House of Commons Debates

VOLUME 133 NUMBER 189 1st SESSION 35th PARLIAMENT

OFFICIAL REPORT
(HANSARD)

Thursday, April 27, 1995

Speaker: The Honourable Gilbert Parent

HOUSE OF COMMONS

Thursday, April 27, 1995

The House met at 10 a.m.

Prayers

ROUTINE PROCEEDINGS

[*Translation*]

GOVERNMENT RESPONSE TO PETITIONS

Mr. Peter Milliken (Parliamentary Secretary to Leader of the Government in the House of Commons, Lib.): Madam Speaker, pursuant to Standing Order 36(8), I have the honour to table, in both official languages, the government's response to 16 petitions.

[*English*]

On Statements by Ministers today the President of the Treasury Board will make a brief statement. I understand that representatives of both the New Democratic Party and the Progressive Conservative Party will make statements in the usual course on this by unanimous consent. There will be a total of five statements.

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HOLOCAUST MEMORIAL DAY

Hon. Arthur C. Eggleton (President of the Treasury Board and Minister responsible for Infrastructure, Lib.): Madam Speaker, 50 years have passed since the liberation of many of the camps that symbolized Hitler's final solution.

Canadians began marking the 50th anniversary of the liberation of Europe on June 4, 1994 when we remembered the sacrifices of thousands of our countrymen on the beaches of Normandy. Today we commemorate Holocaust Memorial Day.

While we mark the end of a tragic time in human history, we must recognize we have all come a long way.

[*Translation*]

The Nazi holocaust victimized all of humanity. It showed how blind nationalism, racism and bigotry can be.

[*English*]

The Nazi Holocaust victimized all of humanity. It showed how blind nationalism, racism and bigotry, a violation of the very basic democratic principles on which our society is based, can lead to incomprehensible suffering and violence.

The names of the death camps liberated half a century ago ring out as sacred prayers: Dachau, Buchenwald, Treblinka, Bergen Belsen, Auschwitz–Birkenau. These places have become holy ground. We must remember them because they symbolize what humanity is capable of and remind us of our obligation not only to millions of men, women and children who fell victim to tyranny but to future generations around the world.

Canada remembers the suffering of Europe. We remember the deaths of six million Jews and the victimization of millions of other innocent people persecuted because of their religion, ethnic origin, sexual orientation or political views.

Canada remembers the selfless sacrifice of thousands of our soldiers who offered their lives for freedom, democracy and for a better future for us today. We honour all of their memories by ensuring we remember why they died. We honour their sacrifice by working for the equality of humanity and being true to our values of respect and understanding.

Canada remembers.

Some hon. members: Hear, hear.

[*Translation*]

Mr. Maurice Godin (Châteauguay, BQ): Madam Speaker, the official opposition joins the government in giving its unanimous support to the motion tabled by the Secretary of State for Veterans. Fifty years have passed since the end of World War II, a war the likes of which this small planet had never seen before. We had to recognize that neither modern institutions nor the new technologies had helped us achieve peace on this earth.

Toward the end of that great war, the whole world was horrified to discover the existence of concentration camps, an inhumane, cruel and barbaric practice. No words exist to describe this atrocity and express our revulsion towards such a monstrous scheme. There is no excuse whatsoever for concentration camps.

(1010)

Millions of men, women and children perished under the yoke of tyranny. They could only hope that other countries would rise up and fight in the name of liberty and justice. That is the effort

in which Canada took part. We and our descendants will never forget the valour and courage of those soldiers. It is our duty to ensure that these defenders of freedom will always be present in our collective memory.

The collapse of the Third Reich revealed to the world the largest extermination effort in history. Millions died in the concentration camps set up by the Nazis in occupied Europe, in their electrified barbed wire enclosures, blockhouses, underground factories, experimental rooms, gas chambers and herding areas. Thousands of convoys led victims on the road to hell.

This planned destruction effort was carried out relentlessly until just before surrender. Those convoys let to the internment and slaughter of innocents. Arrival in camp often meant death pure and simple or an even worse fate: forced labour contributing to death. It was a tragedy to witness the torture and slow agony of one's neighbour or be subjected to the same treatment. Malnutrition and illness led to a point of no return, to an exit from life. It is our duty to take a moment to imagine what concentration camps were like, to better understand how crucial it is that we remain steadfast in our firm commitment never to tolerate crimes against humanity.

Fifty years ago today, trucks of the International Red Cross drove into certain concentration camps, marking the end of this hell on earth. Torturers fled. Today, 50 years later, it is our duty to look at this tragedy as if it had happened just yesterday to our relatives, children and parents, so that we never fall victim of such madness. However—sadly for humanity—genocides and organized exterminations continue. Last year, more than one million Rwandans perished in a carefully planned genocide and, to this day, those responsible for this crime go unpunished.

More recently, the slaughter of thousands of Hutu refugees by the Rwandan Army at the Kibeho camp amounted to carnage. The international community witnessed acts of unspeakable cruelty in Bosnia, where ethnic cleansing was systematically carried out. Such events make us wonder whether humanity has learned anything from the lesson we were taught by history.

We must ensure that this kind of massacres among inhabitants of this planet stop. We must remain hopeful that, one day, we will all live in peace, free from these inhuman acts. To commemorate the liberation of Nazi concentration camps is, of course, to pay our respects to the victims, but also pay tribute to all the men and women of this country who made that liberation possible, our veterans, who deserve more than our admiration. We owe them support, particularly when they paid with their health. I hope that this government will take this opportunity to ponder over the way veterans are treated. We cannot renege on our promise to them.

Nor can we afford to relax our vigilance, lest atrocities like those committed in Nazi concentration camps be committed again. Such is the implacable lesson taught by history, a lesson that we must in turn teach our children, so that we never forget. The Bloc Quebecois, for its part, undertakes to do all it can to ensure that this knowledge remains in our collective memory. Together, let us keep this hope alive.

[*English*]

Mr. Jim Hart (Okanagan—Similkameen—Merritt, Ref.): Madam Speaker, it is a great honour to address the House on behalf of the people of Okanagan—Similkameen—Merritt and my colleagues in the Reform Party to solemnly commemorate the 50th anniversary of the liberation of the Nazi death camps.

We remember the men, the women and the innocent children who perished at the hands of the Nazi tyranny and we honour the many Canadians who fought for freedom and justice at a time of darkness.

(1015)

We recall the generation of men, women, and children that had to endure the horrors of Nazi tyranny from the 1930s to 1945. For someone born after the war, the reality of this dark period in the history of humanity seems hard to comprehend.

We see the pictures of the Warsaw ghetto, the trainloads of innocent men, women and children being sent to the concentration camps, the deadly gas chambers and the horrific mass graves. As I recall these offences of the past I try to imagine how man could commit these crimes against humanity.

I really began to grasp the magnitude of this tragedy when I saw the numbers of people who died in this horrible conflict. The death toll rivals the size of Canada in 1945. Though we do not have all the names of those who perished, the world must remember Yom Hashoah, Holocaust Memorial Day.

I would like to reiterate the pledge yesterday by the leader of the Reform Party. He spoke for all of us when he stated: ''I solemnly vow that we shall honour the memory of those who perished in the Holocaust by remaining vigilant against those who would divide us by promoting hatred and discrimination''.

Those who deny this event must be condemned. Besides solemnly commemorating Yom Hashoah and the liberation of the Nazi concentration camps, I would like to honour the tens of thousands of Canadian men and women who fought for freedom and justice. Too many left Canada to never return. In each battle Canadians fought, and despite the odds and terrible toll they had to pay, they never failed to display great courage and resolution. It is a great tribute to our nation to know that most of those who fought in this terrible war did so voluntarily.

It has been 50 years since the Nazi concentration camps were liberated and the guns fell silent. Many soldiers and civilians who experienced the horrors of this war are doing their utmost to

make sure all Canadians and all humanity remember the cause, the course, and the consequences of this conflict.

Yet in the years to come, as veterans and victims pass on, it will be up to my generation and the generation that follows to keep alive the memory. I feel entrusted with a sacred pledge to be able to go to the Netherlands next week to represent my constituents and the Reform Party in the Canada remembrance ceremonies.

For my part, I vow to keep the memory alive and honour our fallen soldiers and the victims of this terrible event. The people and events we are honouring today must not be forgotten in the dustbin of history. It must be remembered that those who forget the past are condemned to relive it.

Hon. Audrey McLaughlin (Yukon, NDP): Madam Speaker, today we rise in the House to remember. Half a century has not erased the memory of the horror of the six million people who were killed in Nazi concentration camps, nor the horror of World War II, which led to this.

Those who fought for the liberation of camps are also remembered today. We remember the families and individuals whose lives were lost in those camps. We admire the strength of those survivors, many of whom came to this country to help, with courage, determination, and strength, to build this country.

As we remember today, there is truly a lesson for us all, a lesson of courage and a reminder of how quickly prejudices and biases can turn to hate. As Canadians, we must be diligent and we must fight prejudice and racism. However, it is not enough to simply issue statements. We cannot be silent in our communities, in our homes or in our country. Silence and complacency are not options. We cannot rest in the assurance that the horrors of the concentration camps are simply a part of history.

[*Translation*]

We must be vigilant, because right wing extremism and fascism still exist in every country. We must ensure full application of the laws which prohibit hate, and work together to promote a strong and healthy democracy in Canada.

(1020)

[*English*]

The Holocaust in many ways is something that happened to all of us. It is a part of our history and it is something we are all responsible for in ensuring that peace, justice, and freedom in every country in this world are more than just words.

Canada will remember. The world will remember.

Mrs. Elsie Wayne (Saint John, PC): Madam Speaker, I want to join with my colleagues in the House in commemorating the 50th anniversary of the liberation of the Nazi concentration camps. We must never forget the millions who were murdered at the hands of the heinous Nazi regime.

I also want to take this opportunity to pay tribute to the many Canadians who fought so that the future generations could live in peace and freedom.

I shall never forget as a little girl, when I was only five years old, when my brothers came in to tell my mother and my father that they had signed up to go overseas. They were overseas in France, Germany, and Italy. I will never forget the prayers and the hard times my mother had, hoping and praying she would hear from them. And I will never forget when I was a little girl and we went to the train station to greet them when they returned safe and sound.

If there was ever a war that needed to be won, it was the second world war. It hardly needs saying that the world would be a dark and different place today if the allies had not achieved victory.

We must never forget the unspeakable horror the death camps brought forth. They are a symbol of what can result from hatred and racism.

Today we witness the suffering of innocents around the world who are the victims of ethnically motivated conflict. Let us remember what such hatreds can lead to and be ever vigilant in our efforts to make sure it is not allowed to happen again.

Yes, Canada will remember.

Hon. Arthur C. Eggleton (President of the Treasury Board and Minister responsible for Infrastructure, Lib.): Madam Speaker, I would like to move a motion, with the unanimous consent of the House, which I am pleased to say has four seconders: the hon. member for Châteauguay, the hon. member for Okanagan—Similkameen—Merritt, the hon. member for Yukon, and the hon. member for Saint John. I move:

> That this House solemnly commemorates the 50th anniversary of the liberation of the Nazi concentration camps, remembers the lives of the millions of men, women and children who perished at the hands of tyranny, and honours the many Canadians who fought for freedom and justice at a time of darkness.

(Motion agreed to.)

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INTERPARLIAMENTARY DELEGATIONS

Mr. Bob Speller (Haldimand—Norfolk, Lib.): Madam Speaker, pursuant to Standing Order 34 I have the honour to present to the House a report from the Canadian branch of the Commonwealth Parliamentary Association concerning our visit to Hong Kong from March 13 to 17, 1995.

PETITIONS

INCOME TAX ACT

Mr. Paul Szabo (Mississauga South, Lib.): Madam Speaker, pursuant to Standing Order 36, I wish to present a nationally circulated petition that has been received by me. This particular petition was signed by a number of petitioners from the St. Marys area of Ontario.

The petitioners would like to draw to the attention of the House that managing the family home and caring for preschool children is an honourable profession, which has not been recognized for its value to our society.

They also state that the Income Tax Act discriminates against families who make the choice to provide care in the home to preschool children, the disabled, the chronically ill or the aged.

Therefore, the petitioners pray and call upon Parliament to pursue initiatives to eliminate tax discrimination against families who decide to provide care in the home for preschool children, the disabled, the chronically ill and the aged.

(1025)

EUTHANASIA

Mr. Fred Mifflin (Bonavista—Trinity—Conception, Lib.): Madam Speaker, I rise under Standing Order 36 to present a petition to the House.

These petitioners are all from Gambo in Bonavista North in my riding. They note that whereas the majority of Canadians are law–abiding citizens, that the majority of Canadians respect the sanctity of human life, and that physicians in Canada should be working to save lives, they humbly pray that Parliament would make no changes in the law that would sanction or allow the aiding or abetting of suicide or active or passive euthanasia.

CRIME

Mr. Mac Harb (Ottawa Centre, Lib.): Madam Speaker, I have a petition signed by many of my constituents of Ottawa Centre who are calling on the government to take action in order to deal with crime throughout Canada, mainly in urban centres. I would like to lend my support to this petition.

EUTHANASIA

Mr. Don Boudria (Glengarry—Prescott—Russell, Lib.): Madam Speaker, I have two petitions to table. The first one is signed by 58 people, mostly from Saskatchewan. These petitioners are asking that the Criminal Code provisions to prevent assisted suicide and euthanasia be maintained.

With those 58 signatories, the total number of petitions tabled to date on this issue is 29,506.

GUN CONTROL

Mr. Don Boudria (Glengarry—Prescott—Russell, Lib.): Madam Speaker, I also want to table a petition on behalf of another member. I know it is not customary to refer to the absence of a member, but this is the case of the unfortunate illness of the member of Parliament for Nepean. I am sure that I speak on behalf of all of us when I wish her to come back to Parliament very soon.

On behalf of the electors of the constituency represented by the member for Nepean, I want to table a petition signed by 25 signatories who are asking that there be no additional gun control measures.

* * *

[*Translation*]

QUESTIONS ON THE ORDER PAPER

Mr. Peter Milliken (Parliamentary Secretary to Leader of the Government in the House of Commons, Lib.): Madam Speaker, I would ask that all questions be allowed to stand.

The Acting Speaker (Mrs. Maheu): Is that agreed?

Some hon. members: Agreed.

[*English*]

The Acting Speaker (Mrs. Maheu): I wish to inform the House that because of the ministerial statement and pursuant to Standing Order 33(2), Government Orders will be extended by 16 minutes.

GOVERNMENT ORDERS

[*English*]

SUPPLY

ALLOTTED DAY—NATIONAL HEALTH CARE SYSTEM

Mr. Preston Manning (Calgary Southwest, Ref.) moved:

That this House recognize that since the inception of our national health care system the federal share of funding for health care in Canada has fallen from 50 per cent to 23 per cent and therefore the House urges the government to consult with the provinces and other stakeholders to determine core services to be completely funded by the federal and provincial governments and non–core services where private insurance and the benefactors of the services might play a supplementary role.

He said: Madam Speaker, I rise to address the Reform motion before the House, but before I do so I would like to say a word about broken promises.

One of the reasons there is so much public cynicism about politics and government is that governments consistently break their promises. This Liberal government, for example, is not yet two years old but already it has littered the political landscape with broken promises.

For example, there was the promise to base key federal appointments solely on competence rather than patronage, a promise routinely broken almost every week.

There was the promise by the now Deputy Prime Minister to resign if the GST was not replaced within one year of the election, shamelessly broken on October 25, 1994.

There was the promise not to alter federal–provincial transfers without the full co–operation of the provinces, which was broken by the introduction of the Canada social transfer in the February budget.

There was the promise to provide a new blueprint—

(1030)

Mr. Szabo: Madam Speaker, I rise on a point of order.

Two days ago a member rose in the House on a point of order to indicate that the speaker was not addressing the motion on the floor. I believe this is the same case. Therefore, I would make the point that the member should be addressing the motion.

The Acting Speaker (Mrs. Maheu): Resuming debate with the hon. leader of the Reform Party.

Mr. Manning: There was a promise to provide a new blueprint for social reform. It was broken without apology or explanation when the Minister of Human Resources Development failed to deliver his green paper.

There was a promise not to increase the tax load on the long suffering, overtaxed Canadian taxpayer. It was broken to the tune of $500 million a year with the imposition of a 1.5 cent a litre tax on gasoline.

There was a promise of a more open Parliament where MPs would be free from party discipline. It was dictatorially broken when Liberal MPs who voted against the government's gun control bill were stripped of their committee positions.

The first part of the motion we are considering draws attention to yet another broken Liberal promise, one of the most serious of all. For the benefit of members, this is the connection between broken promises and the motion.

When national medicare was introduced at the federal level by a minority Liberal government 30 years ago, Prime Minister Pearson solemnly promised Canadians, the provinces and the House that the federal government would pay 50 per cent of the costs. This was the fiscal promise on which medicare rested. This was the condition insisted on by the provinces and promised by the federal government, a promise without which the provinces would not have agreed to national medicare.

The Liberals even wrote that promise into the old 1966 medical care act, section 5, which stated that ''the amount of the contribution payable by Canada to a province in respect to a medical care insurance plan is an amount equal to 50 per cent of''. It then went on to list the various cost components of the plan.

