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In any event, the tradition of rambling on will not be a tradition with this minister. If it carries on, it will be a break from that tradition.

Let me start by focusing my remarks on a number of areas where important health care developments are occurring. These selected topics will identify some of the directions which I, as minister intend to pursue. They will also give you a sense of some of the broad policy issues the Peterson government will be addressing in the coming months.

With respect to this statement, I must indicate that these areas of action are not designed to be in any particular listing or sense of priorities but are a sample of the directions we intend to take in various areas.

Our government has no higher priority than to guarantee all elderly citizens of this province the dignity, respect and quality of life they have earned and deserve. It is estimated that the percentage of elderly people in Ontario will increase from just over nine per cent today, to approximately 14 per cent by the tum of the century, and to 20 per cent by the year 2025. These statistics and the service needs they project compel us to give considerable thought to the planning of health care programs for the elderly.

For example, we must develop a stronger orientation to preventive measures and health maintenance-so that in living longer people are also healthier and more able. In other words, we must develop and have in place those programs and services that promote the autonomy and independence of elderly people.

We must seek out alternatives to what is now an over-reliance on institutional care. In Canada, more than nine per cent of our elderly people live in institutions. This is one of the highest rates in the world. One of our priorities, therefore, is to develop a better and more effective balance between the institutional sector and the range of community-based care programs available to elderly people.

To lead this effort, the Premier has appointed a Minister without Portfolio for senior citizens affairs, the Honourable Ron Van Home. Many of you, as members, were present in your own ridings when the minister was involved in his consultative process.

The minister is now conducting a review of the programs and services available to seniors in this province. The objective is to determine the most effective way to organize responsibility for funding, delivery and management of these programs. Let me emphasize that in this exercise the Minister without Portfolio is receiving full co-operation from me from the Minister of Community and Social Services (Mr. Sweeney) and from other ministries.

This government is determined that all ministries providing services to the elderly must work together so that any gaps in services might be identified, duplication will be avoided and fragmentation of services, where it now exists, might be overcome.

My ministry and the Ministry of Community and Social Services are moving now to introduce a homemaker program for the frail elderly and are in the process of completing the implementation details. The program will benefit people who need assistance with household tasks but do not need the medical attention that is now a requirement for admission to current home care programs.

We also will need to develop more assessment and placement mechanisms to evaluate the needs of elderly people and direct them to the most appropriate community program or facility. Our goal is to build a comprehensive co-ordinated network of services, in which the elderly are able to move smoothly from one level of care to another as their health status and their support needs change and evolve.

Any community services network must also meet such needs as housing, transportation, income support and recreation. All programs should be readily accessible to the elderly and their families, preferably through a single contact point. This is not to suggest that nursing homes and other institutions will become redundant or of declining importance in any shift towards community-based care. Our population trends alone ensure there will be a continuing demand for institutional care, even with enhanced community support.

At present, of the private sector nursing homes of this province, 95 per cent are run by profit-making organizations and only five per cent by nonprofit groups. It seems a fair question to ask if there is not room in the extended care field for a broader, nonprofit role. In general, nonprofit organizations nave performed well in operating public hospitals and delivering community-based services. Surely this reserve of talent could contribute to the provision of long-term care.

Many ethnic groups and community organizations, for example, would like to establish nursing homes where residents could live and be cared for in the cultural seeing co which they are accustomed. In practically all of these instances, the sponsoring organization would be community-based and nonprofit.

The ministry now is in the process of revising the proposal call procedures for awarding nursing home beds to encourage wider community anticipation. First, we are taking the process to communities across the province. Public meetings will be held at the local level rather than exclusively in Toronto. We expect this move will stimulate more proposals from both public and private organizations. Second, we have altered the submission requirements to reduce the costs of responding to a proposal call. This streamlining should make u feasible for more community groups to compete.

