Since the Prime Minister did not adequately respond to this question, except to say that there are obviously contingency plans—he did not spell them out—we can conclude that the provinces are to be left holding the bag. This would essentially leave the provinces with two choices. They could raise revenues through their own taxation powers and continue to meet these costs, or they could cut back on some of the valuable services they are presently providing. The first alternative would only be available to the wealthier provinces in Canada; the second would most likely be the end result for the majority of the provinces, and provinces like Newfoundland, New Brunswick and Prince Edward Island would suffer very much.

In view of the statement of the Minister of National Health and Welfare on June 17, that Bill C-68 would now be more palatable as a result of the first ministers' conference, I put forward the following points to the minister. The federal proposal to the provinces would entail a transfer of a certain number of tax points to the provinces. Surely the minister and the Prime Minister realize that transferring tax points, particularly if these revenues are equalized only to the national average, will mean reduced federal contributions to rich provinces such as Manitoba, Saskatchewan and British Columbia.

In addition, we must seriously question whether per capita contributions to the provinces will be appropriate. The minister must be aware that costs—I refer here to health costs—may be higher in some provinces as a result of any number of factors. This being the case, I can only envisage a situation whereby we shall not have any national standards in terms of health care as a result of all provinces receiving the same per capita contribution.

When medicare first came in, if I recall correctly there was an equalizing factor to it. People born anywhere in this country received an equal standard of medical care. If this bill goes through as it is—and we have a majority government; we know that we cannot block the bill indefinitely—I am convinced that there are people in outlying areas of Newfoundland, the hinterland of New Brunswick, in northern parts of Canada and in other remote parts of Canada—who are entitled to the same benefits as a child or a sick person in the cities of Toronto or Vancouver—who will not receive the same standard of medical care. In this House we legislate for the whole of the country and not just for any particular province or city.

Nothing has happened since this bill was introduced months ago which has caused me or my colleagues to lessen our opposition to it. Bill C-68 was designed to place a ceiling on the federal government's contribution to the medical care program. Essentially, it is a first step in dismantling the health insurance program of this country. Based on the little we have been able to find out about the intentions of this government with respect to replacing the current cost-sharing agreements, it seems evident that it has every intention of placing the burden of health care on the provinces.

I would like to digress without straying too far from the bill. In the United States, where they tout the great free enterprise approach to medical care, not only is the cost of professional medical care—that of physicians and hospitals—much higher than the cost in Canada, but private insurance premiums are also much higher. Are we going to revert to that kind of program in this country? I hope to God we are not.

I would like to reiterate what I said during debate on second reading of this bill. The Minister of National Health and Welfare pointed out in late January that Canadians enjoy one of the best health systems in the world. While this is true, much of the credit goes to the provinces, two of which—Saskatchewan and Manitoba—have instituted programs such as dentacare, free drugs, the provision of hearing aids and the like. While these progressive provinces are to be congratulated, in my view we must keep in mind that if Canada is to achieve a high uniform standard of health care right across the land, the federal government will have to become more involved in these programs, not less, as it is attempting with measures such as Bill C-68 and new cost-sharing agreements. I can well appreciate this government's desire to cut down on its expenditures. However—and this has been said before—if we must cut government spending, let us pinpoint those areas in which we can most afford cuts.

● (1430)

The federal government's contributions to the provinces under the Medical Care Act have, in fact, been rising in very modest proportions in the past few years. For example, in the 1972-73 fiscal year the percentage increase in federal contributions to the provinces was 7.6 per cent; in 1973-74 the increase was 8.8 per cent; and in 1974-75 it dropped to 6.6 per cent. I do not wish to suggest that these are small sums of money, but at the same time I find it incomprehensible that in times of supposed restraint, when we see the private sector spending millions of dollars building mammoth hotels and office buildings, some of which are currently not being used, we are closing hospitals in the name of restricting government expenditures.

The Minister of National Health and Welfare may say that hospital closings have nothing to do with federal measures such as Bill C-68, but I would point out to him and the government that medical care and hospitals are financed out of one budget in each of the provinces. When you combine restraint in Bill C-68 with the load of current programs not included under federal cost-sharing, and add to it the uncertainty concerning the future terms, for example respecting cost-sharing hospital costs, something in the provincial health budget has to go. Several hospitals in Ontario have either gone or are on the verge of going, although I hope some of them will not.

While it is extremely difficult to understand the reasoning behind the current round of hospital closings—if in fact there is any reason—two incidents which recently occurred in Ontario serve as examples of how federal financing priorities can affect a province. The provincial Tory government announced that two psychiatric hospitals—one in Goderich and one in northern Ontario—are to be closed and the buildings are to be used to treat the mentally retarded. Psychiatric hospitals are not included under federal cost-sharing; centres for the mentally retarded are.

These psychiatric hospitals were not closed because of a reduced need for them—in fact, all information points to their being run efficiently and usefully—but because the provincial government simply felt it could not afford them

[Mr. Blackburn.]