that it would take away that basic share, that simple straightforward notion that the provinces and the federal government would be equal participants in medicare.

That, of course, has turned out to be the truth. The shift has been downward. One can argue and of course many will that more dollars go to some provinces than others, that more dollars go now and the percentages may be less, but the truth is that most of our provinces are well below the shared equal funding technique that was used in 1977. Most of them have dropped to somewhere in the low to mid-thirties as a percentage of the funding for medicare that they get in their province.

In a place like Ontario, or Quebec, or any of our industrialized provinces that are very hard hit by this depression, there is an immense cash flow problem at the moment. It has put traumatic squeezes on a number of things, and one of them is medicare.

As a critic who had an opportunity in the 1970s to go around and look at hospital and health care in Ontario—and many people here have had the same opportunity—as you go across Canada you will see some magnificent concepts in providing medical care. You will see some of the world's finest technology. You will see some of the world's finest practitioners. You will see some of the greatest facilities we have ever been able to conceive in terms of providing medical care in place. You will also see some of the problems that people talk about, hospitals across the road from one another that do not even talk to one another, let alone co-ordinate the care that they provide as new technology comes into the field of health care.

Vast expenditures of money are needed now that were not even conceived of 20 or 30 years ago. We have equipment that costs $1 million or $2 million just in capital costs to get the equipment in place. Then of course one facility wants to have exactly the same kinds of equipment as the facility across the road, and across Canada.

Many people have tried their best to co-ordinate the provision of health care services, to provide district health councils, to look at community health care clinics, to look at health care centres, to provide for prevention, to look at a number of ways in which one could be more cost effective in the providing of medical care for our citizens.

It is not an easy task and there are those who work in the health care field across Canada who have been aware of this for many years now and have been trying to improve the use of tax dollars. They know it is difficult. There are a number of vested interests at work that have key decision-making positions.

I am often reminded that in many of our urban centres with high-tech facilities, downtown Toronto being an example, some days you will find the world's finest physicians practising medicine, with great technology and great care, and great back-up teams.

Other days you will find virtually no physicians at work in that hospital facility and the care is provided by nurses, technicians and other people who have been given special kinds of training on special kinds of equipment.

The nature of the provision of medical care has changed a lot in the last two decades, and it is about to change a good deal more. Provincial governments all across Canada are struggling now to turn the provision of health care into something that is non-traditional.

In many parts of the country others who were the first people into the medical care system struggle, for example, midwives across Canada—even though it seems that the giving of birth is something that has been around for a long time, and midwifery as a profession has been around for a long time—have not been recognized for very long. In the giving of birth there is a range of facilities available, from midwives in the home to very high-tech units in urban centres.

We try to match up how we get people from rural areas or the far north for example into these high-tech centres and provide transportation systems that are useful. That is not an easy thing to do but I am aware that people are trying to do that. The unfortunate thing is to introduce a cost squeeze in the middle of this or to divert the argument into something like user fees as being a solution is unfortunate.

• (1530)

Now these are not new notions. They have been around for some time. For example, in many parts of Canada we have looked south of the border and we have said: "We are not going to establish some new technology in the provision of care for the human heart, when somewhere across the border there is a similar institution that has all of the equipment and personnel now.