|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Province*** | ***Législature*** | ***Session*** | ***Type de discours*** | ***Date du discours*** | ***Locuteur*** | ***Fonction du locuteur*** | ***Parti politique*** |
| Ontario | 31e | 3e | Discours sur la santé | 10 Octobre 1979 | Dennis Roy Timbrell | Minister of Health | PC |

**Ontario’s Health Speech: Third Session of the 31st legislature, October 10, 1979**.

Hon. Mr. Timbrell: Mr. Chairman, first of all, in the spring, since we didn't really do estimates as such, I didn't get a chance to introduce to the committee my new deputy minister, who is now not so new. I guess he is about seven or eight months into the job.

Mr. Campbell, as you know, came to our ministry from the Ministry of Northern Affairs where he was the founding deputy minister. Prior to that, he had served in the cabinet secretariat and, prior to that, in the Ministry of Education and the Civil Service Commission government and every program within the government.

I want to say that I have been very fortunate to have the assistance of people like Mr. Campbell and my assistant deputy ministers and all the senior staff, many of whom are here today. They include Mrs. Vanner, Mr. Bain, Mr. Hagerman, Mr. Corder and Dr. Martin, who have really done a yeoman job in developing innovative approaches in the various program areas of the ministry.

I see Mr. Berry here as well and Mr. Dreezer who is recently back from the National Defence College in Kingston. I don't want to miss anybody.

No. This was not a course in the martial arts.

Riches to riches

I thought I might just take sometime today to speak, not from a prepared text but from some notes, on trends in the ministry in 1979, now that we are a little more than halfway through the fiscal year which we are discussing.

Needless to say, it has been an interesting year for me as minister and for the ministry and all connected with it. We started out the year with the Anti-Inflation Board controls coming off us as much as anybody else, but of course this is a very large industry, if I can call it that, in Ontario, inasmuch as in the hospitals alone I believe the employment figures for full-time and part-time staff come to something in the order of 125,000 people, which is not that far off the total population of our smallest province of Prince Edward Island.

With the controls coming off, a lot of concerns existed at the time as to what effect this would have on costs and on programming. This came at the same time as we were continuing our efforts to keep our increases in spending under control for the whole I don't want to let the opportunity pass without saying that this was quite an honour to be bestowed on Mr. Dreezer and on the ministry in that he was chosen. As you know, the competition for inclusion in the National Defence College annual programs is very intense. It is a credit to Mr. Dreezer and the ministry that he was chosen, and we are glad to have him back.

To carry on, in recent months, as the program has continued to evolve, I think there are a number of items of interest that bear some comment today. A couple of weeks ago the ministry and the Ontario Hospital Association jointly sponsored and convened a conference for small hospitals. You may recall that I had indicated to this committee in April or May that it was our intention to convene such a conference inasmuch as we recognized that in an era of constraint in spending it is our smaller institutions that really potentially would feel any pressure to the greatest extent.

At that conference I capped the results of many months of consultation between staff of the ministry and representatives of the small hospitals of the province and my own extensive travelling through the province over the last three or four months- -by announcing some policies which I am pleased to say were well received by the conference. In fact, just this morning I received a letter from the executive director of the hospital association indicating how much in support they were of the policies enunciated at that conference.

If I may briefly recap, it has been our concern that in the very small hospitals there is a point beyond which you simply can't ask anybody to constrain or further restrain and still maintain a viable program. I look at hospitals like Palmerston and the hospitals on the north shore of Lake Superior and in other parts of the province where they have to maintain a certain number of staff in particular categories to make the whole program viable.

In recognition of this I indicated that henceforth those hospitals with less than 50 beds would be exempted from any further application of hospital bed guidelines. For this current year, they had been included in the group that was given a 10-bed cushion against their active treatment bed allocation. The effect of this will be that, looking ahead to the future in the planning for acute as well as for chronic care services, the hospitals will operate with no fewer beds than they have now.

One example is the five hospitals on the north shore of Lake Superior: Terrace Bay, Geraldton, Nipigon, Manitouwadge and Marathon. I went up there on May 24. I remember it well, because we smashed up the car that morning on the way to the airport.

