In considering the situation which could develop from the abandonment by the federal government of its responsibility, or at least this step in that direction, it is interesting to look at the way in which medical services are provided in the United States. One of the things which makes me proud to be Canadian is the envy with which this country is looked upon by others with regard to the way we provide medical services. We have a long way to go, but at least there is a degree of sensitivity and civilization in seeing that those people who are poor and without adequate medical services are cared for. Somehow, that in a sense distinguishes the Canadian character and it is no coincidence that Senator Kennedy was here recently investigating the way in which we provide medical services.

I found it shocking that doctors in California thought it necessary to withdraw services because the premiums for their liability insurance were so high. In the state of California a person under the medical program can go to a doctor on a reduced premium system, but the doctor does not have to accept that person; so there are people in California crawling from one doctor to another asking to be taken as patients. There are a number of doctors who take them, and a number who do not. The good doctors who take them are flooded with patients under the medical program. That is not the kind of service we want for Canada, and neither does our medical profession.

I will not deal with the Saskatchewan strike because I think it raises issues which are unnecessary to dig over any more. Probably the parties in that dispute have learned something in terms of a humane and civilized approach. I do not think there is any need for the medical profession suddenly to go on salary or to become civil servants, but the profession and the government should examine the possibility, particularly for remote areas where there is difficulty in getting doctors, of community clinics and the provision of specialty services through the community clinic system. There should also, perhaps, be a lateral service so that a patient can decide whether he wishes to use the government community clinic or private medical services. That kind of pilot project is certainly worthy of examination.

With regard to cutting costs, we should examine the amount of equipment in private doctors' offices and the amount of intensive use it receives. There are many medical clinics in this country with laboratory and x-ray equipment receiving little use compared with equipment at the hospital level. There should be some thought given to the rationalization of the very expensive equipment which doctors have to buy and the total cost of medical services as a result. You do not have to get into this business of making a unilateral decision not to share the medical costs above a certain level. In British Columbia, a few pilot projects for home nursing care have started to cut medical costs. In this way people are released from hospital earlier and beds become available.

● (1640)

The reluctance of the medical profession to make home visits is understandable. It is much more convenient for a doctor to visit his patients in hospital, especially if they are all in the same ward. The fact is, however, that such a system is extremely expensive and the cost per hospital bed is high. Home nursing, with adequate care provided, reduces the costs substantially, so the provision of additional delivery services does not always mean an increase in costs.

I think the decision unilaterally to refuse to participate in expanded programs—because that is really what the bill is about—exposes a philosophical departure by the Liberal party. It exposes the bankruptcy of the just society that was so successful in this country around 1968, and it exposes a level of pragmatism that disappoints those of us who have been proud of the health delivery system in Canada. I should like to be able to continue to point out, when I travel abroad, that Canada has a fine medical services system even though it needs improvement in a number of areas. We certainly are not leaders in the field when compared with some of the Scandinavian countries, but we have been proceeding in the right direction. I think this departure is something that the government will regret, Mr. Speaker.

[Mr. Leggatt.]

PROCEEDINGS ON ADJOURNMENT MOTION

[*English*]

SUBJECT MATTER OF QUESTIONS TO BE DEBATED

The Acting Speaker (Mr. Turner): It is my duty, pursuant to Standing Order 40, to inform the House that the questions to be raised at the time of adjournment are as follows: the hon. member for Moose Jaw (Mr. Neil)—Government Administration—Government position on contribution to crop insurance fund; the hon. member for Winnipeg North (Mr. Orlikow)—Anti-Inflation Board—Reason for reducing amount of wage increase for University of Toronto library workers; the hon. member for Dartmouth-Halifax East (Mr. Forrestall)—Penitentiaries—Maximum security psychiatric institutions—Status of institution proposed for Dartmouth.

GOVERNMENT ORDERS

[*English*]

MEDICAL CARE ACT

AMENDMENT TO LIMIT ANNUAL INCREASE IN PER CAPITA COST OF INSURED SERVICES UNDER MEDICAL CARE PLANS

The House resumed, from Monday, February 2, consideration of the motion of Mr. Lalonde that Bill C-68, to amend the Medical Care Act, be read the second time and referred to the Standing Committee on Health, Welfare and Social Affairs.

[*Translation*]

Mr. Armand Caouette (Villeneuve): Mr. Speaker, I decided to rise on this bill because I think it may enable us to understand the illness gnawing at the economic health in Canada.