What is the state of that sacred promise today? Today the federal government's contribution to health care funding is not 50 per cent as promised. It is now less than 23 per cent and falling.

The Prime Minister and the health minister can profess their undying commitment to the principles of medicare until they retire from public life clutching their two–tier MP pension. The truth of the matter is that every day, every hour in every province, in every community, in every part of the country, whenever and wherever Canadians draw on national medicare, the government is breaking its fundamental promise to pay 50 per cent of the bill.

Because it is breaking that fundamental financial promise it is slowly undermining the other principles of medicare. It undermines accessibility as waiting lists get longer and longer. It undermines comprehensiveness as more and more health services are delisted from provincial insurance plans. It undermines universality as the system evolves into a multi–tier system with access to the various tiers being tied increasingly to ability to pay.

The second part of the motion before the House proposes a solution to this dilemma, which I will get to in a moment. Before I do so I would like to clear away one of the myths of medicare, a myth to which the Prime Minister and the health minister cling, a myth which prevents a clear diagnosis of the problem and the solution. That myth is that Canada has a one–tier medical system to which all Canadians have universal access regardless of ability to pay and opening up the Canada Health Act will lead to a U.S. style two–tiered system where ability to pay is the key to access.

The indisputable fact is that Canada already has a multi–tiered health care system, access to which has been made more restricted by rising health care costs and declining federal support. The challenge is to reform medicare so that one of those tiers contains all the essential health services required by Canadians, financed by sufficient federal and provincial funding so that no Canadian is denied access to those services because of inability to pay.

(1035)

How to do that I will discuss in a moment. Lest there be some simple minded folk among us who still cling to the notion that Canada still has a single–tiered medical care system, let me submit evidence to the contrary.

I could quote from the exhaustive 1994 health care study by Dr. Ralph Sutherland and Dr. Jane Fulton entitled ''Spending Smarter and Spending Less''. On pages 98 and 99 of that study, they discussed the myth of the one–tier system and dismiss it as nonsense. They end by saying that the two–tier system is and always has been a reality in Canada.

They then go on to discuss how to make a multi–tier system work for the benefit of all Canadians which is the real challenge and real problem. Rather than quote extensively from the academic or technical literature, I prefer to share with the House a note I received just yesterday from a Canadian physician to whom I put the question, does Canada presently have a one–tier or two–tier system?

He says flatly that a two–tier system already exists. Should a person be admitted to a hospital, he or she can obtain a private room should he or she have the funds to pay for it or an insurance program that covers it. Otherwise this is not available.

People can hire a private duty nurse for 24–hour care if they can afford to pay for it. Many nursing and home care services are also available should the patient be able to afford to pay for them.

Recently midwifery has been introduced. Again this is only available to those who can afford to pay for these services. People can have access to procedures such as abortions in private facilities if they are able to pay the private facility fee.

People who can afford to may have an insurance plan to cover the cost of pharmaceuticals. Those who cannot afford to pay this fee must pay for it out of their own pocket.

The Workers' Compensation Board in this province has contracted many private facilities to provide services for its clients in order for them to obtain these services more quickly than possible in the public system and thus get them back to work in a more timely fashion.

Members of the military have been flown to the base hospital in Ottawa to have surgical procedures performed rather than being on a waiting list. I have also recently learned that the military purchases surgical procedures such as arthroscopies at private clinics as it is cheaper than purchasing the same procedures through the public sector.

As well, we all know the ultimate two–tier system is available to those who can afford to pay for it by leaving the country and having services provided in the United States.

Many leading edge technologies and therapies are not available in this country. In order to obtain them one must leave the country and purchase them in the U.S. A country of our stature should be ashamed of the fact that it is not able to provide those services.

He concludes by saying: ''As I hope is demonstrated by the above examples, almost all aspects of health care in Canada are two–tiered and available to people on a private basis except for the physician's services. This and certain procedures which are only available in public hospitals are the only services that are not presently available in two tiers in this country''.

Why on earth the Prime Minister and the health minister would continue to deny the existence of a multi–tiered health care system or to pretend that the five criteria of the Canada Health Act preclude such a system is beyond me. Childlike belief in the myths of medicare at the highest levels of the federal government must end if the problems of Canadian health care are to be resolved.

The second portion of the motion before us indicates the way in which Reform believes the government could guarantee universal access for all Canadians to a set of essential health services regardless of ability to pay in a multi–tiered system.

In order to provide secure funding for health care into the 21st century, substantive discussions and negotiations are required among all the key players: representatives of health care users, taxpayers, health care practitioners, health care administrators, health care insurers, the provinces and the federal government.

Reform proposes that these discussions and negotiations should focus on completing a health care funding matrix such as that shown on page 48 of the Reform taxpayers budget.

This is the type of framework for refinancing health care, saving medicare, which the Prime Minister and the federal government should have provided through that national health care forum which they have not. This is the framework required to produce meaningful amendments to the Canada Health Act, amendments which the health minister continues to fail to provide. This framework suggests that the first item on the agenda should be a discussion of how best to divide essential health services into core services and non–core services.

(1040)

The core services would be those health care services most essential to Canadians, the financing of which would be guaranteed by the federal and provincial governments up to some minimal national standard. They would be those services which make the most demonstrable contribution to improving the health of Canadians and which must be provided in the most cost effective way possible.

These core services would constitute the heart of medicare. All Canadians would be guaranteed access to these services across the country up to some national standard regardless of their ability to pay.

Provinces and individuals would be allowed to provide and secure services that went beyond the core services if they so desired. The federal government would not be involved in the financing of such services.

Services designated as non–core services, for example, cosmetic surgery as distinguished from more necessary surgery or

fibreglass casts for broken limbs as distinct from plaster casts, would be funded through a more flexible combination of funding sources, including private insurance and user pay.

To those members opposite who will challenge us to elaborate on what should be considered core and non–core services, I would invite them to listen carefully to my medical colleagues, the member for Macleod and the member for Esquimalt—Juan de Fuca, and ask questions at the end of those remarks.

I would encourage all MPs to refrain from getting too deeply into that discussion. It is not our role in the federal Parliament, either constitutionally or practically. It is not the role of a distant federal government that is paying less than one–quarter of the bills to define those services. That is the old way. It is the top down way. It is the Meech Lake approach to medicare. It is the centralizing way and it is not the way of the future.

The definition of those services must primarily come from health care users, the people who use them, from the practitioners who actually practice them and from the administrators at the local and provincial levels. We should do everything we can through parliamentary committees, personal speeches and dialogue, through the national health care forum to facilitate those discussions and to listen. But we should not try to dictate the final division of services.

After those discussions occur, our role will be to commit federal funding to whatever Canadians define as core services, up to some minimal national standard in co–operation with the provinces.

There is no question in my mind that there is an urgent need for health care reform in Canada, particularly in light of the failure of the federal budget to eliminate the deficit. These reforms are required to preserve the best features of the present system; to prevent the funding system from being completely destroyed by interest on the debt; to provide flexibility to allow the provinces' health care administrators and physicians to better adapt to the health care needs of Canadians.

Canadians are asking and will continue to ask: From whom is the leadership for health care reform going to come? I would suggest it is not coming from the federal government under the current Prime Minister or health minister. They resist every proposal for change. They resist the diagnosis that would lead to real proposals for change. They charge anyone who advocates change with being an enemy of medicare, which is a reactionary position, or a proponent of U.S. style health care, charges which are completely untrue. They are only dragged into the discussion of health care reform at all by their officials telling them that if they do not do something, the system is going to collapse and they are going to carry the blame.

Therefore I suggest that the leadership for health care reform, and it is occurring in many spheres, where the public is now ahead of the politicians and the government, must come from the patient user community, from taxpayers, from the medical community, from administrators and local governments, from provincial authorities, from the bottom up, not the top down.

If in 1960 Ottawa had had the monopoly it has today on setting terms and conditions of health care services and financing, the present medicare system would not have come into being. Canadian medicare did not start in Ottawa. It did not start anywhere near Ottawa. It started in Saskatchewan and it really started there in an operational sense with the Swift Current Hospital District in that province.

(1045)

The concept was incorporated by the old CCF into its political platform and then stolen by the federal Liberals. I can assure concerned citizens and real health care reformers across the country they will find allies and advocates of sensible change to the health care system in the Reform caucus.

I urge all hon. members who wish to save and advance the best features of Canadian medicare to support this motion.

Hon. Diane Marleau (Minister of Health, Lib.): Madam Speaker, with all due respect to the leader of the third party, he has certainly spoken of broken promises and has gone on at great length about it.

Speaking of broken promises, during the election and following I can recall the leader of the Reform Party stating: ''I want to make it absolutely clear that the Reform Party is not promoting private health care, deductibles or user fees''. Yet, today what is he talking about? Deductibles, user fees, getting more and more private. That was yesterday; this is today. Talk about breaking promises.

I can recall the Reform Party rhetoric during the last election. How does the hon. member explain his change of thinking or his whole party's change in rhetoric? How, pray tell, would that ensure that people who needed the care got it based on their need and not on whether they could afford to pay for it.

Let us face it. This is from a party that does not advocate any taxation increases whatsoever. Taxes are based on fairness. If you make more money, you pay more tax. They are proposing a tax on illness. The sicker you are, the more costly it is for you. What kind of a system is that? I would like an explanation.

How would the leader of the Reform Party deal with people who are very ill who, by the way, tend to be the poorest? Usually those who are very sick cannot work anymore. He might be charitable to a few and there would be these core services; maybe you could have a band–aid if you could not afford to pay

for it. What kind of medicare is he proposing except the American style of system? And we know what that is about.

Mr. Manning: Madam Speaker, I would remind the minister that while there is only a handful of us here in the House her remarks on this subject are being carefully monitored these days by the practitioners and administrators and particularly by the provinces. The statements made here that completely deny the reality of the health care system do no service to this House nor to the government's position on the seriousness of the problem. They create the impression that we literally do not understand how the system works. That is a discredit to the minister and the government.

From what the minister says, we can tell her views of what Reform said during the election are based on what a clipping service says Reform is about. They bear no resemblance whatsoever to the positions we have articulated, particularly the Reform colleagues with medical backgrounds.

With respect to her particular question of how we facilitate the payment for services for people in this category of poor services, the minister could not have been listening to what I said. We say we should define a set of core services that are essential to the care of Canadians. Those are the services to which we would dedicate entirely the federal and provincial contributions to the funding of medicare. Those services would be brought within the financial reach of every Canadian no matter where they lived, regardless of their ability to pay. The non–essential services can be provided through other financing sources such as insurance and even user pay. That is perfectly clear.

These proposals have been presented by other health care reformers in the health care field itself and in the provinces. It is time for the minister to acknowledge them for what they are, not to pretend they are something else.

(1050)

Ms. Hedy Fry (Parliamentary Secretary to Minister of Health, Lib.): Madam Speaker, the hon. member put forward an eloquent speech, wonderful rhetoric. It shows a depth though of the superficiality of the understanding of what health care is all about and what the five principles of medicare actually mean.

I would not like to add any further rhetoric but to say that with this lack of understanding would the hon. member like to explain to me what he understands by the meaning of the term ''core services''. He bandies it about and uses it a lot. I would like to know from him what he means by core services.

Mr. Manning: I have two comments. I appreciate the fact that the member is concerned about superficiality. I would earnestly suggest if she reads the speech the Prime Minister gave on this subject in Saskatoon and if she reads the speeches that have been given by the Minister of Health, we have a superficiality that betrays the government's position today.

With respect to core services, we think core services should be those services deemed essential to the health care of Canadians as defined by health care users, practitioners, local administrators and provincial governments.

I explained in my speech specifically that we should not try to say what those services are. That is what got Ottawa into trouble in the first place. It made a commitment to a whole range of services which it could not continue to fund.

At every public meeting and meetings with the medical community that I have had where I have put this health care matrix up, you can get an excellent discussion and definition from those people if you put up that matrix. I suggest that if the minister and the member want to know, go and ask the people whose opinion on that definition is the one that counts.

Mr. Rey D. Pagtakhan (Winnipeg North, Lib.): Madam Speaker, certainly from what is before us in the opposition motion on the national health care system the leader of the Reform Party has made it clear at least today that he is for a multi–tiered system. Therefore it is now clear to Canadians that the Reform Party wants to destroy the medicare that we have today.

Mr. Morrison: You destroyed it.

Mr. Pagtakhan: They can say anything, Madam Speaker, but Canadians are serious. They are not laughing about medicare. Canadians want to preserve medicare.

Does the hon. member believe that the single tier system is the best system in the world in terms of cost effectiveness? If the member does not believe that, I would refer him to the report of the Surgeon General's office in the United States. It has shown that indeed we have a lot of savings by having a publicly administered single tier system.

The second point is when the member spoke about health care funding I am not clear as to his understanding of funding for health. Does it mean only public spending on health or private spending on health? I can see from his speech that he would like to shift the cost of health care spending from the government to private individuals, the citizens. However, he has no proposal whatsoever that will contain the cost of proper health care spending which is the critical question facing Canadians to preserve our medicare system.

Mr. Manning: In response to the first question: Is the current system the most cost effective in the world? No, it is not. This is obvious. This is not a matter for debate. Study after study has indicated that the costs are out of control with respect to the Canadian system and therefore it cannot be the most cost effective.

The fact that more and more Canadians are seeking health care outside the Canadian system itself is evident that there is something wrong.

(1055)

The government itself professes a great abhorrence of the American system. We do not agree with the American system. We are not advocating anything of the kind. However, because of the actions of the government, it is driving more and more Canadians to subsidize the American system to the tune of hundreds of millions of dollars a year because they will not stay on the waiting lists here.

The hon. member is a physician himself. Has he ever sent a patient to get health care in the United States because they could not get it here or were on a great waiting list under our current system?

The Acting Speaker (Mrs. Maheu): I am sorry, the time has expired.

Hon. Diane Marleau (Minister of Health, Lib.): Madam Speaker, I would like to thank the leader of the third party for setting forth in his party's motion a proposal which I would qualify as almost perfect, almost perfectly wrong that is. The proposal demonstrates clearly that Reform Party members do not understand how the Canada health system functions, what challenges it faces, what is being done to address those challenges, and what solutions are realistic and make sense to Canadians.

In his medicare proposal and in his pronouncements on the Reform Party's views, the leader of the third party has managed to put together a package that will simultaneously increase bureaucracy, decrease flexibility, maximize federal interference in provincial jurisdiction and most of all, increase the cost of health care in Canada.

How would the Reform Party pay for this? It is simple: It would push people into buying private insurance, if it is available and if they have the money for it, to cover things which are presently covered by medicare. Worst of all, it would tax the sick by permitting and even encouraging user fees.

The Reform Party proposal and pronouncements are not a prescription for a healthy medicare system. They are a prescription for disaster. Before dealing with the specifics of this motion and of Reform's thinking on medicare, let me question the proposals of the Reform Party.

Reform's so–called budget proposed surrendering additional tax points to the provinces for health care. How precisely does this square with its concern about a falling federal share of cash contributions? Certainly not well at all. How would the Reform Party deal with the fact that tax points yield different revenues in each of the provinces? It obviously has not thought of that.

How would that party enforce the conditions and criteria of the Canada Health Act? It certainly appears it would not.

What, if any, evidence do members of the Reform Party have to support their expectations that provinces would agree on a common level of basic or core health services everywhere in Canada as they state they would on page 48 of their so–called budget? Are they not aware that a number of provincial ministers of health have already indicated that such an approach is simplistic and they have no interest in developing a national list?

Which is the federal role? To determine core services, as the motion states, or to have provinces agree on a common level of core services as stated in Reform's so–called taxpayers budget? How would the leader of the third party coerce the provinces?

The Reform Party obviously has no answers for these questions. That is the reason its arguments have no basis in fact and are almost perfectly wrong. It is soapbox rhetoric which could lead to the destruction of medicare, and we are not going to have any of it.

Take this motion, for example. In dealing with federal contributions to provincial health insurance plans, the hon. member mixes apples with oranges. He does it all the time, so this is nothing new.

(1100)

The federal share of funding for health care was never 50 per cent of total provincial government health expenditures. As a result of cost sharing during the 1960s and early 1970s the federal share nationally accounted for roughly 50 per cent of provincial expenditures for hospital and medical care only. Even then provincial governments were spending on health programs for which the federal government did not share costs.

Let us look at some real numbers, not those fabricated by the Reform Party. In 1975–76 after medicare was introduced the federal contribution nationally amounted to 39 per cent of total provincial health expenditures. In 1992–93 the federal contribution, the sum of the cash in transfers to the provinces for health, represented 32 per cent of total provincial government health expenditures.

Another way to look at the numbers is to examine the federal share of total health expenditures in the country. On this basis the federal share dropped from 31 per cent in 1975–76 to 24 per cent in 1992–93.

[*Translation*]

Let me repeat it again, so that, hopefully, Reform members will understand eventually. In dealing with federal contributions to provincial health insurance plans, the Reform Party leader is mixing apples with oranges. The federal share of funding for health care was never 50 per cent of total provincial government health expenditures.

