marked the start of the construction of the new $20-million research tower at Mount Sinai Hospital. Research there will concentrate on various forms of cancer, immunology, perinatology and geriatrics,

 That same month saw the official opening of the research institute and laboratories at St. Joseph's Hospital in London. The institute also has NMR equipment which is being used to assess the clinical importance of the new technology.

Towards the 513-million cost of the institute the Ministry of Health provided $118 million from the Ontario health resources development fund, Another $750,OOO was provided by the Provincial lottery.

 As research and technology embrace the application of new treatment procedures, I should also mention in this context the September opening of the cardiac prevention and rehabilitation centre at Ottawa Civic Hospital. The CPRC provides a wide range of rehabilitation services, as well as community outreach support through counselling and seminars to reduce the risk of heart attack, The hospital received a Lottario grant of $1 ,S million toward the construction of the centre,

 It should be clear that in regard to both the introduction of new technology and in the development of our health research capability, our priority is to first consider those initiatives which have greatest potential for bringing about enhanced patient services and improved health care delivery. With strong leadership and management on both these frontiers, Ontario's world-class reputation among health care systems can only flourish and grow,

 The district health councils comprise consumers, health service providers and local government representatives who volunteer their time to help plan the health care system in their communities, In the context of provincial guide

lines they examine the health care needs of their districts, explore the alternative means of satisfying those needs, develop comprehensive health

care priorities and provide their advice to the ministry,

 In the past year many district health councils have continued their interest in our chronic and long-term care requirements and several new and updated studies have been submitted to the ministry, Councils also undertook to study the mental health service needs of their districts. Interim reports have been received and final reports are now being completed,

 Emergency health services is another area receiving priority attention. Several councils have already applied for funding to conduct studies in this area and more are expected in the coming months.

 The steering committee for the developmental assessment of district health councils submitted its final report in April 191\3 and confirmed the value of the councils in the planning of health care services, Its recommendations have been referred to council chairmen for their reaction and a response to the report will be issued early in 1984.

 District health councils were key participants in the ministry's Health Care: The '80s and Beyond planning process. All councils were represented at the province-wide policy conference in April and the councils hosted and, as I mentioned earlier, participated in the six regional meetings which were held throughout the province during the summer months.

 In September one more district health council, Simcoe county, was added to the system, and last month a steering committee was established to determine the local support for creating a district health council for the Muskoka and Parry Sound districts. There are now 26 councils in place serving 92 per cent of Ontario's population.

 For many years now, the Ministry of Health, working closely with the Ministry of Northern Affairs, has been involved in a continuing effort to ensure that Ontarians in the northern part of this province have access to the kind of health care that is available to people anywhere else in Ontario. The vastness of the north, its scattered communities, isolation, language barriers and transportation problems are some of the issues that the two ministries have sought to address.

 The underserviced area program, for example, has been placing health care practitioners in the north for the past 14 years. Since its inception, it has been recognized in many other parts of the world as one of the most outstanding programs of its kind. While initially designed to serve health needs in northern Ontario, it has since been expanded to serve underserviced areas around the province. Today we have over 400 physicians and 94 dentists currently practising in remote communities as a direct result of the program.

 The underserviced area program offers a series of financial incentives to attract physicians and dentists to remote communities. In northern Ontario a practitioner is offered a grant free of income tax of $40,000, $10,000 a year over four years, for a contract with a guaranteed net annual income of $38,000 for four years.

 Specialists who establish practices in certain northern areas can now obtain tax-free incentive grants of $20,000 paid over four years. Funds for the specialists' grants are provided by the Ministry of Northern Affairs. There are currently 40 specialists in the program.

A travelling specialist program has also been established, and last year over 100 travelling specialists were sponsored under that program.

 The ministry has also initiated a locum tenens service which hires practitioners to go to those communities suffering a temporary shortage of physician services. Locums participating in the program at anyone time have this past year numbered as many as 25.

 In another recruitment effort, the Ministry of Health and the Ministry of Northern Affairs provide 45 bursaries of $5,000 every year to undergraduate medical students who agree to spend, after graduation, one calendar year in an underserviced area for each year they receive a bursary. Any student who fails to meet his commitment is required to repay the bursary with interest, within six months of being asked.

 Because so many communities in the north are in isolated locations or have small populations, the ministry has established a series of nursing stations. The stations, staffed by local nurse practitioners, are visited by a physician on a weekly basis and are administered by a local health agency, such as a hospital or a medical clinic. The nursing stations have been extremely well received wherever they have been located and nurse practitioners have done an outstanding and commendable job.