Mr. Chairman. I assure you quality of care will be the most important priority in forming the policy decisions of our government about care for the elderly. The recent epidemic at the Extendicare nursing home in London shows clearly that we cannot overemphasize this point.

Because so many frail elderly people reside in Ontario nursing homes, we cannot be too vigilant in our concern for their health, protection and safety. This is a matter that I have taken on as a personal priority, and I am committed to seeing that every measure possible is taken chat will enhance and improve the protection of nursing borne residents.

Let me stress that living in an institutional setting need not and must nor entail a loss of personal freedom or sense of purpose. The ministry is therefore considering the introduction of stronger measures to protect residents' rights, such as the strengthening of residents' councils now in place.

Stronger ties between nursing homes and the community would also have a positive impact on the emotional wellbeing of residents. This could work both ways. More volunteers could get involved in the social life of the residents and the homes could serve the community in new ways, such as providing vacation relief for families with an elderly relative at home.

In co-operation with the Minister without Portfolio (Mr. Van Horne) responsible for senior citizens and the elderly and my cabinet colleagues. I am determined that we are going to resolve these issues and that we will begin moving on the health care reforms Ontario senior citizens require.

The Treasurer (Mr.Nixon) recently announced that all hospitals in Ontario will receive an increase of four per cent in their base allocations for 1986-87. In addition, the budget increase provided to the ministry will permit a further 4.3 per cent increase for growth and enhancements in hospital programs. Overall, the increase in provincial spending on hospitals amounts to 8.3 per cent more than in the 1985-86 budget.

These increases wilt bring total hospital spending by my ministry to more than $4.6 billion. In providing this funding increase, our government is emphasizing its commitment not only to maintain the basic components of our health care system, but also to recognize the work-load pressures in hospitals and to provide them with the necessary money for growth within the system. The ministry has also been authorized to approve funding for new programs to be started in the next fiscal year. The annual cost of these programs will total $54 million.

Our government is increasing its spending in the hospital sector at a rate much greater than the rate of inflation. This commitment is being made at a time when the federal government is threatening to reduce its transfer payments to the provinces for health care and education, beginning in 1986-87. Our government will maintain the commitment that the health care system of this province be adequately funded.

I am certain that the announcement of the increase in basic allocation for both next year and the year after will permit hospitals to plan their budgets with greater certainty and allow them to plan more effectively for the provision of adequate and effective hospital care. The modem hospital setting where we see rapid scientific and technological growth, rising utilization patterns and a spiralling impact on costs for services is a major policy challenge.

In this country, as in many others, health care providers, hospital administrators and policy decision makers are now rethinking many of the traditional concepts in health care and considering what, in today's environment, represents effective, economic and ethical use of health care resources.

We now have under way in this province a health services patterns project with representatives from the Ontario Medical Association, the Ontario Hospital Association and the ministry. This group has been charged with analyzing the growth in utilization of hospital and health care services, where it is occurring, why it is occurring and what an appropriate response should be.

As the work of this important committee progresses, I hope the ministry and the many health care provider groups in our province will be able to make some major decisions about the application and use of our health care resources and that together we will create an environment that promotes stronger, more effective management of the Ontario health care system.

One of the immediate issues to which our government must respond is the need to improve health care services for the residents of northern Ontario. This is an issue on which a number of promises were made by the previous government. It is one on which this government intends to Lake action. This month I will be introducing a program that will provide subsidies to northern residents who must travel significant distances for medical specialist and hospital care.

To promote greater medical self-sufficiency in the north, we will also proceed on two other fronts. First, we are developing a recruitment program to encourage more medical specialists to locate in the north during the next several years. Second, we will provide incentives to enable medical specialists to travel from the major northern centres to patients in smaller communities.

In order to move ahead quickly with the initiatives, the ministry sponsored a series of consultations with hospital administrator, medical staff and local medical societies in five northern centres: Thunder Bay, Sudbury, Sault Ste. Marie, North Bay and Timmins.