As a result of cost sharing agreements reached during the sixties and the early seventies, the federal share nationally accounted for roughly 50 per cent of provincial expenditures for hospital and medical care only. Even then, the provincial governments were spending on health programs for which the federal government did not share costs.

Let us look at the real figures, not those fabricated by the Reform Party. In 1975–76, after medicare was introduced, the federal contribution nationally amounted to 39 per cent of total provincial health expenditures. In 1992–93, the federal contribution, that is the sum of the cash payments and tax transfers to the provinces for health, represented 32 per cent of provincial government health expenditures.

[*English*]

These are all real and public numbers. They should be the Reform's numbers because they are the facts.

Provinces administer the health care system. I want to make it clear and acknowledge in the House what I have said elsewhere. Provinces and territories are doing a good job of containing costs but historically the costs of provincial health plans increased in a less controlled manner. It is in part because of this that the federal share of health expenditures has fallen over time. If health costs had risen at the average rate of OECD countries the federal share would be substantially higher.

Expenditures in the public sector are being controlled. Our cost control problems are now in the private sector. Pray tell, why would we shift more to the private sector so we can have even higher and less control of costs?

In 1993 Canada spent $72 billion on health care. This represented 10 per cent of our gross domestic product. Hon. members are aware that with the exception of the United States, Canada's health expenditures are the highest of any industrialized nation.

There is enough money in the system. It is a question of how better to spend the money we have. Of the $72 billion spent in 1993 approximately $52 billion was spent in support of public health services while the other $20 billion was spent in the private health sector. Lately the public component has been growing at less than 2 per cent. On the other hand, private health spending has been growing by more than three times that rate.

(1105)

The public sector or single payer system has enabled the provinces and territories to better control the rate of increase in the growth of health expenditures in the public sector. The World Bank's 1993 world development report noted the cost effectiveness and control advantages of public sector involvement in health: ''In general the OECD countries that have contained costs better have greater government control of health spending and a larger public sector share of total expenditures''.

The OECD review of health reform and development in Canada also recognized the advantage of a significant public sector involvement in health. From the 1993 OECD economic survey of Canada: ''The structure of Canada's single payer health system lends itself to effective supply management and control. It seems the problems of the current system are not related to its publicness''.

With respect to health expenditures in 1994, preliminary estimates by my officials indicate public health expenditures declined in aggregate by about 1 per cent in 1994, while private expenditures increased at about the same rate as 1993. Under these assumptions total health expenditures in 1994 were approximately $73 billion for an aggregate increase of less than 1 per cent, or about $600 million. Expressed as a percentage of GDP, total health spending probably declined to about 9.7 per cent in 1994.

There are a number of reasons we have been more successful in controlling health costs in the public sector than in the private sector.

[*Translation*]

We have in each province a structure which provides the same coverage to everyone. It is not necessary, therefore, to assess individual risks. Payments to providers are made in a simple but efficient manner. Financing of the system is simple; everything possible is done to reduce costs. In fact, researchers from Harvard University found that Canada only spends 1.1 per cent of its gross national product on health care management.

If we spent as much as the United States do on that, health care expenditures would increase by $18.5 billion. Americans spend almost two and a half times as much as we do on that. And there is no evidence that spending more would improve the health of Canadians.

The second reason we are in a better position to control costs is that there is only one purchaser in our provincial health insurance plans. Governments have great clout when it comes to negotiating the level of costs of services. They can set overall budgets for hospital and physician services. In fact, they have done so, as indicated by the figures I quoted.

[*English*]

As Minister of Health I want Canadians to continue to have access to high quality health care at a price they can afford. That is why I am working with my provincial and territorial colleagues as well as other stakeholders to address cost drivers in both the public and private health sectors. So much for the first part of Reform's motion.

Let me now deal with the second part which calls for a listing of core services. There is a remarkable degree of congruence between the provinces. Among them there is broad agreement as to what constitutes the core of ensured physician and hospital services. There are some differences from province to province

but these simply demonstrate the flexibility which provinces can and do exercise in providing a range of additional benefits to their residents. That is not wrong. That is a strength of our system; a system characterized by sound consensus on what are core services or medically necessary services.

The list of covered procedures and services of necessity must be flexible. That is because the way we deliver health care and the opportunities which new technologies and procedures create dictate changes need to be incorporated over time. There is almost no service not medically appropriate in some cases.

(1110)

For example, plastic surgery may be considered medically necessary when it is intended to correct a medical condition. Reconstructing a nose to correct a breathing problem is labelled cosmetic surgery but clearly it is a medically necessary procedure.

Other examples include removal of minor skin lesions when cancer is suspected and tattoo removal in the case of abuse or prisoner of war experiences.

For the most part in Canada we have left the definition of medical necessity to professionals, not bureaucrats. The medical necessity of a service is determined at the point of delivery of the service. That is what the Canada Health Act has allowed. It is based on the medical needs of the patient, not the financial means of the consumer. That is the way it should be; this is simple fairness.

Canadians do not want cash register medicare. This stands in sharp contrast to what is happening with managed care in the U.S. There, third party insurers tell physicians what they cover and what they can or cannot do for their patients. So much for clinical freedom.

This reality is one of the major reasons why a significant portion of doctors who leave Canada to practise in the U.S. do come back home.

The Reform Party says it stands for smaller government, less bureaucracy. Therefore I find it strange it is suggesting a process that would actually increase bureaucracy. Let there be no doubt, producing the list of medically necessary or core services would involve more bureaucracy.

Medical necessity is an integral part of the understanding and operation of the Canada Health Act. It is at the very heart of the principle of comprehensiveness.

In the Canada Health Act the words medically necessary are used in conjunction with other conditions. This ensures that once a service has been determined to be medically necessary and insured by provincial health insurance plans it is accessible in uniform terms and conditions by all residents of the province and available to them when they travel across the country.

In a manner of speaking, these become rights of Canadians. These are rights the Canada Health Act is there to protect. Canadians expect they will have medically necessary services available without point of service charges. They are right in this expectation. This is why facility fees for medically necessary services in private clinics are unacceptable and why I took steps to address this problem in January.

A rigid list of medically necessary services encourages the development of a second tier of health care delivery. It promotes privatization and shifting the burden of costs from society to individuals. These costs would then be borne by patients or by their employers.

Reformers, who profess to know what is good for business, should ask business people what they think about this idea. Let them talk to the owners of small businesses, the independent entrepreneurs who account for so much economic growth in our country, who have tried to buy insurance to cover the health cost of their employees. They know how costly it is already and they appreciate how much more expensive it would be if they had to cover more services and medically necessary services as well.

I ask Reform Party members, in particular the member for Macleod who is a physician, to tell us which services they think are not medically necessary, which services they think should be deinsured and which services they think individual patients should pay for.

Even the premier of Alberta is unable to provide a list of what these should be. The government's agenda is a national one. It is aimed at doing what is necessary to renew our health care system to make it more efficient and effective. It is an agenda based on better health outcomes, not better incomes.

The motion before us urges me to consult with provinces. Since becoming Minister of Health I have made it clear I want to work with provinces and territories and I have. I have met my provincial colleagues. I talk to them on a frequent basis. We have arrived at a consensus about the need to support the principles of the Canada Health Act. Perhaps he should consult with more provinces than he has.

(1115)

I am prepared to continue this collaboration. Our next regular meeting is scheduled for September, but I have already told the provinces that I am ready to meet with them earlier. There is no lack of willingness by this government and this minister to work with the provinces, the territories and others to ensure that Canadians continue to have the very best health care system in the world.

Mr. Preston Manning (Calgary Southwest, Ref.): Madam Speaker, the minister concluded her remarks by expressing her desire to co–operate, collaborate and work with the provinces, and we applaud that. That is constitutionally correct and is the only way the system will be fixed.

However in the course of her remarks she used an unfortunate phrase. I trust it was a slip of the tongue when she asked rhetorically how we can coerce the provinces into national standards if we do not retain the present system.

Surely the minister is aware that she is losing her capacity to coerce the provinces as federal cash transfers decline. She is also aware that it is possible to have national standards without coercion as we have, for example, in the field of education where there is the universal standard that everyone under 16 years of age gets a free education. That was established as a national standard without any national education act or coercion on the part of the federal government.

This talk of coercing the provinces into national standards as her financial position weakens is completely contrary to the spirit of federalism and what she said later on. I should like to give the minister an opportunity to withdraw that statement and indicate that she did not mean in any way, shape or form to say she favours coercion of the provinces, which is a polite word for blackmail, into national health care standards.

Ms. Marleau: Madam Speaker, my response to that is to go on to say that again they do not listen to what I am saying. I have asked the Reform Party to explain how it would coerce the provinces into having a uniform list of core services, and it certainly has not answered that. Its type of top down solution is not exactly what I am talking about.

We are getting a strange mixture of things from the Reform Party. On the one hand I heard the leader of the Reform Party go on at length about allowing the provinces to have more flexibility to allow those in the regions to be better able to deliver services. On the other hand his party is asking us to work with the provinces to develop a hard line definition of what is covered and what is not. There would be a list and we would need a whole series of bureaucrats to make sure it is really this and not that and therefore would not be covered. It always astounds me because the Reform Party cannot have it both ways.

By the way, we enforce principles not standards. The Canada Health Act talks about five fundamental principles. Those principles have served us very well.

The type of fear mongering and statements made by the leader of the Reform Party saying that our health care system is not doing well are wrong. While I will admit that changes are needed and we have to continue to work on it, the idea is for us to shape the future of medicare. That is what the provinces, working along with the federal government, are very much working on to deal with the new technologies and to ensure the dollars spent on health go directly to those things that are most needed.

Change is difficult. It is not easy. Throwing more money at it will not make it better. We will end up with a system like the one in the United States. That is exactly what the Reform Party is promoting.

Mr. Grant Hill (Macleod, Ref.): Madam Speaker, the minister has gone on at great length to talk about our proposal for a definition of core essential issues. She said that this was some kind of nefarious scheme that had never been thought of or heard of in Canada before.

(1120)

Could the minister explain when the Prime Minister said shortly after the budget on the Peter Gzowski program that we must return more to basics in our health care system? That is not an exact quote but very close to an exact quote.

Could the Minister of Health explain what the Prime Minister was referring to when he said that we were trying to do too much with our public funding? That is not a question the minister should be able to dance around and avoid. It is a fairly straightforward question.

Ms. Marleau: Madam Speaker, the Prime Minister has been a member of Parliament for 32 years. He does not need lessons on medicare from the Reform Party. Let us make that perfectly clear. He was here when medicare was brought forward. He saw the growth and the best of medicare. That is why he is such a staunch defender of it. That is what we are talking about.

The member for Macleod talks about core or medically necessary services and having lists. Certainly they are things that have been talked about. The premier of Alberta talks about them all the time and he has not been able to come up with a list.

I would understand if the member for Macleod would agree. After all, he is and was at another time in his life a physician. Does he not believe it is far better for physicians, medical practitioners, to make that determination when they have someone before them? They look at the evidence before them and know what is medically necessary or not, or they should know.

With the help of the Medical Research Council and many other agencies we are proposing to look at evidence based outcomes. Many procedures have been performed that perhaps do not have any real value. Those kinds of procedures should not be performed any more. We need to do a lot more research in that field. A lot of it is being done and we will continue to do it. We are proposing clinical guidelines so that there are fairly uniform ways of determining.

When we hear about an excessively high rate of hysterectomies in one area versus another area when the composition of the communities is essentially the same, there is something wrong. We will work at addressing some very serious discrepancies, but that is not to say that we should have a strictly defined list. I still believe that patients, along with their physicians and their caregivers, should be the ones to determine what is medically necessary.

Mr. Paul E. Forseth (New Westminster—Burnaby, Ref.): Madam Speaker, I have a question for the Minister of Health. Canadians are faced with a fundamental dilemma: there is less government money to go around to support medicare as we know it yet everyone wants to preserve medicare.

How do we reallocate tax dollars and in general bring more resources to bear on medicare in a climate of economic restraint? A lot of our problem is really not internal to medicare but rather the fiscal climate within which it is trying to operate.

Could the minister clarify the larger fiscal climate that affects medicare and the solution to that dilemma? How do we address the overall funding shortfalls for medicare that are getting worse every day? It is a national problem. What will the federal government do about it?

Ms. Marleau: I have said and I will repeat that there is enough money in the system. However I will say there are some areas where we have to set our priorities. Medicare is a priority. It is a priority for the federal government and it is a priority for most provincial governments. They have to base their financial decisions on their priorities.

We are doing it here. We are working at setting our fiscal house in order because we understand we have to do certain things to preserve and protect the very sacred programs which are constitutive to our identity.

(1125)

That is what medicare is. It defines what Canadians really are and it shows the values of caring and sharing which have helped to build this great country. We will continue supporting these solid values.

[*Translation*]

Mrs. Pauline Picard (Drummond, BQ): Madam Speaker, I welcome this opportunity to rise in the House and speak to the motion presented by our Reform Party colleagues, a motion that concerns Canada's health care system. Although we are aware of and condemn the federal government's unilateral withdrawal from the funding of health care services in Canada, the Bloc Quebecois cannot support this motion.

It is true that, as far as funding for health care is concerned, the federal government has betrayed the provinces by reneging on its commitments. It is true that, by continuing to impose its standards in an area over which the provinces have jurisdiction, while refusing to pay the real cost, the federal government acts like the charming host who invites you out to dinner but leaves you with the bill. We agree with our Reform Party colleagues that we should condemn, loud and clear, the present government's shameful withdrawal of funding from health care programs.

By continuing the work started by the previous Conservative government, which it deplored at the time, the present government has made the advent of a two–tier and two–speed health care system unavoidable throughout Canada. That is the tangible result of these harsh but insidious unilateral cutbacks in transfer payments to the provinces for established programs financing. However, the Bloc Quebecois could never support a proposal that the federal government become involved in determining core and non–core services, a prerogative exclusive to Quebec and the other provinces.

To establish a national list of core services would be a denial of the authority of the provinces to determine the kind of care they feel is necessary to maintain the health of the public that depends directly on the provinces for those services. Another reason why we cannot support this motion is that the Reform Party proposes to open the door wide to private insurers. Although federal cuts in funding for the public health care system in Canada has led to a proliferation of private clinics across the country, the Bloc Quebecois cannot support the advent of a two–tier system, one for the rich and one for the poor.

The present government's position on the management and funding of Canada's health care system is at best ambivalent. To me, it is clear the federal government can no longer afford its ambitious plans for managing the health care system. The trouble is, it does not come out and say so to the taxpayer, since by cutting spending unilaterally in a jurisdiction it appropriated at the time, the federal government has shifted the responsibility for breaking the bad news to the provinces. It takes credit for giving us the best health care services in the world, but it will no longer provide funding to maintain the standards it has set and compensate for the tax room it appropriated to pay the real cost of the system.

We should not be surprised that the health care system is coming apart at the seams, and mainly because of the federal government's withdrawal of funding. However, the government should be frank and make this clear to the taxpayers, instead of trying to camouflage the whole situation with its new Canada Social Transfer. It should stop trying to fool the public and give the impression that the whole might be better than the sum of its parts.

When the total amount of transfer payments is reduced in the Canada Social Transfer, it means there is less money for

education, less money for social assistance and less money for health care. One would have to be very naive to believe, as the Minister of Health seems to think, that this new approach will make it possible to safeguard Canada's health care system without involving a major departure from its main principles.

(1130)

In its last budget, the government introduced several measures which are a threat to our social programs. It cut transfer payments by $7 billion, which amounts to offloading $7 billion of its deficit onto the provinces.

The most recent cut in transfer payments is just one more in a series of unilaterally announced cuts over the past few years, a practice the members of this government used to protest loudly against back when they were in opposition. Between 1977 and 1994, the federal government's share in social program funding—health, education and social assistance—dropped from 47.6 per cent to 37.8 per cent. The latest budget follows suit with a draconian cut to the federal government's funding share, which will have sunk to 28.5 per cent by the end of the next two years.

After so many years of offloading to the provinces, the federal government still has not learned that cutting transfer payments is not helping to fix the financial problems of all of the governments in Canada. By insisting on governing areas over which its own Constitution gives the provinces exclusive power, the federal government is preventing the country from finding any real solution to its financial crisis, both at the federal and provincial levels.

We are clearly witnessing the dismantling, the crumbling of the health care system as we have known it up to now. The very essence of the motion before us today bears witness to this. It also confirms the dismal conclusions drawn at the provincial health ministers' conference, which was held in Vancouver earlier this month.

We all know that Quebec and the other provinces are facing a dizzying increase in health care costs. This increase is due mainly to the following factors: an ageing population; new, more expensive, medical technology, and a significant increase in spending on pharmaceutical products.

In the last budget, like other budgets before in which transfers were frozen, the government substantially cut transfers to Quebec and to other provinces for health care. Regardless of whether these transfers are lumped with others in one envelope called the Canada social transfer, the effect is the same: less money will be available for health care and, in this way, the government is eating away at the foundations of our health care system.

Nobody in this House can ignore the radical changes being made across the country to the health care system as we know it. A two–tier and two–speed health care system is no longer a prediction, but a reality.