 One of the most recent initiatives in the underserviced area program has been an effort to recruit psychiatrists for the north. In addition, the tax-free incentive grant for psychiatrists has been increased from $20,000 to $40,000. This measure has resulted in an increased number of applications and as of November of this year 22 psychiatrists have been recruited through the program.

 Two months ago the Ministry of Health announced the formation of an underserviced area advisory committee. The committee will complement the activities of the underserviced area program by making recommendations on the operation of the program, designating areas as underserviced, and advising the ministry of professional recruitment in the north.

 While most of the initiatives of the underserviced area program focus on the shortage of manpower in remote areas, this is obviously not the only problem faced by the north. Residents often have to travel great distances to get specialized or sophisticated treatment, for example.

 When this involves serious illness, a great deal of physical and emotional stress can be placed upon the family. Over the years, the ministry has initiated several programs designated to alleviate this kind of problem.

 In August of this year it was announced that a cancer treatment centre would be established at Sudbury's Laurentian University. The first phase significantly increases cancer patient services in northeastern Ontario and includes the expansion of a medical oncology unit to provide a full range of chemotherapy.

 Before the cancer treatment centre was established, radiation and medical oncologists from Toronto's Princess Margaret Hospital attended patients at Laurentian Hospital for one day each month. Some patients, on the other hand, had to travel to Toronto for advanced chemo- and immunotherapy.

 Just this month, the ministry announced the establishment of a telehealth network in northeastern Ontario, to which we have given support of up to $1,052,600 over the next three years.

 The new agency, to be incorporated as the Northeastern Ontario Telehealth Network, will include representatives from 10 participating hospitals in the region, the Manitoulin health centre and the Sudbury and district health unit, but other health agencies may also participate.

 The principal mandate of this organization is to seek methods and techniques of improving communications through the introduction and use of advanced telecommunications technology in audio, video and data transmission.

 Through the telehealth communications network, health care providers will be able to participate on a regular basis in continuing health education seminars and programs, without leaving their communities.

 In addition, physicians in more remote areas of the north will have the capability of consulting more effectively with colleagues and specialists in larger centres. The telehealth program has been a major health care benefit to northern communities and is now seen as an extremely significant and positive way of overcoming the barrier of distance.

 In May of this year, a similar agency was announced for northwestern Ontario, including Thunder BHY and the Kenora-Rainy River areas. The Algoma and Cochrane district health councils are currently engaged in a review of telecommunications requirements for their respective areas.

 Throughout northern Ontario, long-term care has historically been provided in major urban centres. Consequently, elderly patients have often had to move away from their families and friends to obtain the services they needed. In recent years, however, residents of small and remote communities have expressed their desire to have nursing home and continuing-care services in their own communities.

 In recognition of this need, the ministries of Health and Northern Affairs announced that they would give their support to the establishment of small facilities for long-term care. The Ministry of Northern Affairs provides capital assistance; the Ministry of Health pays operating costs within established funding guidelines.

 Both ministries agreed that the establishment of any new continuing care units in hospitals should be contingent upon local needs and a clear understanding of the hospital's operations.

 Hospitals in Atikokan, Dryden, Sioux Lookout and Geraldton have already been approved for extended care beds. Smooth Rock Fans has been approved for a replacement hospital which will incorporate extended care beds in its plan and design.

 These pilot project hospitals will provide our ministries with a mechanism through which we can obtain accurate data on capital and operating costs as a basis for proceeding with further approvals.

 French language health services: In keeping with the Ministry of Health's commitment to provide Franco-Ontarians with the fullest possible French language health services, the ministry has worked to improve and expand its response to French language needs internally. Secondly, it has promoted the need for increased

French language services at the provider level.

 Last year, the ministry established an internal French language advisory committee. Chaired by the assistant deputy minister of community liaison and corporate resources, the committee has three main functions: to review existing health service policies relating to the province's French-speaking population; to develop recommendations for the improvement of these services; and to assist with the development of French language programs for hospitals, district health councils and other agencies in the health care field.

 Last year, as in past years, a number of grants were awarded for the development of French language services. Among 49 public hospitals in designated areas, $560,000 was distributed for staff language training. And $52,683 went to l’Accueil medical francophone for a French medical information centre in Toronto. To the family and patient communication centre in Ottawa, $10,000 was given to assist in their translation services.

 Dr. Andre Cote was recently appointed co-ordinator of French language psychiatric services. An assistant professor of psychiatry at the University of Ottawa, Dr. Cote will consult with francophone groups and hospital directors in regard to psychiatric services in French. He will also assist the ministry in developing a plan to meet the psychiatric needs of Franco-Ontarians.

