How do we renew our health care system to meet the needs of consumers in a cost effective and efficient manner? What are the implications of allowing greater private funding in our health care system?

There is concern in Edmonton East that private funding competing with a public system will create a two–tier system where access and quality will be based on ability to pay rather than medical need.

To the ideologically driven in Alberta, an increased private presence in the funding and delivery of health care is the answer to controlling costs and improving accessibility. But is it? In the industrialized world, the United States is the best example of a health care system which relies extensively on private funding.

Let us examine the U.S. health care experience in more detail. More private money in the U.S health care system should result in a better standard of health care for Americans but clearly that is a myth. A significant amount of health care spending in the United States is to support an extensive bureaucracy that has evolved under a multiple player system. The average American under a private insurance scheme pays $150 a year in administrative costs alone, compared to $23 for the average Canadian.

Respected Canadian health care economist Robert Evans put it most succinctly when he stated: "Canadians provide care. Americans shuffle paper". Not only is the U.S. health care system plagued by skyrocketing administrative costs and a bureaucratic jungle, it is also plagued by inequities and lack of access.

For older Americans, 65 years and over, out of pocket costs consume 23 per cent of their household incomes. For older Americans with family incomes below the poverty line, out of pocket expenses consume 37 per cent of their incomes. Most telling, the number of Americans who are uninsured continues to grow at an alarming rate. Nearly 40 million Americans or 15.3 per cent of the population had no health insurance coverage at all. The total number of uninsured American children under the age of 18 is 9.5 million or 24 per cent of all American children under the age of 18. The total number of uninsured Americans earning an average family income of $15,700 is nearly 15 million.

This leads me to a second element that private funding components have failed to address adequately: the ability to control health care costs. Cost containment is a necessity if health care is to be sustained and preserved in today's fiscal climate but cost containment in health care is not achieved by shifting the cost burden on the Canadian consumer through de–insurance, de–listing or user fees.

The Deputy Speaker: The member's time has expired.

Ms. Hedy Fry (Parliamentary Secretary to Minister of Health, Lib.): Mr. Speaker, I am very pleased that the hon. member asked this question. As she said before, medicare is a defining value of Canadians. Eighty–nine per cent of Canadians support medicare. All the ministers of health in every province support medicare, with the exception of Alberta.

Medicare is unique to this country because it is based on clinical need and not on the size of your wallet. It is a Liberal value. Medicare was brought in by a Liberal prime minister. A Liberal minister of health, Monique Bégin, brought in the Canada Health Act which defined the five principles and set a series of limits on how they are used.

One of the important things about medicare is that the government, being a Liberal government, is committed to medicare. We are committed to a predictable funding of medicare in the new Canada health and social transfer. We are committed to working with provinces to ensure that we find innovation and creativity in dealing with some of the pressures that are now facing medicare.

We will work in a consistent, cohesive and coherent manner to find all of the answers within the Canada Health Act.

I want the hon. member to know that this government is the first since the enactment of the Canada Health Act that actually has taken non–refundable deductions from provinces: British Columbia, Manitoba, Nova Scotia, Newfoundland and finally, Alberta.

We have a concern about the growth of two–tier medicine. User fees are not on for this government. The program is based on clinical need. If we are going to continue to make medicare important, we are going to have to look at issues such as evidence based medicine such as moving from prevention, from lifestyle based diseases and—

The Deputy Speaker: The motion to adjourn the House is now deemed to have been adopted. Accordingly the House is adjourned until tomorrow at 2 p.m.

(The House adjourned at 8.04 p.m.)