near future to discuss the roles of the federal and provincial governments with respect to how medicare programs should be funded in the future. At least, that is what we have been led to believe. The fact is that the conference should have been held before, and not after, Bill C-68 was introduced, and if a consensus could not be reached in one conference then there should have been several conferences.

Over the past year we have heard that the government's position on shared-cost of medicare is not negotiable. I suggest this is the reason for the lack of consultation on this important issue. What the *Medical Post* warned against has happened. The federal government has resolved the issue of medicare for Canadians to a question of pure economics.

Mr. Speaker, the provinces and the federal government have had enough experiences with medicare and hospital insurance by now to be able to assess these programs on the basis of real data. We have found out where the areas of high cost are and we have already begun to find ways to deal with these high-cost items. But before we can even start to explore these new avenues the government declares the it wants out of the scheme and that its decision is non-negotiable.

We have arrived at a point where it is more important than ever for the provinces and the federal government to sit down and talk turkey about shared-cost medicare. We have learned in the past few years that the major causes of the high cost of medicare and hospital insurance are hospitals themselves and doctors. The high capital cost of building hospitals, plus the cost of maintaining them, is one major area of high medicare costs. We have also found that there are many thousands of people being treated as in-patients in hospitals who can receive the same treatment in clinics and doctors' offices. Some provinces, including Ontario, have already taken steps to correct this situation and thereby reduce the cost of maintaining hospitals, while at the same time maintaining adequate service and treatment.

● (1600)

The other area of highest cost in medicare is doctors. In fact, the cost of doctors' services has been pinpointed as the major item of cost in medicare, and the solution to this problem is much more complex and complicated than in the case of hospitals. We cannot simply say that we are going to limit the number of doctors coming into the profession or that we are going to eliminate a certain number already practising.

It has been estimated that the cost of introducing a trained and qualified doctor into the medical profession is far greater than to introduce a person into any of the other professions. I am talking, of course, about the expense to the public. For instance, it is estimated that the cost to the public for a new physician entering the profession is approximately $50,000 for his services, plus another $100,000 for in-patient hospital care, laboratory services and other services. There is another $100,000 of public expense connected with the training of the physician, which includes internship and specialization in our hospitals.

When we think about reducing the number of doctors entering the profession, we must weigh this against the danger of reducing availability of health care to our people. The problem of too many or too few doctors varies from province to province, and even from area to area within provinces. So we just cannot adopt a policy aimed at reducing the number of doctors in active practice or the number of doctors participating in medicare and say that this is the solution. It might work for a few months or a year, and then we would probably find ourselves with a shortage of doctors at a time when we need more of them.

It has been suggested that the federal government should place some restrictions on the number of doctors emigrating to Canada. It has been proven that in recent years the influx of doctors to Canada has placed restrictions on the number of qualified young Canadians who want to enter our medical schools. In fact, there is a direct connection between the number of trained doctors entering Canada each year and the number of Canadians who are allowed to enter medical school. I do not know whether the restriction on doctors entering the country would be the answer, or even part of the answer, but I do know that this question cannot be answered in any way except by direct consultation between the federal Minister of National Health and Welfare, the Minister of Manpower and Immigration, the provincial health ministers and experts from the medical profession. We can arrive at a satisfactory solution to this problem, but it cannot be found if the federal government simply throws up its hands and tells the provinces that they will have to go it alone.

I should like to read into the record part of the statement made by my colleague, the hon. member for Elgin (Mr. Wise), as follows:

> It should be noted, Mr. Speaker, that opposition to Bill C-68 is not restricted to the provincial governments, but that such groups as the Canadian Medical Association and the ten provincial medical associations stand firmly against it. The Canadian Medical Association takes the justifiable position that these arbitrary budget controls will produce definite hazards for Canada's health care delivery system. They state that the budget controls will have the effect of restricting the availability of health care to the point at which it would have to be rationed. Obviously such an action could endanger the quality of medical services available to Canadians.
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> In a letter to the minister, a letter which has apparently been ignored, Dr. L. C. Grisdale, President of the Canadian Medical Association, says:
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> "The permanent cost increase ceilings proposed will result in the rationing of medical care; the cost increase ceilings will inhibit, if not prohibit, the introduction of new medical procedures and make it impossible for them to be made available to all Canadians who would benefit from them. This will be particularly true for those Canadians who live in less wealthy provinces—frequently those areas where improvements in the health care delivery system are most needed.
>
> The effect on the 'have-not' provinces is particularly significant. Since the introduction of medicare, these provinces with less developed health care systems have benefited from the federal-provincial cost sharing formula. The imposition of a ceiling on federal contributions will deprive these less wealthy provinces of further opportunity to improve the level of medical services in their communities. It will be impossible to evolve a uniform program of equitable availability and quality."

I think those remarks are very significant. We have arrived at a point in medicare where we are all going to have to get our heads together and work out the problems which have come up, and these will have to be solved in a way which will enable us to provide a level of medicare which is at least as good as that we have now, and in some ways we must make it even better. I am disappointed that the government has elected to make a decision on medicare