 Finally, Mr. Chairman, in order to meet the long-term need for bilingual health care practitioners, the ministry is developing an information program for secondary schools which will attract young, French-speaking Ontarians into the health care professions.

On the Canada Health Act, let me begin by observing that our national medicare system is one of the proudest achievements of the Canadian people in the post-war era. The concept that every Canadian is entitled to a comprehensive range of health services, without reference to ability to pay, is deeply engrained in our national identity-I slowed down when the member left, unfortunately.

Do not hasten it, please. The concept that every Canadian is entitled to a comprehensive range of health services, without reference to ability to pay, is deeply engrained in our national identity and indeed is one of the strongest unifying bonds we share. So when we discuss changes to the legislative foundation on which medicare is built, all governments have a responsibility to proceed in a spirit of co-operation and mutual respect. We are all striving towards the same goal of the best possible health care for Canadians.

 It is my fear, however, that the federal government is now overlooking this underlying spirit, which in the past has allowed us to move forward together to create a world-class health care system.

 Let me now comment on some of the specific issues which Ottawa has raised in its statements and position papers over the past year or so.

 On universality, the federal government wants provinces choosing to retain the premium system to report regularly on their procedures for ensuring 100 per cent coverage of residents. In this province we do not believe that premium payments restrict access to the insurance system because premium payments have never been tied to entitlement to services.

 On comprehensiveness, Ottawa is proposing to expand the definition of insured services to include mental health, but with absolutely no commensurate increase in federal funding. Currently, mental health services in Ontario cost $346 million a year and are financed totally from provincial funds. We object strenuously, in principle, to the federal attempt to dictate new standards to the provinces without sharing in the financial responsibility for implementing them.

 Concerning accessibility, we agree that guidelines might be useful in ensuring that all residents of Canada are entitled to a certain standard of health services. Ontario has always accepted and honoured the principle of accessibility to adequate health services for everyone.

 On the specific issues of extra billing and user charges, however, we disagree with the federal approach.

 I want to make it clear that Ontario does not support, and does not intend to impose, user charges that deter access to necessary health

services. We are not prepared to accept, however, the federal assumption that limited user charges by definition constitute barriers. In any case, we do not have user fees in this province which would breach Ottawa's guidelines.

 In extra billing as well, we believe the provincial government should be the principal arbiter.

 Since the inception of medicare in this province, physicians have had the right to opt out of the provincial health insurance plan and bill their patients directly, provided this does not deter patients from seeking and obtaining necessary medical care.

 Among the initiatives we have in place to ensure that extra billing does not compromise the principle of accessibility are:

 A province-wide telephone system to assist the public in locating opted-in physicians;

 An agreement with the Ontario Medical Association and the Ontario Hospital Association to ensure that any patient in a public hospital will have the option of access to physicians' services at the opted-in rate;

 A joint OMA-ministry committee to review patient complaints on billing and extra billing which are reported to the OMA; and

 The recent amendment to the regulations under the Health Disciplines Act which provides that physicians who extra-bill in excess of the OHIP benefit schedule must notify the patient in advance of the amount of the extra fee.

 Perhaps the control of extra billing could involve bilateral agreements between individual provinces and the federal government, but such negotiations would require further work, study and consultation with the medical profession.

 The proportion of opted-out physicians in Ontario has been steadily declining over the last few years, from a peak of 18 per cent in March 1979 to 14.4 per cent in July 1983, and less than six per cent of the total claims processed by OHIP cover services performed on an opted-out basis. I believe these overall levels are compatible with our commitment to a universal and accessible system.

 It is a political reality that the right of the physician to opt out of medicare can be sustained only in the context of visible and guaranteed access to all health care services at OHIP rates in every part of the province. The doctor's freedom to choose, in other words, must be balanced by freedom of choice for the patient as well.

 As I mentioned, the latest federal position paper contained an implied threat that financial penalties would be laid against provinces which allow extra billing. In my view, this is not a constructive approach; any federal attempt to cut funding to offset extra-billed sums would simply reduce financial resources available to the health-care system as a whole.

 The strength of the medicare principles we now have is that they establish objectives without specifying the means to attain them. This allows the provinces the flexibility to deal creatively and rapidly with a changing demographic, economic and technological environment.

 The cornerstone of our national health insurance program has been mutual trust and co-operation between the two orders of government. Surely, negotiation rather than ultimatum is the only route to a lasting resolution of federal-provincial disagreements.

