definition of what is bilingual. Employees occupying "bilingual positions" must, unless otherwise exempted, meet the specific proficiency requirements of a given position. If they so meet those requirements, they are referred to as being bilingual when, in fact, it really means that they are proficient to the level required for that particular position. When the commissioner speaks of "phony bilinguals", he is basing his assumptions on his own personal definition of the term "bilingual": one which, however, does not exist in the public service.

In 1972 the then president of the treasury board explained that "bilingualism" means different things in different jobs. In some positions it means only the ability to deal with simple and straightforward questions in the two languages. In others, it means an ability to understand the other language well, but to speak it only passably well. Again in others it means an ability to speak and understand both languages as commonly used, whereas in still other positions it means a greater capacity to speak and understand both common and technical language.

● (2220)

Take for example two hypothetical positions requiring the use of both official languages: an elevator operator and a government negotiator. Obviously the language proficiency requirements for these two jobs will be different. If the occupants meet the language requirements they are said to be bilingual, according to the public service use of the word. According to Mr. Yalden's definition, however, the elevator operator whose job requires a very limited vocabulary to perform his duties could be a phony bilingual, although he or she meets the criteria for the job.

HEALTH AND WELFARE—FUNDING OF MEDICAL CARE PROGRAM

Mr. Bob Rae (Broadview): Mr. Speaker, I have raised several questions in this House concerning the medicare program, and I want to ask certain further questions with respect to that program. The fact of the matter is that the medicare program is one of the critical foundations and keystones of Canadian society at the present time. When it was introduced in 1966 it quickly became clear that it was something which the Canadian people not only wanted but expected.

We ought to look very carefully at the assumptions which underlie the Medical Care Act. There is the assumption that there would be universal medical insurance and that medical care and hospital care would no longer be dependent on one's economic strength in order to be able to survive and to have access to decent medical care. Since that time there has not been a clear commitment from either the provincial or federal governments or, I am sad to say, from parts of the medical community itself, to the principles that were established in the 1960s and that, indeed, go back to the experiences of the CCF in Saskatchewan in the 1940s and the 1950s.

The first watering down of this program came from the federal government. It is one of the ironies that the federal government convinced the provinces to go into the plan on the basis that there would be 50-50 funding, and then it turned around, when it became apparent to them that this was not going to be a free proposition and that it would cost certain amounts of money, and reduced their long-term financial commitment by passing the Established Programs Financing Act in 1977.

I might point out that we were the only party to warn the government at that time that the effect of introducing this program would be to reduce in the long run the commitment of our federal government to maintain the principles of universality and accessibility, which are the principles behind the plan. The federal government abandoned its role of being responsible in some way for the administration of the program and left that to the provinces.

In the course of the debate in 1976 the Prime Minister (Mr. Trudeau) said that he was taking a gamble, and the then minister of national health and welfare said at that time that it would be unthinkable for the provinces or for the federal government to move away from the principle of universal medical care. As I said earlier today, however, the unthinkable has happened and is happening, and the gamble has not paid off. The government now finds itself in the position of being faced with the erosion of a plan—and I am using the words of the Minister of National Health and Welfare (Miss Bégin)—and of not having the means and the capacity to deal with the problems in the plan.

The fact of the matter is that there are several problems in the plan at the present time. There are doctors leaving the plan and charging a surcharge of up to and over 30 per cent. People were coming into members' offices and showing us doctors' bills, wanting to know if they were forced to pay them. They wanted to know why their doctors were not in the plan. Those were reasonable questions and gave rise to very real fears for people who cannot afford high medical fees.

● (2225)

The second practice which concerns us is double billing and the provinces that allow it. In this case doctors are not only billing the medical insurance plan but are also billing the patients individually. This gets away from the principle which should have been protected by the federal government, that medical care does not depend on income. Citizens are insured either by the provincial program without premiums or the provincial program with premiums.

Finally, there is the question of deterrent fees. Some provinces have introduced fees for long term stays in hospital. In September, 1976, in Vancouver, the Leader of the Opposition (Mr. Clark) said:

> Health insurance today encourages people to abuse the system by making unnecessary trips to doctors—

He suggested that all or a portion of the cost of a doctor's visit should be shown as taxable income for the patient, and that something like a T-4 form could be issued. His solution was to make the patient pay for the visit in another way. It is just a deterrent fee by the backdoor and moves away from the principle of universality. It puts fear into the hearts and minds