I cite as proof the Prime Minister's latest statements, in which he quietly and furtively introduced the new concept of guaranteeing Canadians basic health care services only. By alluding himself to essential minimum standards, which are neither identified nor formulated, the Prime Minister is acknowledging the evidence emerging everywhere in Canada of a two–tier and two–speed health care system.

The two–tier health care system is evidenced by a trend, which is well established in the system and which, without drastic change, will become the norm. There will be a basic service covered by health insurance and there will be the full specialty service paid for by user fees, private insurance or some other financial arrangement.

The two–speed system is already well established throughout Canada: slow public service for those without the means to pay and quick private service for those who cannot afford to wait, but who have the means to pay the cost of a private clinic.

During his budget speech, the Minister of Finance solemnly stated, and I quote: ''The conditions of the Canada Health Act will be maintained. For this government, those [principles] are fundamental''. The government is maintaining the obligation to meet national standards, but, in the same breath, it is cutting the means to maintain them.

(1135)

It is shameful double talk: we want to go to heaven, but nobody wants to die. The government says it is up to the provinces to organize themselves and all that. It would have us believe that this is flexible federalism.

How can the government still think and argue that the provinces will keep the same health services for the public? How will Quebec and the other provinces successfully apply the five main principles of the Canada Health Act, which Ottawa is requiring them to do as it dumps billions of dollars of deficit on them through cuts to social programs?

The government should be strong and come clean with Canadians by telling them that, unfortunately, because of its errors in the past, primarily in the Chrétien and Lalonde budgets, it no longer has the means to maintain our health care system as we know it. But no, the government is deceiving the people by hiding the spectre of the demise of social programs due to so many years of bad management, of diluting provincial jurisdictions and of wastage, because it used its spending power to centralize and unify.

Quebec and Canadian taxpayers hand significant sums of money over to the federal government, and a portion of it was always set aside for health care under the 1977 agreement. The problem is that, for the past 12 years, the federal government

has not been returning the amount due the provinces to them, thus diverting money intended for health care. Instead, it transfers to the provinces the deficit it has accumulated because of its inability to bring its own expenditures under control. The federal government must be sensitive to and, more importantly, aware of the fact that, by increasing the tax burden of the provinces in this way, it is creating a two–tier health system.

We believe in the general principles of universality, comprehensiveness, accessibility, portability and public administration of health care. What we denounce is the fact that these five general principles are now seriously threatened in Quebec and all the provinces by the federal government's failure to honour its commitments.

Reducing or freezing federal transfer payments jeopardizes our health system. When it was first passed, the legislation governing established programs financing provided that 45 per cent of health costs were to be paid via Ottawa. However, because of the economic crisis in the early 1980s and the catastrophic condition of public finances at the federal level, the federal government began unilateral withdrawal action that will result, in 1997, in federal contributions being half of what they used to be. This withdrawal from financial commitments, repeatedly described as unacceptable, unfair and inconsistent by the Quebec government, did not lead to less interference from Ottawa. Not only does Ottawa continue to impose national standards, it interferes through parallel programs, thereby causing costly overlap.

This results in constant pressure toward the introduction of user fees and other billing methods, the curtailment of coverage for certain services, a service tax on drugs, bed closures and major budget cuts in hospital centres as well as disgustingly long waiting lists in several areas.

This is to say that the very foundations of our health system, namely free care, universality and accessibility, are in jeopardy. What does the minister think of her government's withdrawal from its commitments and the hardship caused to provincial health ministries? I think that, if she pays any attention to what goes on in her own department, the minister must be fully aware of the serious implications of such action on our health system. She must certainly see that all the leaks in the system will inevitably lead to a two–tier system, a two–speed system.

Since she took office, the hon. minister has repeated over and over that the Canadian health system is the best in the world and that she cares so much for the health of Canadians that she would never give up the five general principles laid down in the Canada Health Act.

Reality, however, is something else altogether. If she does not, as she claims, sacrifice these five general principles laid down in the Canada Health Act, her colleague, the Minister of Finance, on the other hand, certainly does not mind doing so.

(1140)

By taking the axe to established programs financing, the Minister of Finance is eviscerating the health care system, principles or no principles. They may swear that they are committed to the principles set out in the legislation, but if they do not provide the money needed to enforce them, what will happen? The principles will fade away one after the other, slowly but surely.

I freely admit that the Minister of Health may be committed to the principles that guided the implementation of what she always likes to refer to as the best health care system in the world. However, I think that this commitment, however profound, did not weigh very heavily in budget decisions. It must be recognized that the minister failed miserably in her attempt to secure the funds needed for the smooth operation of the health care system.

In fact, the Minister of Health renounced her responsibility. When the 1994 budget was tabled, she announced with great pomp that the National Forum on Health promised in the red book would be held under the chairmanship of none other than the Prime Minister himself. The health care system was supposed to be spared until the results of these widespread consultations were known. Although the Minister of Health succeeded in holding her forum, which was supposed to solve all the problems, the Minister of Finance for his part did not beat around the bush. Saying to hell with the forum, with consultations and reforms, he decided that the remedy lay in blind, uniform, unilateral cuts across the board.

The Minister of Health, who, like us, must see a two–tier system developing across Canada, should have the courage to rise in this House and denounce her government's unilateral cuts.

It is not true that user services will remain the same. It is not true that the provinces, to which the federal deficit hot potato has been passed on, will perform miracles with shrinking resources. The minister should agree with this analysis since it reflects her own interpretation delivered in this House on March 9, 1992, when she was a member of the opposition.

What we must realize is that, by perpetuating the mistakes of the past, the government is moving toward the position held by the Reform Party, that is, a two–tier health care system that is partly public and partly private. The difference is that the Reform Party does it directly and openly by tabling a motion, whereas the government does it in an underhand and hypocritical manner by refusing to face reality and admit that it can no longer afford to pursue its ambitions.

The government finds itself in that position because it does not have the will to cut elsewhere in its spending and to review its fiscal policy. The government is prepared to sacrifice health, but it does not hesitate to maintain useless and costly dupli-

cation, as well as family trusts, or to pay for costly ministerial suites, among other things.

Whether it is through the government's approach or the one proposed by the Reform Party, the Bloc Quebecois cannot support the destruction of our health care program. If the federal government no longer has the means to meddle in this field of provincial jurisdiction, it should completely withdraw from it and leave it to the provinces, with the tax room that goes with it. In doing so, the government would at least save the administrative costs of the federal programs which duplicate similar provincial initiatives. Both the federal and provincial governments would benefit, not to mention Canadians, who would definitely get more for the same amount of money.

The failure of the health care program reflects the failure of a centralizing federalism. That program can no longer be a great tool to promote Canadian unity, as this government would so dearly love. Let us do without symbols which we cannot afford. Let us be realistic. The federal government must stop trying to impose its utopian vision of an egalitarian Canada and withdraw from those sectors, including taxation, which fall under provincial jurisdiction.

This is the Bloc's position and this is why we reject the motion.

(1145)

Hon. Diane Marleau (Minister of Health, Lib.): Madam Speaker, first, I would like to thank the hon. member for taking part in this debate and for having made a speech here, but I think that she may have missed one or two things in mine. First, Canada is second in the world regarding the overall sums spent on health care. No expert, no economist anywhere would tell us we should be spending more. Not a one. We know that we could even do more with less.

I am sure that Quebec's Minister of Health agrees with me on this point, because, this year, he is proposing a half billion dollar cut, $545 million to be exact, I believe, to the health care budget of the province of Quebec. So he too probably realizes that we do not need to pump more money into the health care system, but to better manage the amounts we do put into it. These things need to be said because this year's transfer payment has not been reduced but increased.

The Canada Health Act gives the provinces a lot of leeway. In fact, they already have all of the freedom they could want, except to levy user fees or charges for hospital care or medical help.

The fact that the Canada Health Act prohibits user fees is important, and Canadians should appreciate that this legislation can help them, especially when they are sick.

The hon. member talked about overlap. The federal government only employs 25 people to administer the Canada Health Act. Is that overlap? In my opinion, we are doing quite a good job, because we are working very closely with the provinces to avoid overlap, especially in the area of health care.

The hon. member made a fine speech, but what I really want to know is the following: Does the Bloc Quebecois support the principles of the Canada Health Act or does it envision a two-tier system? Does it want to bring in user fees? Exactly how does the Bloc Quebecois intend to do things better or to change things? Does the Bloc Quebecois acknowledge that the Canada Health Act has served Canadians very well and that we absolutely must build the system of tomorrow on the values it contains?

Mrs. Picard: First of all, Madam Speaker, I want to thank the minister for her questions.

I would like to remind her of the position of the Bloc Quebecois. In 1977, when the five main criteria in the Canada Health Act were adopted, agreements were concluded with the provinces. The gist of these agreements was that the federal government would transfer to the provinces the money they would need to administer the health care system.

With respect to the cuts I mentioned earlier and to what I said in my speech, I would like to point out to the minister that she misunderstood entirely what I was trying to say, because I always said the Bloc Quebecois supported the five main principles of the Canada Health Act. However, we object when the government cuts transfer payments and then asks the provinces to do more with less money, when we know that the—

An hon. member: Oh, oh.

Mrs. Picard: Exactly, if you had not cut transfer payments, Mr. Rochon would not have been able to—

Some hon. members: Hear, hear.

Mrs. Picard: Madam Speaker, I would like to quote from the speech the minister made in 1992: ''Cutting back on the transfers in these areas has not contributed to better management of our health care system. We have literally forced our deficit onto the provinces and said to the provinces they have a choice: they can either increase their taxes or cut back on their services. What we have seen in many cases is a mix of the two''.

(1150)

In the same speech, the minister also said: ''Cutting back on the transfers in these areas has not contributed to better management of our health care system. They have only contributed to the cutbacks and to the fear that we feel now across the nation, as the middle income group, which is the largest group of Canadians, are frightened and afraid of what is going to happen to them in the future. Will there be a health care system for them, will they be able to get the drugs that they need at the prices they

can afford to pay when they need them, when they get to be a certain age. There is this feeling that perhaps the federal government is letting go of its responsibilities in this matter''.

[*English*]

Mr. Paul Szabo (Mississauga South, Lib.): Madam Speaker, in the comments of the hon. member for Drummond, the statement is made that the federal government is attempting to keep Canada together by using medicare. The member should realize that medicare is not a vehicle to try to keep Canada together. It is one vehicle that has kept Canada together and makes it the best country in the world.

The five principles of the Canada Health Act are universality, accessibility, portability, public administration and comprehensiveness.

I ask the member which of those principles she does not support and why does she feel medicare is not working?

[*Translation*]

Mrs. Picard: Madam Speaker, the Bloc Quebecois agrees with the five main principles of the Canada Health Act. However, and I repeat, we do not agree with dumping the deficit onto the provinces by reducing transfer payments to them, while they are facing increased health costs. The government reduces the payments and then tells the provinces they have to manage the health care system as usual, as the act provided in 1977.

I myself do not want a two–tier or a two–speed system. However, if things continue the way they are going, the provinces will be forced to find a way to manage to serve the public and administer the health care system, because they cannot manage it with the cuts in the transfer payments. This is what is happening, and the government keeps on cutting. The effect of this, at the moment, is that it is better to be rich and healthy than poor and sick.

Mrs. Eleni Bakopanos (Saint–Denis, Lib.): Madam Speaker, it is unfortunate the Bloc Quebecois can only repeat that it is the government's fault. How is it that the Minister of Health in Quebec cut $454 million from his budget, when the federal government's transfer payment actually went up? The blame need not always be placed on the federal government, because provincial governments make their own choices. The choice the PQ minister and government made was to cut in the area of health care on the backs of the poor, just like you said.

Mrs. Picard: Madam Speaker, why did Mr. Rochon, the Quebec Minister of Health, have to cut his administration in order to continue to manage certain forms of health care? Because there was a shortfall of $8 billion.

An hon. member: There you have it.

An hon. member: That is the truth.

Mrs. Picard: In terms of health care transfers since 1982–83, Quebec will yet again be shortchanged by Ottawa, by $2.4 billion between now and 1997–98. Then, with the increase in health care costs and the cost of new technology, it is supposed to do more with less? How can health ministers ensure that the five main principles are applied if transfer payments and social programs are cut. I do not understand how your constituents are not fighting this. You have just cut social programs.

(1155)

[*English*]

Mr. Grant Hill (Macleod, Ref.): Madam Speaker, health care is too important to be left to politicians.

I would like to quote the Prime Minister, as I did in the question and comment portion of the debate. The Prime Minister has said to all Canadians, in a public forum, that we must go back to basics. I would also like to quote the health minister when she said, in reference to the Canada Health Act, that we will enforce the provisions of the Canada Health Act but we will be very, very flexible.

On those two comments and those two reflections on health care I am in wholehearted agreement. That statement will come back to haunt me. I know I will be quoted as saying that I wholeheartedly agree with the Prime Minister and the health minister on all issues of health care. I agree with those statements in particular.

When I say that health care is too important to be left to politicians, how would I determine where health care should go? I would line up in these halls 100 high school students and I would make a speech in this Chamber, much as I am doing today. I would ask the health minister to do the same, and I would ask for the old–fashioned thumbs up or thumbs down on the proposals of the health minister and my proposals. I would determine whether or not I was on base with health care reform or whether the health minister had it right. It is the old Roman up or down. Maybe the pages could do it for me today.

If the Prime Minister and the health minister and I are so close on the issue of health care reform—those were basic statements, brand new statements, statements that have not been made in our country for some years—where do we differ? Frankly, we differ on the cause of the need for health care reform.

I will now go to a brand new survey from Statistics Canada on government spending. The figures I am quoting do not come from the Reform Party, they do not come from a strange source, they come directly from StatsCan.

In 1994–95 the federal government will spend $1,522 per person on servicing the debt. What will the federal government spend on health care per person that same year? Two hundred and sixty–eight dollars. That is the reason we stand in the House today debating the future of the health care system. Anyone who stands up and says that is not the reason is an ostrich, hiding his or her head in the sand, ready to be plucked.

Teenagers in Canada will not listen to that kind of nonsense any longer. Fifteen hundred and twenty–two dollars per person on debt servicing is squeezing the heart out of the $268 left for health care.

Reformers are looking for specific, positive solutions. To do what? To rip the heart out of health care? Not a chance. To preserve and save this most valuable of our social programs. Therein lies the problem. Therein lies the anchor. Therein lies the noose for health care.

My focus with these words will be the Canada Health Act itself. The health minister said: ''I want Canadians to know that the Canada Health Act is alive and well and able to take on the challenges of the future''.

(1200)

I have another quote from Dr. Steven Stern of Ajax, Ontario: ''We must recognize the financial crisis in most provinces that has rendered the Canada Health Act hopelessly obsolete and the fantasy of supplying all medical services to all of the people all of the time from ever escalating middle class taxation is a futile hallucination''.

I believe the Canada Health Act is in trouble. I believe the Canada Health Act needs help. I believe Canadians will no longer allow rhetoric to judge whether the Canada Health Act will survive.

What has broken down in the act? I will talk specifically about provisions in the act that are failing. First, on portability, the act guarantees services provided to Canadians outside the country will be paid for at the same rate as if a person got sick in Canada. That is broken. Snowbirds who travel to Florida and come back to Ontario are paid $100 per day per hospital visit. There is not a hospital in Canada that can provide $100 per day service. Portability is broken.

[*Translation*]

In ''la belle province'', Quebec, there is a provision to the effect that each doctor is entitled to a certain portion. Here in Ontario, the portion is not the same.

[*English*]

Portability is broken and the minister knows it. The minister knows the Canada Health Act is falling down in portability.

On accessibility and reasonable access, where are we with reasonable access guaranteed in the Canada Health Act? One specific breakdown is that Manitobans are waiting 60 weeks for hip replacements when the norm is 12 weeks. Reasonable access is toast under the Canada Health Act.

Comprehensiveness is another plank of the Canada Health Act. How about the issue of what is medically necessary? Here we have provinces unilaterally deciding to take test tube babies off the medically necessary list and put on sex change. Those two things might be discussible under the provision of medically necessary. This is arbitrary and fragments health care across Canada.

What about the bill's provision—this is not one of the planks of health care but one of the very basic provisions of the Canada Health Act—that there will be a prevention of user fees?

In the House I have mentioned to the Minister of Health—this is not a unique thing to the province I will mention—that there is a hospital in Wolfville, Nova Scotia whose facilities were being shut down. It stated its facility was too important to be shut down. The province stated it could not afford the facility any longer but the staff was to keep it running. How were they to keep it running? By volunteer nurses, by a fee for the syringe, the local anaesthetic and the suture so that each patient who comes in with a laceration now pays for those basic facilities. Is it a user fee? Yes. Is it medically necessary? Yes. Is it the choice of the people in Wolfville, Nova Scotia? Yes. Should they be allowed to have that choice? Yes. It is their health; we should not be leaving this issue to the politicians.

(1205)

The act guarantees, and this is not commonly known, reasonable compensation to practitioners who provide the services. I know of three provinces which have broken agreements with their medical practitioners unilaterally, agreements signed, sealed and delivered. Is reasonable compensation being given? The act is broken and there are no repercussions for that.

