ters and that these include health care programs. The Minister of National Health and Welfare, the hon. member for Outremont, subsequently informed the House that there has been under consideration, a proposal for change in the federal-provincial financing arrangements which will be discussed at a joint session of federal and provincial health and finance ministers which will be held January 19.

If these deliberations reach a satisfactory conclusion, we are confident that the provinces will have a much better framework within which to develop health care programs which are not only efficient and effective but also in accord with their respective priorities. These goals can and should be achieved within the broad framework of existing national health standards of the present hospital insurance and medical care programs, relating to comprehensiveness of insured services, universality, accessibility and portability.

In view of the obvious priority which has been given to this matter by the federal and provincial ministers most directly involved, I am certain hon. members would wish to be given a review of developments to date in order that they may understand the importance of these deliberations and be able to take an interest in the eventual outcome. Recently elected members of the House might not yet have had time to completely familiarize themselves with the issues involved, and for them in particular I hope my remarks will be helpful.

The hospital insurance and diagnostic services program implemented in 1958, and the medical care program which commenced in 1968 together account for the bulk of our health care expenditures. These two programs are currently costing the two senior levels of government about $3.5 billion annually. These costs are shared about equally between both levels of government, but the cost-sharing formulae provide a higher percentage of federal financial support to provinces with lower per capita costs, and somewhat less than 50 per cent in the case of provinces which have per capita costs which are higher than the national average.

• (1720)

It is worth while recalling that during the 1950s many hospitals were in serious financial trouble and that many sick persons were not able to obtain necessary treatment because of financial barriers of one sort or another. The hospital insurance and diagnostic services program was implemented in 1958, which subsequently made it possible for all Canadians to receive necessary hospital care of an acceptable standard, on a prepaid basis. Generally speaking, the system has been functioning fairly well, it has met the objectives set for it at that time and the vast majority of Canadians receive care that is adequate for their needs without incurring excessive financial burdens. However, such factors as the increased complexity of hospital care, with advancing technology, the increased availability of hospital beds and improved remuneration for hospital staff have all contributed to a relatively high escalation year by year in the cost of hospital care.

Since the program recognizes, for cost-sharing purposes, only specified hospital services, it does not encourage the development of adequate alternative forms of care at lower cost for those patients who could be treated just as satisfactorily but in a less expensive way than by occupying expensive, acute care hospital beds. With proper arrangements, there need be no compromise in the quality of care actually provided for such patients. Surveys have indicated that as many as 30 per cent of the patients occupying beds in general hospitals could be adequately cared for on some other basis if the services they require were available without financial penalty to the patients themselves. We have tended to be rather lavish with providing health care through hospitalization, particularly through the use of high-cost beds. For example, we have per capita more active treatment hospital beds than there are in the United States.

Our second major health insurance program, the medical care program which was introduced in 1968, was based largely on the findings and recommendations of the Royal Commission on Health Services, the Hall report which was submitted in 1964. This commission, which was appointed in 1961, undertook a most comprehensive and detailed assessment of Canadian health services. In its major report submitted in 1964 it reported that it had found that while nearly 60 per cent of Canadians had some insurance protection against the costs of medical care, approximately 30 per cent of it was totally inadequate. Medicare was established to solve this problem.

The open-ended nature of the federal-provincial financing of these programs is now a major point of concern. No limits are placed on the health services which an insured person may receive provided the criteria of medical necessity are met. This is a fair and just provision. However, neither program provides sufficient flexibility for the provinces to develop alternative and less costly forms of health care consistent with the needs and priorities as perceived by the provincial governments. The nature of the current sharing formulae is such that the provinces only obtain sharing for certain specified services, and thus there is an inadequate incentive to cut costs and provide less expensive services.

Controlling the escalation of the costs of our two major national health insurance programs has become one of the chief priorities of all levels of government. During the last three complete fiscal years the combined average annual rate of increase in the cost of the two programs has been about 13 per cent. This rate of increase significantly exceeds the growth rate of our gross national product. The rate of escalation must be reduced, for obvious reasons. We must take steps to ensure that we are receiving the best possible value for our health care dollars.

The federal and provincial ministers of health have been for some time deeply involved in studying ways and means of resolving these problems. For example, in November, 1968, we appointed a federal-provincial committee on costs of health services to recommend what steps should be taken to contain costs without having an adverse effect on the quality of care. The report of the committee and its seven subsidiary task forces was presented to the conference of health ministers in November, 1969. Most of the areas where improvements could be effected naturally lie within the provincial sphere of responsibility in so far as implementation is concerned.