I might add at this juncture that my parliamentary assistant, the member for Wentworth North (Mr. Ward), has done a considerable amount of work. He has travelled extensively in northern Ontario and has done a wonderful job of accumulating the material that has been given.

During these consultations we sought local advice on the types of additional medical specialties now required in the north, where specialists would appropriately be located, the patient referral patterns that should be developed 10 provide better access to care and the travel outreach programs that specialists might undertake to serve smaller northern communities.

As we move 10 put in place the various components of this program, it is also our intention to create a committee structure composed of northern general practitioners and specialists to monitor program development and to provide recommendations and advice.

Since taking on the Health portfolio, I have become aware that northern hospitals, physicians and many municipalities were unhappy chat our dedicated air ambulance fleet was not manned on a 24-hour basis. With the full support and agreement of cabinet, I announced on October 30 that, effective immediately. Ontario's air ambulance program would be extended to 2.4-hour, round-the-clock service.

We also decided 1hat the skills of the medical attendants would be upgraded in order to provide improved patient care during transit. The training program and the skills level that the attendants will need will be determined by the ministry in consultation with doctors and hospitals that are now using this service.

Finally, we plan to assign all air ambulance attendants to designated hospitals. Once the skills of the air ambulance attendants are upgraded, they will require direct physician supervision because many of their activities, like those of the paramedics, will be delegated medical aces. It is extremely important, therefore, for the attendants and base hospital physicians to work together as closely as possible so that a bonding relationship can be developed between the physicians and the attendants.

I am confident our air ambulance program will now meet all concerns about the previous limitations in service. I am also confident the comfort, safety and security of all air ambulance patients will be greatly improved with this new service expansion.

The health system of this country rests on the fundamental principle that every Canadian is entitled to a range of comprehensive and accessible health services. Access to these services should not be determined by a family's or an individual's financial status or ability to pay.

The Premier {Mr. Peterson) has said the principles of universality and accessibility will be guaranteed in Ontario. During the recent Ontario election, our party campaigned on the platform that extra billing would be banned. That is a promise that has been made: it is one that will be kept. It is the intention of this government to ensure access to the health care system to every person in our province, access not only to basic care but also to the specialized care a patient may require.

Our government has spent considerable time and effort in reviewing the extra-billing issue, how it is practised in Ontario and its impact on our health care services. It is my personal conviction, the conviction of the Ontario government and the conviction of most residents of Ontario that extra billing impedes or has the potential to impede access to medically necessary health care services. As long as it is permitted 10 exist, it will continue to threaten one of the principles on which our health care system is founded.

Next month I will introduce legislation in the House to put an end to the practice of extra billing in this province. Our intention is to introduce legislation that will be responsive to the Ontario context, legislation chat will take into account those features of our health care system that are unique as well as those we share with other provinces. If we are to succeed at that task, we must begin now to develop an appropriate, workable, rnade-in-Ontario response to the extra-billing issue.

With the support and co-operation of the district health councils, we recently began a public information process to give concerned groups an opportunity to learn about extra billing, to express their opinions and to understand why the Ontario government intends to take action. Forums were held in eight of nine centres throughout the province-Kingston, Ottawa, Sudbury, Windsor, Hamilton, Thunder Bay, Sault Ste. Marie and London-and another will be held this Saturday in Toronto. Once the public information sessions are concluded, the next step will be to move to the introduction of legislation to ban extra billing.

As the legislation moves through the House, it will be reviewed by a committee of the Legislature. During that process, interested parties will have another opportunity to present their views and ideas about how the legislation should be framed.

This government wants to resolve the extra-billing issue fairly and equitably. We want to resolve it in a way that meets both the needs of the doctors and the citizens of this province. We are determined to resolve it as quickly as we can.