 Unfortunately, recent federal conduct does not inspire hope that an accommodation will be reached, and I suspect very much that tomorrow will indicate that it has not. Ottawa has already acted unilaterally in a vital area of health-care financing by abandoning its previous commitment to the established programs financing arrangement. This will mean a loss to the provinces of more than $6 billion over a five-year period. Ontario alone is absorbing a loss of $1.9 billion in funding.

 The Edmonton commitment? No, that was later on.

 These reductions have been imposed at a time when the demand for health care is expanding rapidly. In Ontario the Ministry of Health's budget has grown by 58 per cent in the past three years, surpassing inflation by 22 percentage points.

 If there is a threat to medicare today, it is not user fees or extra billing, it is the decline in federal financial support for health care.

 Between 1979-80 and 1982-83, for example, the federal share of national health care financing fell from 48.8 per cent to 39.2 per cent.

 I would also point out, in explaining Ontario's position, that we now provide insured access to many health care programs which are not funded under the federal funding scheme. Historically, mental health services, as I have mentioned, including the operation of our provincial psychiatric hospitals, our community programs and other institutional mental health services, were not eligible for funding from Ottawa.

 Similarly, our ambulance services, the drug benefit plan for the elderly and services of health care practitioners such as chiropractors, optometrists and so on, do not receive federal funds and are not covered by federal definitions.

 Do you have an axe to grind for chiropractors, too?

No, I have not. Have you?

 I attended once, but I have not been able to attend recently.

 I do not like to go anywhere where there is a risk of being manipulated.

Monique, did you say?

 In fact, I have been contemplating a little trip to Ottawa to see what I can do in that respect, but I am not very optimistic.

 That was an appropriate intervention, I think, Mr. Chairman.

 I believe that here in Ontario we have a broader concept of health care services than is held by our federal counterparts. Provincial flexibility in this area is therefore more than a constitutional nicety, it is essential to maintaining the quality of care. This is a concept that we are prepared to do everything possible to protect and to maintain.

 The fact is, while we are witnessing reductions in federal funding and escalating demand for health services, numerous other priorities are asserting a legitimate claim to provincial financing; housing, energy development and social services are just three that I might mention.

 Ontario therefore advocates an immediate resumption of meaningful negotiations on the Canada Health Act. In fact, we might even settle for maintenance of the commitment that the Minister of National Health and Welfare made to the provincial ministers in Nova Scotia only about two short months ago.

 I must say, Mr. Chairman, I was very encouraged last night to hear that the Prime Minister offered to give Joe a ride the next time he went world hopping.

 The federal government's proposals and the draft legislation should be subjected to thorough discussion, as was promised by the federal minister, and consultation with the provinces prior to the enactment of any new legislation. Every effort should be made to arrive at a federal-provincial consensus on these issues which touch the lives of each and every Canadian. The people of Canada deserve nothing less. The provinces, I can assure you, stand willing and able.

 The members of the committee will remember that our last overhaul of legislation on health care practitioners began with the report of the Committee on the Healing Arts in 1970 and culminated in the Health Disciplines Act of 1974. Such a review happens only every decade or two, and we fully expect to receive the full co-operation of all health disciplines in a review now under way.

 I also want to emphasize that the announcement on the startup of the review process this past August was one of the first initiatives undertaken following my appointment as the Minister of Health. I must say, though, that the process was really initiated by my predecessor, in all fairness.

 Oh, it does? I am sorry. Oh, I see. No, I do not think it does. All that paragraph does is indicate that we still place competence above all other considerations.

I am glad to hear that.

 Yes, I noticed his attempt at ministerial responsibility.

 I notice that they do work very well together as a team.

 And have done so for some time.

 This is a process to which I am firmly and strongly committed and I am maintaining personal contact with the review team as it carries out its assignment.

 The review is headed by Toronto lawyer Alan M. Schwartz, who will function as co-ordinator of the review team. Over the next two years, the group will make recommendations to me about which health professions should be regulated by statute and how statutes governing the profession should be updated.

Mr. Schwartz will be assisted by James D. Fisher and Morrey M. Ewing. Now do you know Mr. Ewing?

Do you know Mr. Ewing?

 Well, you will reserve judgement on that.

Well, where you see the

two of them, he is right behind.

 These gentlemen - that is, Mr. Fisher and Mr. Ewing-are members of the Canada Consulting Group in Toronto.

 All three principals have extensive experience in the development of public policy and in providing public policy advice to ministries, agencies and select legislative committees, some of which are even chaired by members of the opposition.