The Speaker was good enough to convene a meeting in Nipigon of the representatives of those five hospitals. As in so many instances, all the attention focused on the acute-bed side of the equation, which, if my memory serves me correctly, among those five hospitals meant something of the order of a 15- or 18-bed surplus over the acutebed guidelines. It wasn't until the meeting, until I started asking some questions, that anybody started to pay any attention to the fact that, as far as chronic care was concerned, 'among those five hospitals they had about a 25- or 27-bed deficit.

As a result of that meeting, they agreed among themselves to plan together, in effect as a subcommittee of the Thunder Bay and District Health Council, to rationalize services, to ensure that they did develop their own chronic-care programs, because all of them certainly have chronic-care patients in what they call active treatment beds. As well, they agreed that they would come up with some plan to raise the quality of laboratory and radiological services in those five hospitals, none of which of course is large enough to sustain a full-time laboratory technician or radiology technician.

I talked With several representatives at the small hospitals conference. They are well on their way to rationalizing between acute and chronic. I think we have to constantly reinforce that we are talking about both and not just the former.

I understand they will probably come up with a proposal similar to what I just announced yesterday or today I am not sure when the press release went out-for the Kenora district. We have approved a consultant radiologist to all of the hospitals in that district to ensure the establishment or maintenance of a high level of radiological services.

Those are examples of what has been happening in that area among the very small hospitals. 1 again would repeat these are exempt from any further application of the guidelines.

For the group of hospitals between 50 and 100 beds-the larger they get the little bit more flexibility they have in their operations -the 10-bed cushion will be retained. So looking to the future, their bed allocation will not fall below the planning guideline plus 10 beds. Also I would anticipate that this year's many conversions to chronic establishment of chronic units or enlargement of chronic units in those hospitals will continue.

I went on further to indicate that day that the government had been reviewing the capital program for all hospitals. You may recall that two years ago-Mr. Conway 1 am sure will recall, since he has been my critic the longest-I announced our intention for a capital program for the hospitals of $115 million a year. That portion of my budget had to be restrained m 1978-1 think it might have been at the time of the discussion of the premiums. As a result, what had been intended to be $115 million a year had become $86 million a year. Of course there is an outstanding list of capital projects, new hospitals, replacements, alterations, and so forth, Hotel Dieu in Kingston

Oh. I didn't see that.

Oh, good.

Old, old backyard. But there is a fairly extensive list of capital projects under way and outstanding. In recognition of this and also in recognition of the fact there is a new source of lottery money available to us from the Loto Canada operation-the government had agreed to my request to allocate $100 million over the next three years as the money becomes available -for hospital capital projects. So this will allow us to get back on track with the capital program we had announced and begun in 1977 and therefore to accelerate a few projects that have fallen a little bit behind.

I wish the member for Huron-Middlesex were here because there is one hospital in his constituency that had some concerns m the spring. It had come to meet with my staff and me and I think might even have appeared here at the committee at some point in the spring. ,I am thinking of Goderich.

We had indicated in the spring to Goderich that there was certainly a way to meet their concerns that involved conversions from active to chronic and taking a careful look at their operation. I was pleased to note-and I know that Mr. Breaugh's party noted it because you had somebody there at the conference-that the chairman of the board got up and did acknowledge the ministry had been very 'helpful and -had, in fact, solved their problems. This is the case in most of the hospitals we have been dealing with because we have been dealing with them on an individual basis in terms of the program.

It's interesting to note, Mr. Chairman, the present indications are, looking at the total bed situation in the hospitals, looking at acute and chronic and extended care-and I will have firmer data on this within, I would say, about a month-that we are going to end the fiscal year with no fewer beds than when we started the fiscal year. We may, in fact, be about 100 beds or so to the good, as it were, or have an increase of about 100 beds which is what I was telling the committee last spring.

One of the major disagreements I have had with some of our critics has been the zeroing in on strictly one part of the healthcare system to the total exclusion of the rest, and that obviously is bound to lead to one set of conclusions which is totally inappropriate.

I am just saying that looking at the number of beds, acute and chronic and extended care, with which we started the year and those with which we will conclude the fiscal year, the present indications are, and I will have firmer data and I will have more to say on this in about a month, I would think that we will end the year with no fewer beds overall and probably a slight increase. That is not to say that some hospitals won't have fewer beds because that will be the case. Others will have more. Many will have converted hospital beds from active to chronic or to rehab and those kinds of things.