If the act is broken and I ask the minister to stand up and tell Canadians that what I have said is inaccurate or untrue, should the minister be protecting this most valuable act? I think she should. Her reaction is to reinterpret sections of the act. She has gone on to define the hospital to include private clinics. She has decided semi–private clinics do not deserve the funds they have been getting. That issue is one that we may argue a lot but this does not sound like going after the basic principles of the act to me at all.

We have been over funding provisions. I hear members of the Bloc say the federal government should not be withdrawing funding. There is no question in my mind the federal government has no choice. I do not think there is any point in going back and deciding the reasons for these choices. The federal government has no choice.

I listened to more rhetoric not so long ago in my province of Alberta. The Prime Minister says the Canada Health Act does not allow private health care. I shook my head when I heard that,

recognizing that almost 30 per cent of what is provided in Canadian health care is private.

I asked the Prime Minister about the Shouldice Hospital in Ontario for hernias, about totally private laser eye surgery, about physiosports medicine clinics, about chiropractic, about cosmetic surgery that has been taken out of the fee schedule, about laser treatment for snoring, sleep apnea and bad breath. All these things are available so close to the House of Commons privately and there is no room under the Canada Health Act for private health?

We have two tier health in Canada now. We will end up if we ignore the Canada Health Act, if we do not improve the Canada Health Act, with universal access to nothing. The $1,522 of debt servicing will choke that $268 and we will kiss it goodbye, and that will be wrong.

This is not an answer that comes from me but I am now elucidating the answer from my colleagues. My answer is to give sensible Canadians choice over their most important resource, their own health. That is why I would line up the 100 high school students.

A journalist phoned me the other day. He said: ''I will ask you what you mean by your core essential services because I have asked a whole host of other individuals in Canada and none of them will tell me what they would take out of the core essentials. I know you will do it because you Reformers are not filled with political rhetoric yet''. I had the opportunity to tell him some of the things I would take out.

For members opposite I will give a specific example of one thing I would take out of our broad health care coverage and put beyond the core essentials. This is actually being done in Quebec. The members of the Bloc will not be interested in this. Quebec has decided that psychoanalysis is no longer coverable under health care. Psychoanalysis is the treatment where one lies on the bed, the psychiatrist sits there and one comes in week after week for years on end to figure out what was the matter with one's psyche.

(1210)

Quebecers in their wisdom, I give them credit, have said psychoanalysis is not something that should be covered under our core essential health care budget. They pay for psychotherapy which is much tighter, better controlled, involves looking after something like anxiety or suicide, possibly giving medication and a fairly rapid return to the workplace.

Outpatient psychotherapy is covered and with outpatient psychoanalysis you are on your own. You can either get insurance coverage or pay for it out of your own pocket. In their wisdom they are doing what Reformers are suggesting.

Will this be a big bureaucratic process? Not on your life. This is a process that will also be flexible. This is surely a process that our national forum on health should have and could have addressed.

I listened last night to the minister make a very good speech. It was tight and controlled. I really credit her for this. She said, using different words and phrases, virtually the same thing I am saying. There are things we are doing today in health care that are ineffective.

She said we must look at those things. That is what we are talking about. Define the essential core. Look at the things that are ineffective and set them aside. They are discretionary. They may well be covered by private sources, insurance or other sources.

We are not so far off. The rhetoric may put us a long way apart but we are not so far off. Evidence based issues, let us call them what I call them or call them what the minister calls them, core essential, evidence based; not so far off.

The national forum on health, which has people with vast experience from all over the country, should and could be doing this very thing today.

My time is rapidly drawing to a close. I hear delight from across the way. It is a shame because this debate in the House is so important and has not been done for so long. I will be disappointed if there is not a frank and open interchange on this.

There are other problems with health care beyond the federal portion. There are problems with accountability. There are problems with abuse. There are problems with our medical legal system and there are big problems with our drug costs.

Each one of those deserves a good, frank expose as well. I have colleagues who will talk about other innovations we think might have some benefit for health care, funding changes that might well be present. I ask each member to consider what will happen if we ignore the $1,522 for debt servicing versus the $268 being spent on our health.

Hon. Diane Marleau (Minister of Health, Lib.): Madam Speaker, I thank the hon. member for Macleod. As I listened to his speech I realized that we are a lot closer than perhaps is apparent in many cases.

I listened to some of the interventions the hon. member made and I will make a few statements to perhaps rectify some of the misconceptions out there.

I have not ever said there have not been problems and that there do not continue to be serious problems with other sections of the Canada Health Act. Portability and out of country portability is one of the areas we are working on. We are trying to reach a solution with provincial governments. We believe in working co–operatively with them.

When it comes to Quebec and the portability issue there has been considerable movement on the part of Quebec to address some of the problems of people from Quebec travelling to Ontario and not getting the coverage they should have.

(1215)

There is an agreement of sorts in place to cover any treatment here in the Ottawa Valley or in the Abitibi section up north. I am hopeful, because I know that the Government of Quebec is extremely interested in serving the people of Quebec, wherever they travel. I would hope we can get some kind of an agreement on that in the near future.

When it comes to accessibility and reasonable access, there will continue to be waiting lists. Some provinces have done a lot of work to address that. Not to be discounted, some provinces have a central registry of where there are rooms available so that hip replacements can be done. As you well know, there are waiting lists, but often when the need is very great those people jump to the front. When they get access to hip replacement it is generally because their need is much greater. Although access is not always perfect, everyone works to address the problem.

The member has talked about a place in Nova Scotia, Wolfville. I do not have the particulars of Wolfville, but user fees and facility fees have been and will be outlawed. Just go back to my letter of interpretation in January. I would expect that Wolfville would be addressed by that letter of interpretation. If the member has any other information, please let us know.

There are a number of other points the member made, including Quebec's psychotherapists and what is happening in the province of Quebec. They are working with medical professionals to determine the medical necessity and what they will cover. That is the beauty of what is happening with the Canada Health Act. We encourage that.

These are the kinds of things that are happening across the country. When one province gets one thing right, others often follow suit.

The member spoke about the Shouldice clinic. Yes, it is a private clinic, but it is covered by the Private Hospitals Act in Ontario. There is an act in Ontario that governs that. Therefore, people do not have to pay additionally. They get access.

We have to understand that while we have a good system, it is not perfect. Any other suggestions the member may have would help us. One of the things he seems to be proposing, at least as I understand, is a system of user fees for certain procedures or items, which would be based not on need but more on the ability to pay. This is where we fundamentally disagree.

When a facility charges a facility fee and general taxpayers are paying the physician fee, they are in essence subsidizing queue jumping for those who have the money. That goes against our principles. I would hope it goes against yours, although it does not appear to do so. That is a tax on illness. That is not a fair tax, at least in my book. Perhaps the hon. member can tell us how he thinks a facility fee is fair.

Mr. Grant Hill (Macleod, Ref.): Madam Speaker, what has been missed in all of this discussion is unless we define the core essential we cannot decide whether or not a user fee has any place in our system. For discretionary, elective things, surely the minister would not deny those things to be done. That is why we need the definition. That is why there cannot be this airy–fairy situation where one thing is medically necessary in one part of the country and one thing is medically necessary in another.

On the issue of facility fees, the semi–private clinic, there is a philosophical argument on that specific issue. If the procedure is medically necessary, it must be paid for by public funds in Canada today. If the procedure is medically necessary and it is done outside a hospital and the costs generated to do that outside the hospital are not borne publicly, where should they be borne? I believe they should make no impediment whatever to the public system.

(1220)

I ask the minister, although this is not interchange time, to find me a country—without using the U.S. example, which is commonly used and where that is not done—where that produces a problem.

Mr. Harold Culbert (Carleton—Charlotte, Lib.): Madam Speaker, I listened with great interest to my colleague for Macleod. We had the opportunity of serving together on the Standing Committee on Health.

I would ask the hon. member what his definition of core is. He would know that there are criteria established presently from one province to another about what is included and what is considered outside those parameters.

Generally speaking, Canadians look on our medicare program as one that is accessible to all Canadians for good health care, regardless of their status in life. Surely my colleague is not suggesting that we should revert to a system that is dependent on how wealthy one happens to be, or a system such as the United States currently has, where we know there are literally thousands of people who are left outside the system.

I want to refer to one particular incident that I am well aware of regarding efficiencies. Of course we must change from time to time in order to be much more efficient. There is no question. That is why health care has to be upgraded continually from that perspective. That is exactly why the Prime Minister appointed the National Forum on Health to study that whole scenario.

Surely my colleague for Macleod is not suggesting that we open up to some other system, for example the system that is in the United States, which does not work. The medicare program is so important for all Canadians, and treats everyone from coast to coast on an equal basis.

Mr. Hill (Macleod): Madam Speaker, I appreciate the opportunity to respond.

Let me give the member another example of something I would take out of the core. It seems to be lost on the member that the core must be defined. The core has the essential things.

Although I have some expertise in this area, I do not pretend to be able to define the core perfectly. When health care started, there was no such thing as joint replacement. The first joint replacement literally came with health care.

The hip joint prosthesis ranges from $1,000 to $7,000. I would decide which of the prostheses is cost effective for Canadians and say that if you want a $7,000 prosthesis, pay for it yourself: we in the public system will give the Chevrolet prosthesis; if you want a Rolls Royce, you pay for it.

Ms. Hedy Fry (Parliamentary Secretary to Minister of Health, Lib.): Madam Speaker, I rise to speak with a mixture of emotions. There is some confusion, some humour, and some sadness.

I am confused that members of the third party would bring forth this kind of motion when it so clearly contraindicates everything they have ever said in the past during their campaign and even during their proposed budget earlier this year.

(1225)

There is some pleasure because I am proud to be able to speak for the system of health care we are espousing in this country and in which we so firmly believe. And there is a little sadness because one of the movers of this motion is a physician and has shown such a lack of understanding of the system, the words, the terminology and the principles that medicare is all about. It saddens me that he should rise to speak to this motion when he so obviously does not understand the system. I would like to know why he does not understand it.

What we have heard is simplistic rhetoric. It is the kind of thing we have come to expect from the third party: there is always a simple answer; let us not confuse the complexity of the question, let us just throw a simple answer at it.

What is so simplistic about it and what is so rhetorical about it is in terms of the statement of the problem, which is not factual. The statement of the problem is not based on fact at all. As the Minister of Health said when she spoke earlier, the figures quoted, which indicate a decrease in the percentage of payments to the provinces from the federal government, are absolutely untrue. The statement talks about total health care cost. It does not show any understanding of what the cost the federal government contributes to, as written in the established programs financing, is all about. That cost is purely for hospital and physician services. It is not for the whole bailiwick of health care services, which each province has expanded or constricted as it feels it wants. That is not what the federal government sends the transfer payments for; it is purely for physician and hospital service. That is the first bit of disinformation that came about in this.

The second thing that is simplistic and rhetorical about the whole thing is the solution, the constructive alternatives we were given. They have absolutely nothing to do with ensuring efficient, universal, affordable, quality health care in this country. Universal quality health care is far more complicated than giving a cute, uninformed speech. It is a complex issue.

Let us look at the preamble of the speech made by the hon. member for Calgary Southwest. He talked about the fact that we already have a multi–tier system. That alone shows a lack of understanding of what is meant by the term comprehensive, which is one of the five principles of medicare. It shows a lack of understanding of what medically required services means. It shows a lack of understanding of what the terms universality and accessibility actually mean under the Canada Health Act. The hon. member did not even read the Canada Health Act. He does not even understand the definition of the terms.

The whole idea of having a multi–tier system is one of the usual red herrings that are thrown at us. Of course we have systems where there are always and have always been non–medically required services that patients pay for. They have always paid for them. If anyone wishes to have a face lift, they can always pay for one. There are many instances where people think they want something that is not medically required and they go out and buy it. That does not constitute a multi–tier system; that constitutes a system that operates outside of what the Canada Health Act defines as the five principles of medicare. The hon. member should go back and read the Canada Health Act.

The other thing the hon. member said in his preamble was that users should define full services. Users define full services? I do not know that many patients would want to define what an essential service is and what a medically required service is, because they are not physicians. They may want to participate in the decision making of what is appropriate in the treatment, but they would not want to define what is clinically necessary and clinically required for them. That is why they go to a physician or a health care provider. That alone seems to me to be a rather simplistic and very impractical solution.

What else do we have if we have started off with the first part of the motion being based on a false premise? The whole scaffold on which the argument is based is nothing more than

smoke and mirrors. It is a weak scaffold because it is based on lack of fact, lack of information, and lack of knowledge.

The hon. member said that we talked earlier on about the 50 per cent the federal government is supposed to transfer to the provinces.

(1230)

As the minister and I said earlier, we were never supposed to transfer 50 per cent. In 1975–76 we transferred 39 per cent of total health care. That 39 per cent constituted a greater percentage toward hospital and physician services only which is where it was supposed to go. Therefore, the rest of it is nonsense.

That has not gone down a great deal when we look at the fact that in 1992–93 the total percentage of transfer has gone down to 32 per cent and the provinces have expanded their total pot. That again is a false presumption of what the percentages should mean.

There again I think the mathematics and the understandings were not done. If the figures were wrong and the assumptions were wrong, is the whole concept we are debating today wrong? It must be because it is based on a false assumption and a false concept.

Everyone is saying that we need more money for health care. The concept of more money does not seem to sit well with the third party. The leader of the third party said in his budget speech and in fact said in Saskatchewan that he would transfer more tax points to the provinces. He would give them more money.

Simple mathematics, and I am not a mathematician, tells me that in taking away from one side of an equation there is surely a corresponding addition to the other side. Therefore, if we take money away from our big pot to give more tax points to the provinces, what the hon. member did not factor in in his budget speech is that he is going to be $10 billion deeper in the hole in the deficit. How does that make sense with fiscal responsibility and cutting the deficit to zero in one year that we were talking about? It does not make sense. None of it makes sense.

It is widely recognized as a fact that anyone who understands health care economics knows that throwing more money at health care is not the answer. In fact the quality, the outcome, the efficiency and the effectiveness of a health care system does not depend on money. If it did, the United States which spends the most amount of money not only per capita but as a percentage of GDP on health care would have the best health care system in the world. However, it does not.

At the moment the country that ranks the highest for having the best health care system in the world is Japan. It spends a lot less money than Canada spends as a percentage of GDP. Money and a good system do not equate. Money in a health care system does not equal outcome.

We know that many other things determine whether people are healthy or not. They have to do with socioeconomic factors, environmental factors, lifestyle factors and quality of life factors. None of those things are part of giving people more medical care. We can give people more medical care and we will not decrease those outcomes one whit. Throwing money at the health care system is not the answer.

The challenge is how wisely we spend the money we put into the health care system so we can use the money for the socioeconomic and other issues that determine health. It is one of the big challenges we have to look at when we talk about health care.

Let us look again at the third party using money as a criteria for effective and efficient health care services. If we talk about that then we are talking clearly about the fact that if one cannot afford the health care system and more money has to be thrown at it then people must pay for the health care system. Therefore, we are back to this hidden or not so hidden agenda the third party is talking about which is in fact finding a way to get the user, the person who is sick, to pay for their health care.

It is a not so clever plot to say the system needs more money, the system needs more money, the system needs more money. Then we are going to have to say that if we are going to balance our budgets, and we cannot find the money from government, let us charge the people, the ill. Let us tax them. That is what is so underhanded and so disturbing about this motion, the whole concept that is underlying what we are talking about here today.

It is a typical mentality that comes from people who espouse a south of the border policy on health care. We look at the United States and the kind of health care it gives. Yes, there is a two tier system there and yes of course people are allowed to buy health care but it is based on one criteria, the pocketbook. Those who can afford it can have unlimited access to health care. Those who cannot afford it, we see what the outcome is.

(1235)

At the moment the United States is sixth among the developing countries in its health care outcomes. It does not have the health care outcomes of a developed country because those who cannot afford it, with poverty being the major determinant of health, those people are sicker.

That is the way the Reform Party would have us go and it concerns me. In fact, if we give the rich unlimited access to health care what we see is that the number of interventions and the amount of laboratory tests are greater as a percentage of users in the United States than it is in Canada. The people who are using them more are based purely on the people who are in a

high socioeconomic bracket. In other words there are people who are having care and interventions.

Open heart surgery is one example. The rich are getting more open heart surgery. It does not fulfil the criteria of whether they need it or not. The fact is they want it, they want to buy it and they are getting it. I do not consider that to be good medicine and I do not consider it to be good health care. I do not think we want that situation in this country.

Let us look then at the solutions the third party recommended. The solutions it talks about are core services. We all know on reading the Canada Health Act and if we understand the principles of medicare, that the definition of medically required services is a provincial jurisdiction. The provinces have to define medically required services. This is a good thing. The provinces are where the regional disparities lie. Different provinces have different health care problems. Different provinces have different needs.

We talk about bottom up care. It is appropriate to have the provinces deciding. That is what we have tried to do when we have discussed how we give the provinces more decision making in health care. It is to allow them to provide appropriate services for people where they need it, when they need it and how they need it. They know that better than the central government.

