heading "Public Medical Care". Since that time there have been changes—$20 per capita, tax points and the Canada Assistance Act—but in no way do they change those basic rules.

There are five types of health care. First, there is intensive care for people who are very ill. There is active treatment. Costs for active treatment run from $100 to over $200 per day. Patients are transferred as quickly as possible to chronic care at $40 to over $100. They are transferred from there to an extended care home, which runs to about $14.10 per day. We then have home care, which at the present time is on a trial basis. There are three pilot projects underway in the province of Ontario in three major cities, but what the results will be I do not know. In any event it is a patchy thing right now.

● (2212)

Home care is only for short periods, obviously designed to keep costs down. The transition is made as quickly as possible from stage one to stage four, keeping in mind the patient's condition. Many of the extended care homes do not have the necessary equipment for treating minor illnesses, or conditions such as emphysema or cardiovascular disease. They do not have the ability to render oxygen occasionally to bring up a patient's oxygen level. As a result, the patients have to be transferred back to the hospital under emergency conditions by ambulance with all the attendant increases in cost and inconvenience to the chronically ill.

This situation should be remedied without delay through the provision of a sick-bay in the extended care homes and trained personnel who know how to operate an oxygen tank safely. This surely could be done as it is now under the home care program with certain instructions, warning signs and intelligent personnel in charge. I hope I have made myself clear in this regard. I am sure the minister is an intelligent lady and will see that the act is carried out responsibly, cutting costs by efficient methods which will improve medical care without cutting quality.

There is one other thing I should like to add which is perhaps not relevant, and I apologize in advance. I do not believe court orders in respect of the production of a patient's history should be issued at any time except under extreme conditions. If a patient's chart is required the patient should be contacted and asked to sign a consent form. In that case the doctor can release the patient's case history. We must make every effort not to break up this relationship that exists between a doctor and a patient. If the relationship is broken up there will be a deterioration in respect of histories. No doctor who has been given information by a trusting patient will include that information in a case history, particularly if there is any danger that such information may be used adversely against that patient.

**Mr. W. Kenneth Robinson (Parliamentary Secretary to Minister of National Health and Welfare):** Mr. Speaker, at the outset I should like to say that the government is quite aware of the doctor-patient relationship and would certainly not like to see this hampered in any way. This is a point well taken by the hon. member for Simcoe North (Mr. Rynard).

What the hon. member has pointed out is that there may in fact be a gap in services. Although he knows that the present plan provides for quality, portability and comprehensive service, there may in fact be gaps in carrying this out. The hon. member speaks from his extensive knowledge and experience about intensive care, active treatment, extended treatment, chronic care and home care. All these have to be kept in mind when we are considering the kind of health care citizens of Canada need, expect and are entitled to. The hon. member has made this very clear.

I am pleased to comment on the important concerns raised by the hon. member for Simcoe North. His continuing and learned support for the provision of high quality and cost-efficient health services, particularly for Canada's senior citizens, is well known to all members of the House of Commons.

This government, in collaboration with all provinces, has in recent years been promoting the development of alternative forms of health care so that the high costs and trauma associated with transferring patients to costly forms of hospital care can be avoided. The hon. member has pointed this out very well.

Detailed discussions have been held for a number of years about the possibility of increased federal financial support for lower cost forms of health care such as home care. These discussions culminated with the introduction, as of April 1, 1977, of the extended health care services program. Through this program the federal government provides a substantial financial contribution to assist provinces in the provision of many forms of lower cost health care.

● (2217)

Specifically, this new program provides all provinces with assistance in the provision of nursing home and adult residential care, home care, and ambulatory health care services. For example, this program encompasses the provision of home oxygen therapy for persons suffering from chronic heart diseases and emphysema. As well, the federal financial contribution will assist the provinces to provide renal dialysis in the home, rather than in expensive hospital settings.

I should like to make one other point. The licensing and inspection of hospitals, nursing homes and other institutions providing care to the sick and disabled is, of course, a provincial prerogative under our constitution, as is the responsibility to ensure that adequate standards are met. Nonetheless, the minister is always prepared to discuss with provincial counterparts such important matters as the standard of care to extended care patients in nursing homes. The technical advisers of the Department of National Health and Welfare also are available to provide assistance to provinces in developing programs and standards of care.