On nursing home beds, I have recently, in the last few months at least, announced several areas where additional beds have been approved based on the local studies that have been done, 30 in Peterborough about a month ago, 28 in Timmins which I announced this morning and I anticipate adding, again based on some local studies that have been done, extra beds in several other counties within the next few weeks. All well, I expect to have in my hands within the next three or four months studies which are under way but not as yet completed in places like Muskoka. I 'believe Essex has one under way as well as a few other counties like that, so we can expect to see changes in that area.

I think it's worth noting, also, Mr. Chairman, because apparently it was missed this morning-this we will discuss next Wednesday I know but it's worth reading into the record that Apparently for some reason the leader of the third party missed the announcement yesterday that we have granted money to form an additional-I think it's 21--community mental health programs in Toronto, North York, Etobicoke, York and Peel. This is money coming out of the savings associated with the move of the inpatients from the former Lakeshore Psychiatric Hospital to the Queen Street Mental Health Centre. This is in addition to the- Gosh, I thought you would be interested in some of this.

This, Mr. Chairman, is in addition to the $1.6 million which is spent on the existing outpatient programs of the former LPH which remain in existence serving the population.

The programs, Mr. Chairman, are as follows: in the city of Toronto a grant which would be the annualized cost of budget to the Parkdale Community Legal Services-I think you are familiar with them-to establish an activity recreation centre. This centre will provide social, educational and recreational programs to help former psychiatric patients and other adults and the centre will offer life skills training and referral service and a variety of activities six days a week and evenings;

Also in the city of Toronto, a $35,000 annual budget to provide continued support to a project known as Regeneration House, which is a group home assisting in the rehabilitation of former psychiatric patients;

In the city of North York, an annual budget of $44,800 to the North York Inter-Agency Council for a program Ito assist in the coordination of mental health services in that very large city;

A further $9,230 annual budget to the same North York Inter-Agency Council for a program which is going to be operated by the YWCA for socially isolated women and those recently discharged from psychiatric hospital;

A $5,230 annual budget to Community Resource Consultants for Club North York, who is going to provide social, therapeutic and recreational programs for adults who have recently been discharged from a psychiatric facility;

Over in the borough of Etobicoke, a $150,205 budget to establish a mental health service agency which will identify community needs and co-ordinate and develop new programs, including outpatient services and home visiting for chronic psychiatric patients;

A $67,208 budget for a crisis centre at the Etobicoke General Hospital to offer immediate care to people in severe distress, including hospitalization if necessary. That hospital has a psychiatric unit which has recently been enlarged by 19 beds;

Thirty thousand dollars to provide continued support to Opportunity for Advancement, which is a preventive program for sole-support mothers who might otherwise require some psychiatric hospitalisation. Counselling, referral and follow-up services are going to be provided.

Twenty-seven thousand, five hundred dollars to provide continued support to Friends and Advocates, which is a program for adults recovering from mental illness, offering group sessions, recreation and social activities in a one-Jto-one, befriending and support program;

Moving on to the borough of York, a $155,130 budget for a psycho-geriatric consultative land home rehabilitative and support service, which is being sponsored by the West Park Hospital and Community Occupational Associates. This program will provide services Ito the northwestern area of Metro;

One hundred thousand dollars to York Community Services for the establishment of comprehensive rehabilitation services for chronic psychiatric patients aged 18 to 45, who will receive recreational, vocational and educational retraining;

Seventy-five thousand dollars to the Northwestern General Hospital for an expanded day hospital program, assessment services and follow-up clinic for psychiatric patients;

Thirty-five thousand dollars for a psychiatric day hospital expansion at the Humber Memorial Hospital;

Nine thousand dollars to the Keele Street Women's Group, which is sponsored by Mental Health York, for a socialization and life skills program for women discharged from psychiatric hospitals, and $5,250 to Mental Health Metro for Breakthrough, a rehabilitation and educational program to reintegrate Italian-speaking women, formerly patients of psychiatric hospitals in the community;

Moving over to the region of Peel, $143,800 for a community mental health centre at the Mississauga Hospital. This program will provide short-term intensive therapy, day care, long-term maintenance and follow-up care for psychiatric patients living in Peel.