The Ontario drug benefit program is an essential component of this province's health care system. Under ODB people 65 years of age and older, those on provincial assistance programs, those in extended care facilities and in the borne care program are able to receive prescription drugs at no charge. ODB now represents approximately 40 per cent of the Ontario drug market. More than 1.3 million people use the service each year. This government is committed to ensuring continued coverage for all eligible Ontario residents.

In the past six years, however, the cost of financing the Ontario drug benefit program has risen by approximately 23 per cent annually to $350 million from $100 million. This year it was projected that costs could be in the order of $400 million. This kind of growth is not acceptable to our government.

More than 2.300 therapeutically effective and quality-tested drugs with their prices are listed in the Ontario drug benefit formulary that is published twice each year by the Ministry of Health under normal circumstances. Most of you realize however that there has not been a new formulary since January 1, 1985. Pharmacies arc then reimbursed by the government for drugs dispensed under ODB according to the formulary price plus a dispensing fee.

A growing number of manufacturers found their - marketing position was improved by submitting unrealistically high prices for multiple source drugs, the interchangeable drugs, to the formulary. This meant the prices for drugs listed in the formulary were often much higher than what pharmacists were actually paying for them. The greater the price spread between a manufacturer's listed price and the actual acquisition cost of a drug, the greater the profit to pharmacies and the greater the chance that pharmacies would choose that product to stock and sell. It can easily be seen how this resulted in excess costs to the drug benefit plan.

The facts of this situation are outlined in the Provincial Auditor's report of 1984 and examined at length in the Gordon commission report that was received by the Ministry of Health a year ago. This problem is one our government inherited. It is one that developed during the previous administration. Two of my predecessors in the previous government have publicly admitted their frustration at being unable to carry out corrective action.

As Minister of Health, I was not prepared to accept unrealistic prices for Ontario's drug benefit formulary. To do so would only have placed a continuing and unnecessary economic burden on Ontario taxpayers and consumers. On November 7, I introduced two bills in the Legislature designed to give the government legislative authority to manage the Ontario drug benefit plan and to ensure that high quality, low-cost drugs are available and accessible to the Ontario public.

The first bill, the Ontario Drug Benefit Act, gives government the authority to determine what drugs are to be included in the Ontario drug benefit plan; who is eligible to receive drug benefits; and the prices the government will pay for drugs listed in the formulary.

The second bill, the Prescription Drug Cost Regulation Act, allows government to designate which drugs are interchangeable. It also specifics that unless a prescription says "no substitution", pharmacists must inform customers about their right to an interchangeable product. Pharmacists will also be required to itemize the price of the drug and the dispensing fee either on the customer's receipt or on the prescription label.

The two acts are complementary in that government use of public funds will be more properly controlled and consumer interests in the marketplace better protected.

The growing incidence of acquired immune deficiency syndrome or AIDS has rapidly become a major public health issue in Ontario. Across Canada, 322 AIDS cases have been diagnosed and 45 per cent of the victims are Ontario residents. Of that total, l58 AIDS victims have died; 164 remain alive.

When we look at our own statistics for Ontario, we get a clear picture about how this disease is continuing to grow. In 1982, five cases of AIDS were diagnosed in this province. In 1983, there were 13 cases and in 1984, 45 cases. This year, to date, 87 new cases have been discovered.

Last August I announced that the province would provide up to $1 million to the Canadian Red Cross Society as part of Ontario's contribution to the startup of a nationwide blood screening and blood testing program. Our ministry's central laboratory in Etobicoke is also beginning diagnostic specimen testing, a service that formerly had only been available to Ontario physicians at the Laboratory Centre for Disease Control in Ottawa.

While these initiatives are all important and will make a positive contribution in the fight against AIDS, I am also concerned about the many myths and misconceptions that persist about the disease and about the Jack of information resources that are available to the people of Ontario.