We believe our role to play as the central government is to bring about and co–ordinate what it is we see within the principle that those medically required services are based on clear clinical guidelines. This is why the health forum was set up. The health forum is dealing right now with how we define, how we look at outcomes. It is dealing with how we look at what is the care and the criteria necessary to provide those outcomes so that we are not guessing as the hon. member for Macleod would have us do and set all sorts of criteria for who should get it and what a core service is.

The hon. member for Macleod has decided that a core service should be something that is on a list of items. A core service is not an item. If we take for example the item of ultrasound for pregnant women and say that only one ultrasound will be done on a pregnant woman, that does not make any sense. Some pregnant women clinically require more than one while others only require one.

We need to look at clinical guidelines when we talk about core services, not whether the item is a good idea or not, not to generically define items. That will not give us good care.

Nor should it be like the hon. member for Macleod said to the Calgary *Herald* when he defined who should get health care and who should not and that if a woman in her past history had been promiscuous and had her tubes blocked she should not have a tubal ligation paid for by the government. What sort of subjective, moral, paternalistic health care system are we talking about here when we want to define core services that way? That concerns me a great deal.

We also hear terms like private insurance. We all know from the United States and Robert Evans of UBC has shown us very clearly that multiple insurance systems and multiple payer systems are more expensive. They are more inefficient and in fact do not create the right kind of outcomes.

The United States has multiple payer systems. The administrative costs are 25 per cent of the health care costs. Recent studies have shown in the United States that if that 25 per cent on administration could be rolled into a single payer system, there would be enough money to give health care services to the 37 million Americans who do not have it right now. If the money spent on Massachusetts Blue Cross alone could be decreased in administration there would be universal health care in the United States.

When we talk about health care and about multiple systems, we are talking about greater costs. We are talking about defining who can no longer be insured because they are now chronically ill.

In the United States someone who is chronically ill becomes uninsurable. Even if that person has millions of dollars to buy insurance, he cannot buy it. That person has to pay out of his pocket. That is okay if he has millions of dollars but someone who is a middle income worker cannot.

(1240)

The other term ''benefactors to pay'' as I see it is a nice term for user fees. We are hearing all these little words that have been put in so that it sounds wonderful. We are talking about a two–tier system that in this country does not define what we see as health care.

When we talk about health care we are talking about looking at how we can save money on health care costs. Recent studies at the University of Ottawa and Judith Maxwell have told us that we can save $7 billion a year in health care costs if we do some real things. For example we could shift from hospital based care to community based care. We could look at how we set clinical guidelines for care. We could look at how we help the determinants of health so that the socioeconomic factors that create illness in people are decreased.

There are many things we can do to decrease health care costs without changing the five principles of medicare, without having to make people who are sick pay. The only way the third party can see for solving the problems is to define core services with the kind of hidden agenda it is defining. Reformers are talking about user fees and multiple insurance systems.

What is wrong with that solution is that every system of health care in the world is based on some sort of rationale. The rationale in this country has to do with clinical need and that is the way we want to keep it. I do not ever want us to see where the rationale for our health care system is the pocketbook.

Therefore I strongly speak against first and foremost the problem which is not factual and also the solutions put forward this morning by members of the third party.

[*Translation*]

Mr. Pierre de Savoye (Portneuf, BQ): Madam Speaker, I listened with great interest to the comments made by my hon. colleague. I know that she is very knowledgeable about health issues and that she really wants to ensure that the Canadian health care system is in the best of shape.

I would, however, like to remind her and this House that medicare was invented by Quebec a few decades ago through the good services of Mr. Castonguay. That is why we as Quebecers care about maintaining the essential characteristics of a good health care system.

Of course, such a system needs predictable financing. The Canadian provinces and Quebec have had to deal with the cuts in established programs financing that have been carried out for over a decade, in violation of the 1977 agreement promising reliable funding to the provinces; they had to make do and, in some cases, even improvise in health care matters. That is where the shoe pinches.

By redefining the transfer of taxpayers' money to the provinces, the federal government has gradually destabilized the Canadian health care system. In fact, the federal government has, unintentionally, I admit, contributed to this decline of the Canadian health care system, which is already leading to a two–tier system.

Basically, we have a right to ask the following question: Why does the federal government not transfer to the provinces and Quebec all the tax points linked to health care financing so that the provinces and Quebec can determine themselves the best way to provide services in compliance with the five fundamental principles of health care?

I would like my colleague to give me her opinion on this.

(1245)

[*English*]

Ms. Fry: Madam Speaker, I thank the hon. member for rewriting the history of medicare a bit. Some people would argue that it was Saskatchewan and others would say it was Quebec, but that is a moot point.

The hon. member mentioned money. We keep hearing about money being a factor in providing effective health care. There is an English saying that necessity is the mother of invention. Because of necessity and because there has been very little money, provinces have begun to be inventive. It is not an invention that has decreased the quality of health care.

Something that has been necessary for many years which neither the provinces nor the federal government faced up to was that we needed to change our health care system to make it more appropriate to the needs of people and to make it more effectively and efficiently managed. As a result of the necessity, people are beginning to manage the system.

The amount of money put into a health care system by any study of any country does not equate to quality of care. Otherwise, as I said, the United States would have the most wonderful health care system in the world because it spends the most money. Yet Japan, which spends the least, has the best. There are more things that determine the health status of a country and the health of individuals than money spent on intervention and on medical care.

I spoke as well about the ways in which we could decrease the cost of the system, improve accessibility and improve the ability of patients to make decisions within their own health care system. That is by shifting from acute care to community care, by shifting and creating guidelines for care, by looking at outcome analysis and by setting up technology assessment, by doing all the things we are learning to do that some provinces have already begun to do.

Judith Maxwell of the University of Ottawa is predicting in her report that if we continue to do such things we will need to put less money, almost $7 billion less, into health care. It is very important to understand that and not fall prey to the rhetoric that continues to say that we should keep throwing money at health care in the hope that it will stick somewhere. It never has and it never will.

All the studies on mortality, morbidity and quality of life are telling us that is not what will create the outcome we are looking for.

Mr. Keith Martin (Esquimalt—Juan de Fuca, Ref.): Madam Speaker, what does hon. member think about the recent comments of the British Columbia Health Association about being significantly concerned about access to essential health care services in British Columbia? This is not something occurring solely in British Columbia. As the member well knows, it is occurring across the country.

My party has proposed an alternative form of the Canada Health Act. We would allow the provinces to have such structures as private medical clinics. Not a dollar from Canadian taxpayers would go toward paying for it. Members of the public would have the choice to pay for the services, whatever they happen to be, in private clinics. We must bear in mind that the services would be offered to anybody in a public hospital or a clinic.

What is so wrong? How will private structures involving the exchange of private moneys impede the ability of the public sector to provide services? Also, why does the government have such an aversion to choice when we have choice in almost everything else in our lives?

Ms. Fry: Madam Speaker, I thank the hon. member for his question.

What is wrong with setting up private clinics so that people who want to pay can pay? We only have to look at the United States where people who want to pay can pay and buy as much as they want whether or not they need it and people who cannot afford it have inadequate and inappropriate access to health care.

(1250)

A major determinant of health is socioeconomic status. Poverty is the greatest determinant of health. Poor people need more services. We are basically saying that we have some false savings here. We will not save any money. The people who need the services more will be the people who cannot afford them. They will still be going to the public sector. That is the first point.

Second, if we look at the United States model, private clinics have tended to create massive costs and inefficiencies in the system. They have taken away clinical autonomy from physicians who no longer have the ability to choose what they do for their patients but have to ask a non–medical person, some insurance adjuster, what they should and should not or can and cannot do. That is not what I consider to be choice.

We have choice in this country. In the United States they are not free to choose a physician. They are only free to go to a physician who is under a particular insurance plan and works for a particular insurance company. In Canada we are free to choose a physician anywhere and everywhere we like.

We have what is known as access to anyone we want to see. That is choice. In this country we are free to go to any hospital we choose. We are free to have a bed in the hospital next to anyone we choose to be with. We do not have to go to one for the poor if we are poor. We can sleep under a bridge or lie next to some multimillionaire in a Canadian hospital.

What the member is considering is wrong. If he does not believe me, let him think about what happened in the United Kingdom. I did my medical training in the United Kingdom. Its wonderful easy answer was that it would take care of the poor and those who could pay would pay. We have seen a two–tier system in which the poor have been relegated to second rate medicine. Physicians do not want to work in the areas where there are large poor populations. The United Kingdom is sending for physicians from developing countries to go there to provide care. That does not create equality of care. That is what is wrong.

Mr. Keith Martin (Esquimalt—Juan de Fuca, Ref.): Madam Speaker, my colleagues will be dividing their time from now on.

It is with great sadness that I am here today to speak on the motion. It is with great sadness and anger that I listened to the response of the government to the most important thing in people's lives, their health.

The government continues to put forth the fantasy that medicare can continue in its current form. This is criminal, reprehensible and an outright lie. The reality is that medicare is like a ship with holes in it that is sinking with its captain, the government, saying all is well. Unfortunately when we look inside where the people are, the patients, we find that they are dying, suffering and in pain. That is exactly what is happening in health care in Canada today. It is a profound tragedy and should not occur in a country such as ours.

The provinces have found that demand is increasing. Costs are escalating with an aging population and more expensive technology. Also revenues are going down as was demonstrated in the last budget with an $8 billion decrease in transfer funding from the federal government.

Who is caught between a rock and a hard place? In reality it is the patients who are sick, who are unwell. When they go to hospital they discover that essential health care services cannot be provided in a reasonable amount of time.

The provinces are hamstrung by the current Canada Health Act. They are forced to engage in rationing. I will give some real life examples from across the country. In Victoria, B.C., where I live, 40 per cent of hip replacements for elderly people who are in severe pain take 13 months. The British Columbia Health Association is very concerned about the critical lack of access to essential services.

In Prince George a very interesting and sad thing happened. People going for surgery were given the option of receiving autologous blood transfusions, which allow people to have their own blood taken and purified for use in their next surgery. The cost charged to each patient was $150. The reason for that was the Red Cross and medicare system could not pay for it. They gave the patient the option of using their own blood in a safe fashion that would not subject them to HIV, hepatitis and a number of other diseases.

(1255)

Two months after this came out the Ministry of Health said that it could not be done, that patients could not be charged for it. It prevented the Prince George Regional Hospital from doing so. Now patients have to get packed cells for blood transfusions at $500 a unit.

In Alberta it takes three weeks for emergent and urgent open heart surgery. The surgeons there say it is a miracle so far that nobody has died, but it is going to happen.

The Prince George hospital, because of the funding cutbacks that have been foisted upon the provincial government, is forced to cut back its operating room days by 12 days a year, knowing full well that it has hundreds of people waiting for urgent surgery.

The minister said that doctors were returning to Canada. I had a conversation with one of her close advisers the other day who said that it was the bad doctors who were leaving the country. He asked: ''Isn't that so?'' Half our neurosurgeons leave the country. Eighty per cent of orthopedic surgeons in some cities have left as well as 50 per cent of obstetricians and gynecologists.

Dr. Joel Cooper of the University of Toronto, a world famous cardio–thoracic surgeon, left. Dr. Munro from the Hospital for Sick Children left. These world famous individuals left the country not because they wanted more money but because, in their words, they could not practise the way they were supposed to and were sick and tired of having their patients suffer. That is not adequate health care.

The reality is that the population is increasing and costs are rising. The minister said that we do not have a two–tier system. What nonsense. A billion dollars every year goes to the United States. Why? It is because Canadians cannot obtain essential health care services in a timely fashion so they go to the states. Why do we not keep that money in Canada?

The minister said that private expenditures were increasing. Of course they are increasing. Why? It is because people will not wait for the current public system to provide their health care services. They do not want to be in pain and they do not want to die. The government is forbidding them from doing that and is not accepting the fact that it cannot provide essential services in a timely fashion. That is a travesty. It is also extremely arrogant for the government to tell the public that it is forbidden to do that. In effect the government is sacrificing people's health on the altar of a dead socialist ideology.

We must recognize the financial crisis of today and the decrease in funding. We must recognize that people cannot be taxed more and that demand is going up. We must recognize that the Canada Health Act is hopelessly obsolete and unable to provide the same health care services to all people all the time, especially essential health care services. Sick people are in effect dying.

We must move to a new era. We will present constructive alternatives. Let us make a new made in Canada health act. It should not be one from the United States or one from England but one from Canada. We do not want an American style system. There is no resemblance whatsoever in what we propose to the system south of the border.

First, we must get the federal government, the provinces and the people together to define essential health care services for which all people across the country will be covered regardless of income. We may want to look at the Oregon model to begin with.

Second, let us allow the provinces to experiment with alternative funding models, such as private clinics, private insurance and the like. Why? It is because the system needs more money to provide health care. It is true that it needs to be revamped, but it also needs more money to reflect our current fiscal crisis and fiscal crunch in health care.

(1300)

This is not a threat to medicare, rather it will make it better. What is so wrong with enabling private clinics to provide private services in the private sector where only private dollars will be exchanged? It will not in any way affect the public system.

In fact the demand on the public system will go down so that those people who are in this system will be able to get essential health care services in a more timely fashion. Is it a two–tier system? Yes, but we have one now. Is it unequal? Yes, but it provides for better access for all people regardless of their income. It ensures quicker access to those essential services that Canadians are not receiving now.

It is time to move forward. It is time to move with courage. It is not the time to delve into a morass of ideology but open our eyes and work together. My colleagues and I are more than happy to work with the Minister of Health in the interests of the Canadian public and the health of Canadians, to develop a fair and equitable solution and to provide better health care for all now and in the future.

We are not the enemy. We are merely trying to ensure that we have an improved system from coast to coast. Let us set up those national standards. As individuals we are not going to do that here, nor should we. We cannot nor should we play God. This must come from members of the public. It must come from the provinces. It must come from health care professionals. It must come from the federal government.

Let us ensure that we have portability for these national standards, that we have comprehensive coverage for essential health care services for all people, that we have good public administration of essential health care services, that we have universal coverage for essential health care services for all Canadians.

Last, let us ensure that we have essential health care services provided in a timely fashion. The Canadian people are not receiving their essential services in a timely fashion. One only needs to go into the field, go into the hospitals, to see the people who are not receiving them. Morale is the lowest it has ever

been, as is the pain and suffering on people's faces when told they have to wait 13 months potentially for their hip replacement or three months for their urgent heart surgery. That is not good medicine. That is bad medicine.

Ms. Hedy Fry (Parliamentary Secretary to Minister of Health, Lib.): Mr. Speaker, typical of the third party is the sentimentality, the rhetoric, the lack of any real fact but let us spew it anyway. Let us do the emotional dance on people.

I would like to ask the hon. member if he could give me clear statistical data which shows that the outcome in acute care is not one of the highest and best in the world, that people who clinically need care are not getting it.

We have to be very careful to clear the wood between need and want. Health care is not a marketplace commodity. The difference between what a patient needs for appropriate care and what a patient thinks he or she wants is very different.

We provide the best health care in the world that patients need. When we talk about people needing urgent care and not getting it I would like to ask the hon. member if he can give me clear examples of people who have increased mortality because they need acute care and do not get it. That, Mr. Speaker, is not true.

Mr. Martin (Esquimalt—Juan de Fuca): Mr. Speaker, I cannot believe the hon. member is saying what she is saying. I will repeat again, this is not rhetoric.

(1305)

I just spent half of my speech giving the government constructive solutions on what to do. My colleagues, Dr. Hill and Mr. Manning have spent the last hour giving constructive solutions to the government.

The Acting Speaker (Mr. O'Reilly): I have to interrupt the member. Although he is complimenting them on doing a good job, it is not the custom of the House to name members but to use their ridings.

Mr. Martin (Esquimalt—Juan de Fuca): Mr. Speaker, we have been giving constructive solutions. At the end of my speech I stated that members of the Reform Party would be more than willing to help get the Canadian health care system back on its feet and to ensure that medicare is provided in a fiscally sustainable fashion in the future. Obviously somebody is not listening.

We talk about essential health care services and who is not getting them. I can give the House cases. I have just mentioned the three–week waiting list for urgent heart surgery in Alberta. If that is not an essential health care service and irresponsibility I do not know what it is. The physicians who are dealing with these patients—the member knows because she is a physician—would be more than happy to inform her that this is completely inadequate. This is not something happening only in Alberta but it is going on across the country. In Ottawa it is a five–month wait for open heart surgery and in B.C. it is a thirteen–month wait for people who are in severe pain.

What the member and the government have been saying is that the government will decide what the patient needs. The government will decide what the public can and cannot do with their health care system and for their health. How arrogant to do this when health care is that which is most important to all of our hearts. That is irresponsible.

I would be more than happy to provide a long list to the hon. member of situations that demonstrate the fact that our current medicare system is not working.

Mrs. Sharon Hayes (Port Moody—Coquitlam, Ref.): Mr. Speaker, I am pleased to rise to speak today to the Reform Party's motion on the future of health care and medicare in Canada and the nature and extent of the federal involvement in that. The motion states:

> That this House recognize that since the inception of our national health care system the federal share of funding for health care in Canada has fallen from 50 per cent to 23 per cent and therefore the House urges the government to consult with the provinces and other stakeholders to determine core services to be completely funded by the federal and provincial governments and non–core services where private insurance and the benefactors of the services might play a supplementary role.