Ninety-six thousand, three hundred and sixteen dollars for a psychiatric outpatients program at the Peel Memorial Hospital which will expand the range of outpatient psychiatric services available in the north part of Peel;

Sixty-six thousand, five hundred and forty-seven dollars to establish a crisis intervention service at the Mississauga Hospital, which I mentioned just a minute ago, which will provide an around-the-clock service for severely emotionally distressed people;

Thirty-four thousand, six hundred dollars for an alternative housing program sponsored by Mental Health Peel to promote an optimal level of adjustment and maintenance for discharged psychiatric patients in the community;

Finally, $14,590 for a North Peel residential support program sponsored by the Peel Regional Health Unit to provide short-item transitional residential accommodation to discharged psychiatric patients.

These grants, Mr. Chairman, as I said, come from the savings associated with moving the inpatient programs to Queen Street. These are over and above the dozen or more new programs we have announced this year in the community mental health area. I won't take the time now to read those into the record but they cover II variety of areas of the province. A combination of these represents about a 50 per cent expansion this year in the number of programs being funded by the ministry and continues the trend which we have promoted in recent years of further accent on community mental health prevention and maintenance programs.

The original estimate was that we would have savings of $2.6 million, and this represented half. In fact, I'd have to say that the savings are probably slightly less, and this would represent more than half of the savings.

Good. During September, Mr. Chairman, I also announced a number of initiatives on the part of the ministry in the area of prevention and health education. You may recall I indicated to you a year ago in the 1978-79 estimates that we had established a new division in the ministry under Dr. Helen Demshar, for health education land promotion, which is now on its feet and running.

I am very pleased, Mr. Chairman, with the results to date, and their activities. I want to run through three of the programs that we think are significant.

First is the poison prevention project, which I announced in Peterborough about a month ago. We are testing this program, which is basically aligned at getting parents to poison-proof their homes. I thought it was a little bit more serious subject-with anywhere from 25,000 to 125,000 kids poisoned a year-I thought it was a little bit more serious than that, Mr. McClellan. But, as I was saying, the basic goal is to get parents to poison-proof their homes.

Last year, there were 25,000 children, under the age of five, brought into the healthcare system, most of them into emergency departments, who had been accidentally poisoned in the home. Reliable estimates are that in fact it was something in the order of 125,000 children under five who were poisoned, and that 100,000 one way or another were treated with various kinds of home remedies, !lit home, rather than being brought to the doctor's office or to emergency. Fortunately very few of them die, but none of them should die. Depending upon the results of this program, the program that we will eventually launch province-wide will be altered according to the reaction to it in the Peterborough area.

That 'is in addition to the two regional poison control centres that I announced in June, which would be after, I guess, when I was last here. These two centres are at the Hospital for Sick Children in Toronto, and at the Children's Hospital of Eastern Ontario, or CHEO, as it is known.

I beg: your pardon?

It makes it easier. The centres will provide treatment services, of course, to patients on a 24-hours-a-day basis. They are acting as a major reference source to 'all Ontario hospitals on toxic substances land antidotes and they are going to help us to develop even better statistics and the educational programs to combat the problem.

I would invite any member who is interested to perhaps call ahead and pay a visit to the Poison Control Centre at Sick Kids' down the street. I think you'd find it rather interesting, the massive amounts of information that they've got to keep on circular files and microfiche to be able to answer a doctor who calls from Marathon or wherever to find out how to deal with a particular household product or a household plant or animal. It's really quite amazing, the information they have to have at their fingertips, and the ladies who run it do an amazing job.

The second program for which I have high hopes is the program dealing with junk foods in the high schools. We all recall from student and/or teaching days the really rather pathetic proliferation of convenient but very low-in-nutrition foods Not at all; I'll come back to that.

The program is an attempt to promote a trend which we think is there anyway but needs a shot in the arm. When I was in Sudbury about three weeks ago I indicated in an address at the Sudbury Secondary School that in the spring of 1980 we would be making awards of $1,000 to each of the 20 successful applicant high-school student councils which submitted proposals to encourage improved nutritional habits among their peers and which show the best promise for continuing those trends.

The competition will close on February 1, and I am pleased to say that we have had a great deal of interest shown in this by the student councils. We purposely decided to go that route rather than to the administration, because we think if we can motivate the students, that will go a lot further to motivating their fellow students than if it comes, as it were, from on high, from the administration, whether it's the principal, the board or whatever. As I say, the interest in that is very gratifying.