In order to promote a well-defined and co-ordinated approach to public information and education, the ministry has established an Ontario AIDS public education advisory panel chaired by Dr. Jaye Brown, associate professor of social work at McMaster University. The panel has been given responsibility to identify our educational and informational needs with regard to this disease. It will review the resources that are currently available and undertake the development of communications programs for both the Ontario public and specific high-risk groups.

Up to $200,000 in funds has been made available to support the activities of the panel. An additional $100.000 has been made available by the Ontario government to the AIDS Committee of Toronto, ACJ, for its support and counselling program to AIDS victims.

I would point out that al the recent provincial-territorial health ministers' conference held in Toronto in September, the AIDS issue was a concern for all ministers and a topic to which we devoted a great deal of attention. All ministers agreed that public education is now an important priority in the fight against this disease. Ontario has agreed to snare the resources and results of our public education efforts with the other provinces.

I must mention that the matter of patient confidentiality with regard to testing procedures for AIDS has become a concern. I have therefore ordered that the laboratory requisition forms for AIDS antibody tests be designed so that information about risk group categories would not be required. 1 did this because of legitimate concerns raised by many people who felt that detailed and personal information about patients should not be collected. I concurred with that view and I ordered that the identification of risk groups be eliminated from the forms.

At this time, I must underscore the fact that the decision is always reviewable. I understand there will be a provincial-federal deputy health ministers' conference later this year, at which lime we hope to be able to develop ways and means of ensuring that all provinces require the same information. Certainly, we will be looking to standardize procedures and practices right across the country.

I would also like to inform this committee that the Red Cross will now report all positive results of its blood-screening tests to the medical officers of health. The ministry will not be collecting this information as was originally planned. I felt it was unnecessary for the ministry to become involved in this process.

I fully expect these changes will allay the concerns of those who were worried about the reporting of lab tests and the collection of information. I would like to stress, however, that the ministry will have access to the statistical information, and the medical officers of health in each community will have the information they need to continue to protect the public.

I am determined that every effort will be made in this province to inform people about this disease, to initiate measures that will protect them from it and to ensure that AIDS victims receive the support and counselling services they need.

Just in passing, I might say when I went home from work on Monday evening. I caught the tail end of a program aired by Rogers channel to, I think. It was recorded in Vancouver and featured a panel of five physicians who had done a great deal of work m San Francisco. I think that type of program is also of considerable interest to us in Ontario because it provided an awful lot of good information and experience about what had happened in San Francisco.

In today's environment, mental health care and treatment is changing dramatically. Public understanding about the nature of illness has improved and, among professionals, it is recognized that for many patients institutionalization may not be the most appropriate environment for health recovery.

In Ontario, we are striving to build up a balanced mental health system, one that ensures quality care for those who require an institutional setting and one chat offers appropriate support and aftercare to patients who are living in the community. Appropriate community aftercare and support services can help facilitate the transition from an institution. They can help reduce the number of readmissions or prolong the period between admissions. In some cases, the right kind of community support means institutionalization is not necessary.

The development of community mental health programs is, therefore, a priority. In 1981-82, the ministry allocated $21million to fund 157 community mental health and addiction pro-grams. Today, 306 programs are funded for a total of $51.3 million, a funding increase of 140 per cent over the past four years. Funding covers alcohol and drug addiction programs, supportive housing programs. co-ordination programs that promote effective delivery of mental health services and programs armed at prevention, rehabilitation, psychogeriatric services and volunteer support.

While the ministry is committed to the development of more community-based pro-grams, institutional care services are also being improved. Action is being taken, for example, to improve accessibility of mental health services to Ontario's francophone population. The ministry hired the consulting firm of Touche Ross and Partners to review French-language needs at the Brookville and North Bay psychiatric hospitals, both of which serve large francophone populations.

The reports have been completed and already a number of the recommendations have been implemented al North Bay, including the appointment of a French-language co-ordinator for the hospital. In Brookville, the hospital and its community advisory board are now addressing the recommendations.