The Reform Party believes that a fundamental responsibility of government is to safeguard the well–being of Canadians. Principle 10 of our statement of principles says: ''We believe that Canadians have a personal and collective responsibility to care and provide for the basic needs of people who are unable to care and provide for themselves''.

The Reform Party also believes that the current health care system is inefficient and insufficient in providing this essential service to Canadians. The current system must be reformed to guarantee the continuation of care and the ability to address the future real demands of our health care needs for everyone's benefit.

As for the benefits now of parents, my parents, the people in the House, people across Canada, our children and our grandchildren, we need that ongoing credibility of a system that right now is itself sick.

Throughout my speech I will compare and contrast the Reform and the government approach toward securing the future of our health care system. One area that reveals this contrast between the Reform approach and the government approach is the issue of consultation. The motion urges the government to consult with Canadians and health care stakeholders about the future of medicare.

In its much touted red book, the Liberal Party committed itself to ''establish a national forum on health in partnership with the provinces and health care experts to find innovative ways to control health costs while keeping medicare publicly funded and accessible for all Canadians''. It sounds good but to this day the government has broken its promise. It has not fulfilled the commitment it has made, a commitment to consult with Canadians about the future of medicare and the roles that will be played by the federal and provincial governments and other health care stakeholders. Because of the heavy handed approach of the federal government in this area, the provinces have refused to participate.

(1310)

Consultations are not always what they appear to be or what they are announced to be by the government. For instance I would like to remind the members here of the travelling committee that was to consult Canadians on social policy reform. What happened? A flawed attempt and a report that was delayed and delayed and ultimately shelved.

Reform on the other hand has long advocated that the federal government actively consult Canadians on vital and important national issues such as the health care system. We believe consultation must take place at all levels, with patients and users, with physicians and health care professionals, with administrators of those systems and with provincial governments. We do not believe in the top down, Ottawa says, approach. We believe that Canadians need to be part of the decision making process, especially in an important system like health care.

This Reform commitment to consultation is reflected in the motion being debated today recommending that a consultative process about the future of health care be actively and honestly pursued.

Another area that reveals the contrast between the Reform and the government approach is the area of federal funding. As noted in the motion, federal funding for health care has fallen from 50 per cent to 23 per cent over the last years.

Health care was originally implemented in 1957 with the Hospital Insurance and Diagnostic Services Act. The federal government adopted this act under pressure from the provinces, some of which had provincial insurance schemes. The act established a shared cost system providing universal coverage and access to hospitals to all residents of participating provinces. By 1961 all provinces had joined this plan.

In 1977 this act was replaced with the Established Programs Financing Act. This transferred money from the federal government to provinces for both health and post–secondary education funding. In 1984 the Canada Health Act came in prohibiting extra billing and user fees and thus imposed financial penalties on provincial governments which would violate these things.

The history of health care politics is essentially the history of the federal government demanding and expecting more and more from provinces and providing those provinces with the diminishing ability and the flexibility to meet those expectations.

The present government has been in office for less than two years and it is definitely continuing this trend. In 1995 the government announced it was replacing the established programs financing plan and the Canada assistance plan with the new Canada social transfer. Under the previous system this money was transferred separately. The Canada social transfer will be a block fund provided through cash payments and transfer points.

Under the new system federal funding for health care will be reduced. In 1995–96 the federal government will transfer to the provinces some $29.7 billion, approximately at the same level that was the case for 1994–95 funding. Under this new system funding under the Canada social transfer for 1996–97 will be reduced to $26.9 billion and further reduced in 1997–98 to $25.1 billion. The government's approach to reforming health care is to cut funding without consulting or receiving input from Canadians.

In February Reform announced a taxpayers budget prior to the government's budget. In it we would give provinces additional tax room through the transfer of tax points, providing that the provinces participate in an annual federal–provincial health consultation. These regular consultations would ensure a two way communication between the two levels of government which would benefit and make better our health care system.

A first priority between the federal government and provinces would be to agree on core versus non–core services. Core services would be required to be maintained at a certain and a common standard across the country. Such things that would be necessary for core would be deemed desired by most Canadians and required by the key players in the health care field, rather than bureaucrats in Ottawa.

These services must be financially sustainable and available over a long period of time. All such services would be covered regardless of Canadians' ability to pay. Non–core services, on the other hand, would be decided also by Canadians and would be those the federal government does not have the responsibility to fund, but would be the responsibility of private funding or through insurance. Reform's approach is bottom up, not top down consultation.

(1315)

As we would reduce federal cash transfers by some $800 million we would at the same time increase revenue levers and flexibility for the provinces with a transfer of tax points to those

provinces so that over time they would raise more revenue to be allocated to their health care system.

Funding for health care systems would increase over the medium and long term, steadily into the next century. This would give greater peace of mind to Canadians. It would give better flexibility to demoralized provinces and the result would be a better medical system for everyone. Our approach safeguards health care for the future while the government's approach leaves the future of health care uncertain in reality and in the minds of Canadians.

The shortfall in funding and uncertainty is of particular concern to residents of B.C. The government's planned federal funding for health care in B.C. does drop significantly. Federal transfers in 1995–96 to B.C. are approximately $3.6 billion. This is funding for health care, education and welfare under the Canada assistance plan and established programs financing. In 1996–97 under the new Canada social transfer scheme funding to B.C. will drop to $3.2 billion. Clearly something has to give. Clearly such an approach will put the resources of the provincial government under great strain.

I have heard some comment today about simplistic rhetoric. I recall the government during the last election using what I would say is worse than simplistic rhetoric, scare tactics. I remember signs within my riding: ''Save Canada—Save Medicare''. That kind of rhetoric when the government now puts our medical system at risk is a testimony to what I say is unfair representation by the government.

The Acting Speaker (Mrs. Maheu): Unfortunately the time has expired. Questions and comments.

Ms. Hedy Fry (Parliamentary Secretary to Minister of Health, Lib.): Madam Speaker, the hon. member made the comment that provinces obviously do not like the system and the way the Canada Health Act was imposed by the government on British Columbia when it was breaking the act.

I would like the hon. member to name one province that has not supported all the principles of the Canada Health Act roundly within the last four months. I would like to know which ones have not supported the federal government in ensuring the Canada Health Act is effective and taking whatever steps are needed. All of the provinces, as far as I am concerned, have supported the concept. They believe in the system and in the Canada Health Act. They support the five principles.

The last meeting of provincial health ministers with the federal health minister reiterated that. Alberta said it will support those principles.

Mrs. Hayes: Madam Speaker, I do not want to look to the past but to the future concerning the workability of the Canada Health Act and whether it is the provinces or Canadians who look to the care of their health system.

I have talked to health professionals in my riding and they are wondering how certain services will be addressed. I suppose we could get into debate. Do Canadians want unlimited access and attention for any or all complaints or health concerns, a system that gives service to all the people all of the time? Do they want long waiting periods? These kinds of things from the citizens of Canada are coming to provincial and federal tables to be addressed. What we see is a system which will not be able to answer these things in future years.

(1320)

I know of men and women facing uncertainty. They are waiting for tests to determine the extent of an undiagnosed situation, perhaps cancer. They have sleepless nights. Seniors are waiting for months with a decreased ability to walk or breathe while they wait for operations.

I do not see how the government can say the present system will continue to work with decreased funding to the provinces with inflexible guidelines which will not allow caregivers to give the care needed by Canadians.

Ms. Beth Phinney (Hamilton Mountain, Lib.): Madam Speaker, the hon. member says she does not believe in top down Ottawa directives to health care authorities in the provinces. How exactly does she see the Canada Health Act and its five principles of accessibility, comprehensiveness, universality, portability and public administration as constituting top down direction? The provinces and the territories administer the health care system, not Ottawa.

Mrs. Hayes: Madam Speaker, I thank the hon. member for her question. Rather than a constant delivery of services, what we see in the health care system are differences between provinces. There are different expectations among users at the present time.

This would probably be more focused on the real needs of Canadians if Canadians had a part in the process of deciding which services they want to fund. For instance, we have heard today that Quebec is no longer funding psychiatric services. I know Canadians who expect that service to be funded. There are other parts of Canada in which funding for abortions is available. I know Canadians who disagree with that. Is it a top down decision or is it a grassroots decision that these kinds of procedures are being funded?

It is in those kinds of areas where—

The Acting Speaker (Mrs. Maheu): I am sorry, the time has expired.

Ms. Maria Minna (Beaches—Woodbine, Lib.): Madam Speaker, I am grateful for this opportunity to talk about medicare and the Canada Health Act. I want to explain how and why the government supports medicare and why we on this side of the House will continue to support it.

The Reform Party asks whether we have the will to uphold the principles of the Canada Health Act. There are no grounds for dire predictions that the federal government will not be able to uphold the Canada Health Act or that Canada's health care system will disintegrate as a result of the budget.

Let me remind the House how clear the budget speech was on this matter. The Minister of Finance said no change would be made to the Canada Health Act. The Minister of Health was equally clear when she spoke to the Canadian Hospital Association last March: ''There is no change in the government's commitment or in my commitment to uphold and enforce the principles of the Canada Health Act''. As the Prime Minister said in Saskatoon, for Canadians these principles are not negotiable.

The new transfers will be a block funding arrangement. That may worry some members but let us not forget that block funding for health and post–secondary education is 18 years old. The established programs financing funding mechanisms put in place in 1977 were a block funding arrangement. There is no requirement for the provinces to spend the money on health. What there is and what was nailed down in 1984 when the Liberal government passed the Canada Health Act is the requirement that provinces deliver health care services in compliance with the five conditions of the act or face a deduction from the money transferred to them.

Nothing in the budget will change the government's technical ability to enforce the Canada Health Act principles. The enforcement mechanism remains the same. If deductions from transfer payments are necessary they will be made.

(1325)

Canadians can rest assured that Canada's social and health transfer will not reduce federal ability to enforce the principles. We will enforce them because these principles of universality, accessibility, comprehensiveness, portability and public administration are ultimately rooted in our common values. They are Canadian values such as equity, fairness, compassion and respect for the fundamental dignity of all. We will also enforce the principles of the Canada Health Act because they support an economically efficient health care system.

It is worth reminding opposition members the principles of the Canada Health Act are not just words. They have meaning. I want to touch briefly on each of these principles.

The first principle is universality, although residents in a province must be insured by the provincial health plan to receive federal support. What this really means is that we all must have access to services. People cannot be deinsured because they might be costly for the system to cover. We cannot be turned away at the hospital door because we have not paid our quarterly tax bill or provincial premium. If we need health care we will be treated the same as anyone else.

Accessibility on uniform terms and conditions is the second principle. It means we should not face any financial barriers in receiving health care: no extra billing, no user charges, no facility fees, no up front cash payment. If the service is medically necessary we will get it at a time defined by medical considerations, not by the size of our wallet.

Next is comprehensiveness. This principle recognizes Canadians have a range of health care needs and that those needs should be met. Scratch the surface a little more and we see that comprehensiveness again means we practise fairness. It would not be fair to ensure only some medically necessary services and not others. I do not believe we can, nor should we try to, choose at the federal level which service is medically necessary. We should continue to interpret the Canada Health Act as required coverage of all medically necessary services.

The government will continue to take the position that if a province ensures any part of the cost of a service, it is an indication it believes it to be medically necessary and all of the costs must be covered.

Justice Emmett Hall in his original royal commission on medicare recommended a very comprehensive package. Liberal governments of the 1960s, 1970s and 1980s accepted the concept of comprehensiveness, although not quite as broad a concept as Justice Hall's. Liberal governments in the 1990s will not turn their backs on this principle.

The fourth principle is portability. It means Canadians maintain their health plan coverage when they travel or move. The portability principle is rooted in one of the fundamental elements underpinning our federation. It recognizes our right of mobility. Canadians are free to work and travel anywhere in the country without fear of losing their health insurance coverage.

Portability is what makes our national health insurance truly national. Each separate health insurance plan may be provincial in origin but is recognized nationally in every province across the country.

The fifth principle is public administration. Our health insurance plan must be operated by provincial governments on a not for profit basis. In my view this principle never seems to get the same attention as the others but it should. It is at the core of our ability to contain costs in the system and thus to deliver quality care at an affordable price.

One would think that of all five principles, the Reform Party would be able to relate to this one. Public administration is the means by which we ensure all the other principles. When health insurance is operated and funded through government, we can guarantee that health care is universal, accessible, comprehensive and portable because we have direct control over it.

It is through public administration that we also demonstrate our collective responsibility for our health care system. Canadians are responsible for paying for their health care system. We do it collectively through our taxes. We pay so that everyone can benefit according to need. We have agreed to provide this most essential of human services together. We must not lose that.

Public administration also demonstrates something else about Canadians, our pragmatism. We want value for money and administering health insurance publicly is the best way to get it in health care. We need only look to the experience of our American neighbours to compare the efficiency of public administration with private administration.

Not only does public administration make sure more of our health care dollars go toward patient care, government can be more successful than the private sector in keeping health care costs under control.

(1330)

In 1993 we spent about $72 billion on health care. This represents 10 per cent of our gross domestic product. The public component of that 10 per cent has been growing at less than 2 per cent. Compare that to private health spending, which has been growing at 6.4 per cent.

Over the last three years per capita spending on the publicly administered part of our system has been declining. Since our GDP has been growing, it is safe to predict that in 1994 and 1995 we will come in with less than 10 per cent of GDP devoted to health care.

Saying the federal government wants to maintain the principles of the Canada Health Act is not enough. We have to know the public is behind us. We all know that as politicians we cannot escape the will of our constituents. They put us in office and they can take us out. The same is true for the government. Canadians are all saying one thing to us very clearly: they want us to enforce the principles of the Canada Health Act.

In Canada's health care system there are no first or second class citizens. We enjoy rights and privileges as Canadians that are the envy of the world. We can live wherever we want in Canada and have access to health care when we need it.

The many values that make up Canada's social fabric are reflected in the five principles of the Canada Health Act. They reflect the Canadian concern for justice and equity in our health care system and they are not going to disappear. Canadians, including I am sure everyone in this House, will not allow that to happen.

As I said a moment ago, we only need to compare ourselves with the United States. They have been trying for years to get a health care system. They have a private health care system that people purchase from private companies. They spend between 13 per cent and 14 per cent of their GDP on health care. What does this extra money get them? There are 38 million people who are not covered at all, and millions more are minimally covered. That does not sound like a great exchange: more for less. Therefore, I do not see what good privatizing our health care system will do.

I also want to point out there are countries that have allowed extra billing. I know of one, Italy, that has allowed and allows to this date extra billing and private clinics. However, it may happen that a person is in a public hospital. The doctor will say: ''I need to do a surgery, which is very expensive; I can only do it if you come to such and such a clinic, but it will cost you so much money''. That is setting up two classes of services: if you pay more, you get served faster, and maybe that specialist will treat you there.

In this country it does not matter if one is poor or rich or even homeless. If you require assistance or surgery you choose the specialist or the doctor who will treat you. That is what a comprehensive and accessible medicare should be about. We need that kind of security, that kind of stability. Our health is the most precious thing we have, allowing us to do all of the other things we want to do. We talk about unemployment. If people are insecure about their health they cannot study, they cannot train, they cannot work.

This gives Canadians a sense of stability. They do not have to worry or lose their homes and become paupers because they are ill or their children or parents are ill.

Yes, we have a new world. We have a much larger population of seniors. We need to look at different treatments. That is true. That does not mean in any way retrenching one bit on the principles of health care, not one bit. I would never support any such direction. We must look at new treatments and new ways of assisting people.

Preventative medicine in this country must become the norm, and not, as it is now, a reaction. We are still treating symptoms in many cases, and not dealing with preventative medicine. If we were to deal aggressively with that over and above the costs we now have, we would lower health costs in this country considerably. We should be looking at how we can improve our medicare system and our health system and its delivery through preventative and other measures, and not diminish the principles of health care. That is totally unacceptable. This government would never support that.

We need to redouble our efforts to make sure even programs like psychiatric services are considered to be fundamental services. We have far too many children who are on waiting lists. Yes, a province has decided that is not a necessary service.

Maybe we need to look at that. It is a preventative service. This is what I mean by looking at innovative ways of dealing with the cost of medicare, not denying Canadians the right to access medicare.

(1335)

[*Translation*]

Mr. Michel Daviault (Ahuntsic, BQ): Madam Speaker, I am pleased to rise today to speak to the Reform Party motion concerning our health system. This motion provides for the compilation of a list of health care services considered as essential, to be fully funded by the federal and provincial governments, and a list of so–called non–core services, funded by private insurance and some form of user fee.

Naturally, we are against this motion for reasons that I will explain in my remarks. For one thing, the first part of the motion reads:

> That this House recognize that since the inception of our National Health Care System the federal share of funding for health care in Canada has fallen from 50 per cent to 23 per cent—

While recognizing readily the federal government has reneged on its commitment, we feel that what should be denounced is the fact that the provinces were never compensated for this, and therefore saw their tax burden increase.