One of the major ongoing problems in health care, of course, is the maintenance of a high level of immunization among the public. We began this year a widespread campaign aimed at promoting higher levels of immunization and reminding people that diseases like polio, notwithstanding what they might have thought, are not eliminated; that they can and do, as we have experienced in the last two years, crop up from time to time; and that it's a simple matter, either through the public health clinics or at the doctor's office, to be immunized on the schedule recommended against things like diphtheria, poliomyelitis, measles and so forth.

Between now and next spring the Ministry of Education will develop the appropriate legislative vehicle to back up a campaign that will begin in the schools in the fall of 1980, which will require parents to sign one way or the other, either that they are granting permission for their children to be immunized-again, according to the schedules recommended---or that they are denying that permission and assume full responsibility for any consequences.

We anticipate that campaign will significantly increase what is already a very high level of immunization in the province; we are well over 80 per cent, which is one of the highest levels of any jurisdiction in the western world, but obviously there is still room for a lot of improvement, because certain of our health units get well over 90 per cent. I am thinking, for example, of Perth, where Dr. Tamblyn has developed a program; they are up to around 92 or 93 per cent immunization in that area.

Anything we can do to back up the efforts of the medical officers of health and their staffs and the schools and the doctors in the community will obviously be in the best interests of the children. It probably costs us about $5 or $6 to immunize against poliomyelitis, compared with the tens if not hundreds of thousands of dollars it costs us to maintain somebody throughout his lifetime as a result of the effects of paralytic polio. I think I'll come back to that.

On the OHIP side, Mr. Chairman, the growth and utilization continues to the point where we now, in the health plan, are paying on average about 250,000 claims every working day for services provided to the populace of the province. That works out to better than seven or seven and a quarter claims per person per year, which is something in the order of about a 30 or a 35 per cent increase in the use of health services in the last five or six years.

You will recall, I am sure, going back about a year ago, the predictions which were being made at that time, that the numbers and percentage of doctors opted out, or not participating directly in the health plan, would hit 30 or 40 per cent. There are a number of references in Hansard attributable to a spokesman on the opposition side of the House.

I am pleased to say the number and percentage of nonparticipating physicians did peak in February as had been predicted at this time last year. I'll come back to why that prediction was made and the significance of February or the first quarter of the year. In fact, it has actually been reduced slightly in the last eight months. At present, 17.8 percent of the physicians are nonparticipating, which is the same as it has been for the last couple of months, but is down from the 18 which was the peak in the first quarter.

As a matter of fact, I am glad you made that observation, because it is interesting to note that between 1973 and the present day the population of Ontario increased by eight per cent, but the number of physicians in the province increased by 19 per cent or approximately 2,000 in a six-year period. Not only do we not have increasing numbers of doctors opting out or nonparticipating-it has stabilized-but we have more physicians participating in absolute numbers and in terms of ratio to population than we had six vears a!!o.

I'll be answering that tomorrow.

It took a lot of time.

I think there are a number of factors that contribute to that, which we have discussed before.

Certainly, there is an increase in physicians. As you know, my predecessor made the estimate about four years ago that every time a new physician came on the roll, as it were, it cost at that time about a quarter of a million dollars per physician. I've not tried to Cost it but it's probably closer to $350,000 to $400,000 per physician per year now.

Who could be more deserving? As you know, in June we settled on a new mechanism for negotiations which is currently in use, and the negotiations are under way. I think the fact the situation has stabilized in the last eight months lends even more weight to what I was saying a year ago about the expiration of the AIB program.

You recall, as far as the application of that program is concerned with respect to doctors, they individually came out from under AIB controls, depending upon when their first fiscal year after April 14, 1978 occurred. At this time last year I was predicting the numbers would peak in the first quarter. They did. They have slipped back a bit since then, and I am optimistic that when we finalize our negotiations there will be a further significant recession in those numbers. But I would emphasize again that, notwithstanding those figures, we have more participating physicians in the province than we had six years ago.

I'll be answering that tomorrow.

This is something that I'm sure there'll be a chance to discuss further next week when the leader of the third party is here. I'm looking forward to that discussion.

I hope.

More heir than apparent. Speaking of drama, hype and anticipation, there's been an awful lot of drama built up around the province over the last couple of months about these tours that were being conducted by the leader of the third party, the critic and certain other members.

We must compare clippings some day. I have to say that if this material which was released this morning is the end result of all that, it's absolutely pathetic -that party would start out having decided what they wanted to find and, not being able to find facts to support the theory they wanted to put across, they then had to resort to this very, questionable series of allegations this morning. I'd like to just go through them one by one, and we'll have more to say on this next week.