 This type of independent format is needed, I believe, to ensure that the review is perceived to be objective and impartial by all participants in the health care system: practitioners, administrators and consumers.

 We therefore proceeded to design an orderly and thorough process that would allow all views to be heard; one that would provide a ready forum for hearing both practitioner and patient concerns.

 We also decided to revise the legislation for all professions at the same time, rather than deal with each group individually. I believe this all-encompassing approach will lead to general principles which can be applied across the range of professions. By reviewing all professions together, we will also be better able to co-ordinate and integrate the roles of all the health professions so as to optimize our quality of service to the public.

 Let me now briefly describe the general goals of the review. Initially, the review will assist in determining which currently regulated health professions should continue to be regulated and which currently non-regulated professions should be brought under the regulatory umbrella.

 The appropriate form of regulation will also have to be decided. Some professions are seeking full-fledged self-regulation along the lines of the Health Disciplines Act, while at the other end of the spectrum, groups may prefer regulation in combination with other disciplines under a single governing body.

Yes, I am sure.

 Perhaps the most important objective of the review is to settle an array of outstanding issues among several of the health care professions, which is a massive undertaking, I must say, in itself. Almost all of our unresolved regulatory issues, for example, involve disagreements between adjacent professions about their respective scopes of practice and their roles in the delivery of health care.

 The review team will consider if the legislation for each profession should define the scope of practice and, if so, what the definition should be. It will ask if licences should be granted conferring an exclusive right to practise and it will consider other appropriate alternatives. Titles to be protected must also be decided and the relationships with other professions will have to be clarified.

 A further goal is to ensure effective standard of practice mechanisms through all the health professions. For example, what conditions must be met for entry to practise and who will properly determine these rules? How does the profession ensure the continuing competence of its members? Should the professional governing body have the authority to prosecute misconduct of a personal, ethical or business nature?

 The first phase of the review will consist of intensive consultation with all interested parties. The review team has circulated a detailed list of proposed topics for consideration to all the health disciplines, to organizations representing institutions which employ or train health professionals and to consumer groups. Participants are invited to suggest additional topics, and the review team is ready to assist in any way possible with the preparation of briefs. The second phase of the review will develop proposed solutions to regulatory issues.

 Every attempt will be made to bring conflicting parties together to resolve contentious issues through negotiation. Surely it would be far better for professions to settle scope of practice and other disputes among themselves, rather than forcing the minister to intervene to reconcile the competing demands. I would certainly prefer that course of action.

 The timing of this second phase depends on the number, depth and complexity of contentious issues that emerge. While a deadline cannot be set at this time, our overall schedule requires that specific recommendations that can be incorporated into law be ready by February 28,1985.

 The reaction to these plans thus far has been very enthusiastic, with the exception of certain members of the Legislature who tend to

 -mumble and grumble a litde as we go along.

I know him well.

 People are pleased the review is being conducted by an independent team. They like the open format and the opportunity for informal dialogue.

 All organizations have been given to understand that arguments and information which are relevant to the review must be presented directly to the review team. As minister, I am prepared to consult with health care organizations and associations on other matters. In the area of the legislative review, however, all related questions are to be brought directly to the review team.

 In health care planning, we must recognize the interdependence of all professions and the need for co-operation. The review process we now have under way will accomplish its goal if all participants keep uppermost in their minds our common commitment, to protect and promote the health of the people of Ontario.

I want the whole orchestra.

 That concludes the estimates, at least my introductory remarks. We just have to debate the estimates; I would like to conclude them all and wind them up right now.

 I shall never be able to match you, Sean.

 I look forward to discussing many of the issues raised with the members of this committee. I would like to say before closing that this has been an exciting and stimulating year for all those involved in the health care system, both as providers and consumers. The recently concluded health policy conferences have brought us to the beginning of a new era.

 They have proven there is room for consensus, even among disparate groups, about the directions we should be taking. They have proved that people can put aside their personal interests and work together as a team when called upon to do so. They have also proved it is possible to begin to reform a system as complex as that of health care while leaving its fundamental strengths intact. They have proved that change can be a welcome and challenging prospect.

 They have never ceased, to my knowledge. They ceased while I was in hospital, but other than that, they have been very vocal.

 I am greatly encouraged by the results of the health policy conferences. I am now looking forward to receiving responses to the final report on that process and, more importantly, to acting on the recommendations that arise from them.

 I feel confident that, having achieved consensus on major issues through a process of consultation, we will be building our future health care system on a firm and solid foundation with the co-operation of all sides of the House and all members of the Ontario Legislature.

 Now we have five minutes to hear from the Liberals.