We arc dearly making progress in mental health care in Ontario, but much more still needs to be accomplished. With an increasing elderly population, we will need to enhance our psychogeriatric programs. We will have to build on the foundation we have laid in the area of public education and we must strike the right balance between institutional care and the broad spectrum of community-based services.

We are fortunate in that we have a dedicated network of mental health planners. service providers and volunteers who are committed to these objectives. Through them we will meet every challenge in mental health in this province.

In the past few years we became accustomed in Ontario to hearing Ministers of Health talk at length about the need for more health promotion and disease prevention initiatives. Despite the rhetoric, we are still without a co-ordinated health promotion effort in this province, a situation that as Minister of Health I am determined to see turned around.

First, we must agree on what we want to achieve and what measures we can use to evaluate our activities. I believe it would not be particularly difficult to reach agreement on general goals for the improvement of health, through prevention, for residents of Ontario. The ministry has been preparing this framework and shortly will be circulating it to district health councils and other planning groups as well as health care provider and consumer organizations. The ministry will then begin the coordination of a public process in which objectives are developed, based on our accepted general goals and relating to the reduction of lifestyle hazards for Ontario residents.

One of the barriers to health promotion that now exists relates to program information. There are well over 200 organizations and agencies in Ontario, government and nongovemment, which are active in health promotion activities. A basic description or a reference source for all these activities has not been available, however. To address this lack of availability of basic program information, the ministry is now compiling a provincial directory of health promotion pro-grams, a first in Ontario.

Outlining activities ID the area of smoking cessation, alcohol and drug abuse, nutrition and fitness, the directory will identify programs and activities, give a brief description, state their objectives and indicate the targeted population group. But descriptive program information, basic and necessary as ii is, does not overcome a second barrier co effective health promotion, namely, the problems surrounding program evaluation.

What works? What does not work? What is the most effective approach? In some communities, particularly those close to academic centres, specialized information is sometimes available, depending upon local research interests. That is good, but access to this information is at present uneven and uncertain across the province.

Some very fine work has been done, particularly in the area of smoking and alcohol programs, but we still see too many subjective assessments and too many suspect methodologies. There is little reliable assessment of ongoing programs and new program proposals.

To address this issue and in response 10 advice from the implementation group, chaired by Sieve Podborski, I propose to establish a health promotion evaluation fund. Beginning fiscal year 1986-87, an amount of $1 million will be allocated. I have asked that special emphasis be placed on the evaluation of projects which promise to be effective in promoting healthy lifestyles.

While recent trends in Ontario indicate a growing awareness on the part of employers about the benefits of health promotion, not only for their employees but also for the community at large, there is little recognition of these activities.

I have therefore established a new awards program to recognize employer excellence in health promotion. The awards will be selected on the advice of regional nomination committees, with representation from the health care system and from business, and presented yearly at a province-wide function.

Because of the active involvement of district health councils in health promotion, I have suggested that Action Centre, the annual meeting of the district health councils, would provide an excellent occasion to acknowledge local employer efforts. I have asked the DHCs for their input into the nomination and selection of award recipients.

Another barrier to effective health promotion is public access to information. This may seem surprising at first glance in view of the heavy use of print and electronic media by many agencies, but there are still many difficulties for the French-speaking population, for those in search of information on sensitive topics, for the young and for those who may have difficulty in knowing what information services are available.

One promising project, still in its early stages but already giving evidence of great potential, is the telephone response system called Dial-A-Fact being developed by the Addiction Research Foundation.

The foundation has identified 41 most frequently asked questions about alcohol and other drugs. Short three to five minute tapes have been prepared and can be heard by dialing a toll-free number from anywhere in the province. Public response to this experimental service has been impressive, growing to a current level of 5,000 calls per month.

Accordingly, I have asked that Dial-A-Fact be developed further to address the public's growing need for information and that services be expanded in French and other languages. We will review progress with this project early next year, particularly with regard to its future potential and its value and function within the health care system.