You make certain statements. I'm not about to let half-truths or untruths go unanswered.

Oh yes it is; it's quite parliamentary.

The first thing is that at several points in the statement of, and in the questions which were put to, the leader of the third party afterwards he kept referring to medicare as something which the NDP created, referring to Saskatchewan. I wish, if he wants to use Saskatchewan as his model that he would look at Saskatchewan and what is actually happening in Saskatchewan.

Recently, as I've just been discussing, there's been a lot of attention paid to the number of non-participating physicians in the province or opted-out physicians. Some people have even gone so far as to try to leave the impression that the numbers continue to increase, which of course is not the truth.

It's not the truth.

That the numbers of physicians opting out or non-participating continue to increase. In fact, as I've just explained to you, they've actually receded slightly.

How many more doctors do you want to drive out of Windsor? You've already driven out one neurosurgeon; how many more do you want to drive out of that city?

We'll come back to that, yes. The fact is that in the province of Saskatchewan today between 30 and 40 percent of the physicians practising in that province are extra-billing some of their patients for some services, which is what is known euphemistically as mode three.

I always know when the NDP are on weak ground when they start to get silly. Obviously, they must feel their feet sinking out from under them.

I'm sorry, I thought you were talking about Saskatchewan.

Let's talk about Saskatchewan for a moment, because you like to hold it up as the example of what you did, your great achievement, what a wonderful thing it is and what a great example for the country. There you've got between 30 and 40 per cent of the doctors under mode three, extra-billing for some of their services.

Since 1962 there have been three modes available to a physician. He could either bill the insurance commission directly or he could, and still can, bill a third party carrier directly at the same rate as the, I think it's called the MCIC, and they would in turn be reimbursed by the MCIC; or-and this is where the 30 to 40 per cent fit in-they can elect to charge some of their patients some of the time for some services. Of course, they could provide a couple of services to a patient on a given day and bill MCIC for one of them and bill the patient for the other and he collects back the MCIC payment and actually pays the difference.

That's, of course, not talked about very often by the leader of the third party because I suppose that might be construed by some as being a form of opting out, and in fact was even defended by the leader of the New Democratic party in that province, who happens to head .the government, Premier Blakeney, in an extensive interview with the Regina Leader-Post, I think it was February or March, as an appropriate mechanism to ensure the maintenance of the freedom to practise medicine and as a form of, I think he called it an escape valve, that they could tell if there was a difficulty in negotiations or in the relationship with the profession. That sort of thing, of course, is never talked about.

Yes, I think somebody had better. If you're going to promote a particular model then we'd better understand that model.

There's also the fact that in a conversation I had with the Deputy Premier of Saskatchewan over the summer it was interesting to note that most of their doctors in the province are, in fact, from overseas.

I'm suggesting that what happened, in fact, was that they have had a problem in retaining their physicians in the province. TO my knowledge, they are all of the last provinces that still promote their immigration into the province from overseas.

NO, that's not the point at all. You’re missing the paint altogether, but that's not surprising.

I’m suggesting that it should be possible-and it certainly is possible in most provinces -to meet our physician requirements from the resident and landed immigrant population of the country rather than having to go overseas to find our physicians. That's what I’m suggesting.

What amazed me I've read the clippings and I’ve read very carefully the material which was released this morning and, for instance, they start off in the material this morning talking about Hamilton. When you went to Hamilton, as just a matter of interest, did you go to MUMC, the McMaster University Medical Centre?

Did you go to the perinatal unit?

What did you think of it?

Good. It didn't came out that you looked at things like the perinatal program, or that you went to Saint Peter's or to Chedake and looked at the chronic care programs there, or that you Went to St. Joseph’s and looked at the coronary care program there, or that you took a look at the chronic home care in Hamilton or the existing patient coordination services-

The paint is I’m not sure which number it is but I think it's number four or number five or Murphy's Law, that if you fiddle with same thing long enough you’ll break it. Of course, the third party started out with a…

No, listen; if it touches home. The paint is that the party to my extreme left, which is only appropriate, started out with a particular thesis which it felt hard-pressed to try to substantiate. The fact of the matter is that if you go to Hamilton you’re going to find there, in the perinatal unit at McMaster University Medical Centre, a program which has saved, now, literally dozens and dozens of extremely fragile and very small premature babies. You are going to find programs at St. Peter's in Chedake that have not only added years to people’s lives, but have added quality to people’s lives in those extra years.

You are going to find in the oncology programs, in the cardiovascular programs, in the orthopaedic programs, in the Civic and St. Joseph’s programs, steps which have relieved a great deal of human suffering. None of that is mentioned.

When you went to Thunder Bay, did you go and take a look at the new cancer clinic which I opened last year? Did you go and take a look at the new CAT scanner at McKellar Haspital in Thunder Bay? Did you go and take a look at the new 100-bed Heritage Villa Nursing Home in Thunder Bay? Did you go and take a look at any of these programs, such as the chronic care program in Thunder Bay? It never comes out.

This is the amazing thing. Apparently you did all this in two weeks time, yet people who have spent years in running hospitals in the health care system, people who have spent years working in the ministry to help in the development of programs, people who have spent years in accreditation reviews of hospitals, aren't finding that the system is falling down around our ears, as you would like everybody to believe. In fact, the system is alive and well and functioning better than it ever has.

In here you talk about Atikokan. You say in your statement that three doctors in Atikokan have to take their holidays in the area so they can be available for operating room work in case of emergencies. We checked this out with Dr. Copeman, who turns our underserviced area program-and did well at that, I might add.

He indicates to me we ha\'e two doctors in that area who are operating in the underserviced area program and that meets the needs of the area.

We have what is called a locum pool. That is a mechanism by which we provide people to go into these communities to allow the physicians to get away for holidays O'I' continuing education. Yet we have never had a request from Atikokan and that pool is well known.

The most amazing thing is to read your comments on Elliot Lake and Blind River.

I understand that when you first approached the hospital-when would that have been, May?-you were told-and I think you made the call yourself, Mr. Breaugh-there were no problems there but that if you wanted to come that was fine, it was up to you.

I visited Elliot Lake on September 22 or 23, at which time I met with the boards of the Elliot Lake and Blind River hospitals. You may know that both hospitals belong to the Sisters of St. Joseph of Sault Ste. Marie.

At that time the chairmen of the two hospitals handed me a role study for which they had asked me for funds to carry out last winter and which the ministry had agreed to pay for. I am trying to remember who did the study for them; I think it was EHE, a firm in Ottawa. That role study had not only been endorsed but recommended by the boards of both the Blind River and Elliot Lake hospitals.

I saw the administrator of Elliot Lake and the chairman of the board again at the small hospitals conference on September 28, which means it would have been September 21 that I was in Elliot Lake. But rather than what you describe, they propose to reduce the number of beds in the two hospitals by one third-from 4.5 beds per 1,000, which is where they are presently, to three beds per 1,000.

They proposed that there be fewer nursing home beds in the district than even !the minimum guidelines we use would provide, and fewer chronic-care beds than even our minimum guidelines would provide.

To do this, they go on to propose a series of outpatient programs at the hospital for day surgery, programs for addiction of various kinds in the community and expansion of the role of the health unit. I may say that that particular health unit has been given the go ahead to form a chronic home-care program in that particular area, which will be expanding into the Elliot Lake part of their district.

That's coming from the people who own, who run and who from day to day are responsible for those hospitals. It is not the kind of material that you get from a one hour swing through there for lunch with the assistant administrator. I think you were there on September 28. It's quite a contrast.

I might say that in the exchange this morning the leader of the third party zeroed in on Sault Ste. Marie. Obviously, he is not aware that a contract has been agreed upon by the Sault clinic and the ministry. He correctly pointed out that the Sault clinic has had a very positive effect in that community, not only on the status of the health of the people but in terms of hospital utilization. As you will know, because I know you have read extensively in this area, our rate of hospital utilization in this province is much higher than in many jurisdictions to the south of us.

In fact, if you compare the average rate of hospitalization in terms of patient days per one thousand population among the patients of health maintenance organizations in the United States, it's something like 500 days per one thousand population per year there, while we're presently running in excess of 1,300 patient days per thousand population per year. That's quite a contrast.

The Sault clinic, in going on 18 years of operation, has had a very positive influence in that community. Some of the estimates range as high as 40 per cent fewer patient days. I may say too, that the rate of hospitalization in the province overall has gone down as well, if I can remember the figures correctly, by something in the order of 13 per cent in the last six years.