The health disciplines legislative review is the next topic of discussion. Our government recognizes the importance of regulation of the heath care profession as a method of ensuring that the public obtains competent and effective health care service. As you are aware, an extensive review is now under way to modernize and restructure Ontario's health professions legislation.

Let me confirm my personal support and encouragement for this much-needed review process, indeed, it represents one of my key priorities as minister. I have been thoroughly briefed by the review team and I am keeping in close touch with the progress of their work.

The review has received an enthusiastic response from health professionals, institutions and consumer organizations. In all, some 131 groups have participated, representing 73 health care professions. I might just say the last estimate by the way is that more than 6.000 pages of material, has been accumulated by the review team.

It has been more than a decade since the last attempt to overhaul the system. As you may recall, the Committee on the Healing Arts was formed in 1966, reported in 1970, and led to the enactment of the Health Disciplines Act in 1974. I do not see many of us who would have been around since 1966, so probably none of us would recall that it started in 1966. The overall exercise took eight years and produced new legislation for only five professions. I expect the current review to be much quicker and much more comprehensive.

Given the rising utilization of health care services and the - growing sophistication of diagnostic and therapeutic procedures, it is necessary that we take every precaution to guarantee consumer protection in the health care field. Assuring the best possible quality of patient care is the fundamental object of the review process.

The review is an open, participative exercise. A lot of people get involved in this process, which permits a thorough and orderly consideration of both the professional and consumer viewpoints. All organizations affected have been invited to express their opinions and any concerns they might have about the briefs which have been submitted.

In December 1984, the focus of the review narrowed with the release of an interim list of professions to be regulated. Of the 73 professions participating in the review, 39 were included on this short list. This decision and the upcoming decision on the final list of professions to be regulated will be based on the criteria developed by the review team. The review team received submissions from all groups on this issue last month. I expect to receive the review team's recommendations regarding the final list within the next few months.

The final list will likely include some professions to be regulated for the first time and may also exclude some currently regulated disciplines. I fully recognize that difficult choices may be necessary here, but after reviewing all sides of the arguments, I will announce my final decision on the professions to be regulated.

We will then move to the second phase of the review, which will address a variety of unresolved issues among several health care disciplines. Most of these outstanding regulatory disputes involve disagreements between related professions about their respective scope of practice and their roles in the provision of health care.

The professions concerned have been urged to negotiate their differences among themselves, keeping in mind, of course, that any proposed solution must serve the public interest. I want to underscore that it must serve the public interest. The review team will assist in these negotiations if necessary, but no one should assume that the issues will be put on bold if professions cannot reach consensus among themselves. I see it as my responsibility as Minister of Health to make decisions to ensure the best quality of care and I intend to meet that responsibility.

In addition to settling the scope or practice issues, the second phase of the review will determine the structure of the new legislation and develop due process provisions. The review team has recently released a discussion paper on these legal matters, and all interested participants have submitted briefs in response.

Once the policy and procedural questions have been resolved, the decisions will then be translated into draft legislation for presentation to the participating groups. The eventual outcome will be the enactment of new legislation governing the health professions.

It is not yet possible to set a deadline for the completion of the review, but I emphasize that the ministry and the review team are determined to move ahead as rapidly as possible without compromising the integrity of the analysis or the commitment to consultation. I am confident the health disciplines review will create an environment in which all professions may work more effectively together, and we can move towards our shared goal of the best health care service for the people of Ontario.

In conclusion, I have touched on only a number of issues to which the Ministry of Health is responding. There are other important policy matters that have not been mentioned here: women's health issues, the need for more co-operation among hospitals and provision of services, the review of electroconvulsive therapy, improved access to health care for francophone Ontarians and the evaluation of the patient advocate program in psychiatric hospitals. These are all matters under policy development, and I would be pleased to discuss them with the committee during the time allotted to us.