In fact, the federal government's unilateral approach to maintaining its status as a partner in the Canadian medicare scheme is far from making all the provinces happy. The provincial health ministers do not agree either on how to prevent the Canadian medicare scheme from being affected by reductions in services and in federal transfer payments.

As reported by Jean–Robert Sansfaçon in *Le Devoir* on April 13, the Minister of Health candidly explained, by paying a simple lump sum, the Canada social transfer, instead of making several different and progressively smaller payments for health, education and social assistance, Ottawa will be able to maintain a level of control that could otherwise elude it because of its reduced contribution. As clever as it may be, the reporter added, the Prime Minister's strategy is nonetheless grossly unfair.

Ottawa plans to reduce transfer payments to the provinces by $7 billion over three years starting in 1996–97. In Quebec, these cuts will jeopardize the health care system. During the health ministers' conference held in Vancouver, the Minister of Health, Mr. Rochon, released a study from his department indicating that Quebec, which is already experiencing an $8 billion shortfall, the equivalent of the annual budget for the Quebec health services network, following the changes made to health transfers since 1982–83, will be deprived of a further $2.4 billion in federal moneys, between now and 1997–98.

As pointed out by the hon. member for Drummond, who is celebrating her birthday today and to whom we wish all the best, the federal contribution is decreasing, having dropped from roughly 45.9 per cent of Quebec's health expenditures in 1977–78 to 33.7 per cent in 1994–95. It can therefore be estimated that, for Quebec, the most recent cuts in established programs financing will result in a reduction of some 10.6 per cent of the federal contribution to health expenditures.

This is typical of the federal government. It unilaterally decides to withdraw from a sector which, in any case, does not fall under its jurisdiction, without giving the provinces the appropriate financial compensation for this withdrawal. The Prime Minister said that this was an excellent system and that the government wants to maintain it. Why then withdraw from it if the system is so good?

The fact is that, once again, the provinces will have to maintain this excellent health care program, but without federal support. So, after imposing, back in 1984, the five great principles of the Canada Health Act, the federal government is now unilaterally and implacably withdrawing its financial support, while keeping the power to impose national standards.

Let me remind you of those principles. There is first of all the matter of comprehensiveness; this means that all health services provided by hospitals, medical practitioners and dentists must be insured. Two, universality means that all the people covered by the provincial plan should have access to all insured health services. Three, portability means that coverage of provincial plans is transferable from one province to another, and that health care services are also provided to insured persons who are temporarily out of their home province. Four, accessibility means that provincial plans must provide services on uniform terms and conditions, which means that billing is prohibited. As for public administration, it means that the health insurance plan must be administered on a non–profit basis by a public authority designated by the provincial government.

(1340)

In Quebec we have no trouble with the five criteria. As far as we are concerned, they represent a minimum consensus. But what does the federal government have in mind, especially when we hear the Minister of Health spouting her earnest rhetoric as the great defender of the integrity of the Canadian medicare system? The cuts introduced unilaterally in the federal budget are draconian.

Perhaps I may quote from a presentation by the Minister of Health before the Senate Committee on euthanasia and assisted suicide, in which she referred to palliative care.

[*English*]

The minister said: ''I want to touch on 10 areas requiring attention if the individual who is the focus of my concern is to be provided with high quality care at the end of life. First, we need better diagnosis and prognosis. We need provider training. It is essential. We need fully developed teams of providers, ranking from physicians and volunteer support networks to dealing with problems of the end of life. We may even need to develop new specialties in this area''.

[*Translation*]

She went on to say: ''Research into pain control and management should be a priority. We need to know more about comfort and the supports that focus on time of administration of drugs and dosages. We must introduce support networks for patients and their caregivers''. Finally, and this is perhaps the best part of the speech:

[*English*]

''We need institutional development. There are not enough palliative care centres, especially outside of major urban areas. We need centres to coordinate community and home care, staffed with professionals with a sense of outreach and mobile forms of delivery''.

[*Translation*]

Not only does the federal government take it upon itself to establish criteria, it also assumes the right to set priorities in areas that come under provincial jurisdiction, and now the Minister of Health, in response to the serious concerns she formulated, is going to cut transfer payments to the provinces. Is she doing the actual cutting? No. She is just taking orders from the Minister of Finance.

In other words, Canada's health care system is adrift, and although in Quebec there is still a very broad consensus in favour of the main criteria of the Canada Health Act, we understand why the Reform Party is suggesting ways to make the system more efficient because, in the end, the debate is about these main criteria. Will we keep doing what we are doing now, which means making cuts in all services, something the Quebec Minister of Health is forced to do because of federal cutbacks, or should we de–insure certain services? I think our Reform Party friends did well to raise this matter in the House.

The government has initiated major changes in health care funding, and we have to look beyond the rhetoric of the Minister of Health. In a speech to the Hospital Association on March 17, 1995, the Minister of Health once again recalled certain aspects of the system: ''There is nothing in the budget that changes our technical capability to enforce the criteria of the Canada Health Act. The mechanism itself remains unchanged. If deductions must be made from transfer payments, deductions will be made either from the monetary portion of the new Canada Social Transfer or, if necessary, from other monetary transfers''.

This is the so–called big stick. However, later on in her speech, the minister herself opened the door to a two–tier system. She said: ''On the other hand, we must be reasonable. The government and I are not going to ask the provinces to cover services like plastic surgery. In practice, we must allow the provinces some flexibility in identifying the range of insured services. However'', she admitted, ''we must realize that, by excluding certain medical services from medicare, we open the door to the privatization of coverage of health care services and to a lessening of our ability to control costs''.

(1345)

Later, she alluded to her guilt, saying that as a politician—and I agree with her, that is essentially what she is in this case—she has to respect the wishes of Canadians, and Canadians are sending the government a clear message that they want the principles in the Canada Health Act to be upheld.

They are strangling the provinces, but are doing it under the pretence of self–professed good intentions. However, as Saskatchewan's Minister of Health, Lorne Calvert, said:

[*English*]

''We are asking, if the federal government unilaterally withdraws more and more from funding to regions, how do they plan to maintain the integrity of the system?''

[*Translation*]

Despite the many opportunities she has had this morning, the minister still has not answered this question. The federal government's share of health care funding is currently sitting at around 23 per cent and we are willing to bet that it will shrink even more. The net figure for health care, social assistance and education transfers from the federal government is $29.7 billion for 1995–96. This will drop to $26.9 billion in 1996–97, then to $25.1 million in 1997–98. And the minister admitted in her recent speech to the Canadian Hospital Association that a portion of this is for health, but she did not break it down.

In perhaps an attempt to justify the scope of the cuts, the Prime Minister pointed out that the United States spends 15 per cent of its GDP on health; Europe, 8 per cent, and Canada, 10 per cent. So, he asked in an interview on CBC's ''Morningside'' why Canada would not be able to do it, for example, with only nine per cent of GDP?

Does the Prime Minister not know that the Americans have private health care and that close to 40 million of them have no health care coverage whatsoever? Does he also not know that the

American government's attempt to implement a public health care system is meeting with strong opposition from the private sector?

I do not know if the government even realizes that, by implementing such cuts, it is imperilling its own system. The Prime Minister himself, by his statements on essential services, is actually helping along the demise of the current system and is paving the way for a two–tiered system.

Basically, this seeming desire to rationalize health care costs is expressed in freezes and reductions in transfer payments—and I would remind the minister that reference was made in the same speech to an annual increase in health care costs of approximately two per cent. These freezes and reductions in transfer payments conceal the governments real intention, which is to reduce the deficit on the backs of the provinces.

So, how can the government still claim it is legitimately justified in imposing standards and dictating policy on the management and operation of the provincial health care schemes? The government is passing itself off to the provinces as upholding the law and wants to consult them to find out how they should tighten their belts to cut costs and health services while meeting federal standards.

I would point out that, in this context, the consultation was between the federal Minister of Finance and the provincial finance ministers. Then, once everything was all wrapped up, the federal Minister of Health and her provincial counterparts were casually told that they would have streamline their systems.

The forum on health is surely another example of lack of respect for the provinces. Minister Rochon has already reiterated Quebec's opposition to the forum, another indication of the government's intransigence with the provinces.

I would also recall a statement made by the former Quebec Minister of Health, who is now the Minister of Labour in the federal government and who is curiously absent from the debate today. When she was Quebec's Minister of Health, she described the government's behaviour in connection with the forum on health as absurd. She went on to ask how the government could imagine reviewing the health care system without the participation of the provinces, which are responsible for delivery of services. She felt it was simply out of the question.

In the case of the Minister of Labour, we could say that customs change with time and speeches change with the level of government.

(1350)

Under the 1867 Constitution Act, the provinces have full and exclusive jurisdiction over health care. The federal government's costly interference in this area, notably through program duplication, was based on its constitutional power to spend.

The federal government maintains that its involvement in health care is justified by the fact that the implementation and maintenance of medicare is a paramount issue of national interest and part of the rights and benefits associated with Canadian citizenship. Because of its debt, the federal government is withdrawing financially while still upholding the national interest and keeping the powers it gave itself.

According to Minister Rochon, the real solution would be for the federal government to withdraw completely from health care and transfer the tax points belonging to Quebec and, I would add, to each of the provinces.

The second part of the motion reads as follows:

> —therefore the House urges the government to consult with the provinces and other stakeholders to determine core services to be completely funded by the federal and provincial governments. . .

Several members of this House, both on the government side and on the side of our friends from the Reform Party, have mentioned exceptions, examples of programs or treatments covered by special agreements.

I would also like to remind the House of the importance given in Quebec to the five fundamental principles of health care, which were the subject of major debate during the election campaign. As you will recall, the former Liberal provincial government, of which the new federal Minister of Labour was a member, wanted to eliminate the newsletter *Malade sur pied*, which lists the drugs that are covered or available. It also wanted to charge $20 in user fees for chemotherapy treatments for cancer patients. This directive provoked an outcry in Quebec. As a result, the Liberals quickly suspended it and the new government wasted no time in cancelling it.

We cannot eliminate all user fees. I know that Quebec charges user fees for some services, but the cuts imposed by the federal government force us to make unconscionable decisions, and I think that the federal government must take the blame for the health care cuts in each of the provinces.

The Quebec government is also considering the feasibility of introducing a basic universal drug plan that would benefit not only welfare recipients and seniors but the entire population and cover all new drugs and treatments for diseases such as AIDS and cancer.

In this regard, Quebec is still striving to ensure universal access. By supporting these measures, we in the Bloc Quebecois are telling the federal government that, if it cannot enforce these principles we care about, it should give us our tax points and we will deal with the matter. However, the federal government should not tell the provinces what they should do—and not in health care matters, in my opinion. As far as the other provinces are concerned, if a western province wants to take a different approach, it should be allowed to do so, provided it continues to

negotiate with all the other provinces. The issue of portability can be settled with or without the federal government, so that Albertans can be treated in Quebec and vice versa.

I think that the federal government must bear the greatest blame in this area.

In closing, I would like to remind you that we will oppose this motion, although we wish to commend the Reform Party for raising this issue in the House.

(1355)

[*English*]

Ms. Hedy Fry (Parliamentary Secretary to Minister of Health, Lib.): Madam Speaker, I was a little disturbed by the last part of the hon. member's speech.

He can correct me if I am wrong, but I understood the member to say that he would like to see national medicare disbanded and provinces deal with provinces in terms of issues such as portability.

This government is committed to Canadian medicare, which is based on treating all Canadians equally as they cross from province to province. I would really like to see whether the member would like to elaborate on the dismantling of medicare that I just heard or to correct me if I was wrong.

[*Translation*]

Mr. Daviault: Mr. Speaker, the hon. member probably forgot the first part of my remarks. The point I am making is that we, in Quebec, agree with the five principles, which we regard as a minimum consensus. However, it is rather cynical for the federal government to hide behind these five principles and cut transfers to the provinces.

The hon. member said earlier that necessity is mother of invention. I do not think that the federal government's goal in cutting transfer payments to the provinces is to spur lazy provinces to action. It is only trying to get out of a difficult financial situation. This is not a health strategy but a financial strategy and, in that regard, the health minister must submit to the finance minister's wishes.

We feel we are at the crossroads. Quebec remains committed to the principles of universality, accessibility, portability, and so on. However, if the federal government cannot do its job, we, at the provincial level, are prepared to go over its head and negotiate directly with the other provinces to ensure the portability of the system. The federal government should get serious, uphold the five principles and provide the required funding. It is true, up to a certain point, that money does not guarantee the quality of health care, but when you cut—

Some hon. members: Hear, hear.

The Speaker: Dear colleagues, it being 2 p.m., pursuant to Standing Order 30(5), the House will now proceed to statements by members.

STATEMENTS BY MEMBERS

[*English*]

DENTAL HEALTH MONTH

Ms. Hedy Fry (Vancouver Centre, Lib.): Mr. Speaker, I want members to notice that I am smiling today to remind the House that April is Dental Health Month in Canada.

This month provides an opportunity for all Canadians to show off their teeth by sharing their smiles. I am proud to note that Canadians enjoy one of the highest standards of oral health in the world. This is thanks in large part to Canadian dentistry's commitment to disease prevention.

For years now the Canadian Dental Association, provincial associations, and local societies have sponsored many educational activities and projects of interest to both children and adults. These include mural displays, radio, television, and billboard ads, newspaper supplements and free dental clinics.

Please join me in saluting the efforts of the Canadian Dental Association and allied national and provincial associations for their commitment to good oral health.

I would like to ask all the members of the House to just say cheese.

* * *

[*Translation*]

SCHIZOPHRENIA SOCIETY OF CANADA

Mrs. Pauline Picard (Drummond, BQ): Mr. Speaker, it is with pleasure that I inform hon. members of the launching of the Schizophrenia Society of Canada's public awareness campaign. The purpose of the campaign is quite clear: to change the public perception of schizophrenia, and to replace misconceptions with more factual information. The theme is quite catchy: if you think it is hard to pronounce, imagine what is it like to live with.

This disorder affects one out of every 100 Canadians. To combat the disease, we must become more knowledgeable about it. The campaign by the Schizophrenia Society of Canada is timely; it will improve our knowledge about schizophrenia, and that is a major step forward.

S. O. 31

(1400)

[*English*]

GUN CONTROL

Mr. Lee Morrison (Swift Current—Maple Creek—Assiniboia, Ref.): Mr. Speaker, I recently received a letter from Darrell McKnight, a Fredericton man whose shotgun was seized under order in council a few weeks ago.

His comments were so sensible that I will read them verbatim:

> I don't purport to know more about law than the Attorney General. However, when I was very young, my mother taught me that taking something which belongs to someone else was wrong. It was called theft, and there used to be a law against theft—even theft by government.
>
> This incident is typical of the level of honesty and fairness we can expect from the Attorney General. To call him a thief would not do him justice because he is much more powerful and dangerous to this country than a common thief who must break the law to steal from us. The minister just changes the law with the stroke of his own pen.

That is what one ordinary Canadian feels about rule by order in council.

The Speaker: I want to give all members all the latitude we can in the House but the statements we make in here should be attributable to ourselves, especially during Statements by Members.

* * *

ISABELLA BAY SANCTUARY

Ms. Maria Minna (Beaches—Woodbine, Lib.): Mr. Speaker, I am proud to rise in the House today on behalf of the students of Norway public school in my riding.

The young people of this school have taken up a very admirable cause. They wish to see the establishment of Igalirtuuq, a sanctuary on Isabella Bay, Baffin Island, for the bowhead whale. The bowhead whale is in danger of becoming extinct and so a sanctuary would help protect the species.

The 10 and 12–year olds at Norway public school have written letters to the Minister of the Environment and circulated a petition at a recent school open house. I will be presenting these letters along with the petition to the Minister of the Environment next week.

The students have worked very hard to inform themselves and others about the bowhead and other types of whales. They want to save the bowhead whale from extinction and they are asking the House to help them.

I congratulate the children for their strong commitment to their cause and I ask the Minister of the Environment to do everything she can to set up a sanctuary in Isabella Bay so that the bowhead whale may be protected.

SEASONAL EMPLOYMENT

Mr. Wayne Easter (Malpeque, Lib.): Mr. Speaker, I congratulate the working group on seasonable work and unemployment insurance on the excellent report ''Jobs with a Future''.

As it correctly points out, there is no such thing as a seasonal worker but only seasonal work. People who work in seasonal jobs may have no other work available to them in the off season.

Seasonal industries and the people who work in them have overcome the challenges of the harsh Canadian climate and geography and have built on the base of our abundant natural resources one of the most prosperous countries in the world.

Seasonal work currently provides jobs and livelihoods for over a million Canadians. Seasonal industries and the people who depend on them will continue to make major contributions to our regional economies even as we move into the new information economy. Unemployment insurance reform must take into account these special circumstances of those employed in seasonal work.

I encourage all members to read this well documented report and support it soundly.

* * *

BURLINGTON TEEN TOUR BAND

Ms. Paddy Torsney (Burlington, Lib.): Mr. Speaker, today I rise to recognize the accomplishments of the Burlington Teen Tour Band, role models to Canadian youth.

The Burlington Teen Tour Band is committed to excellence in music and has achieved recognition both nationally and internationally in travelling around the world as true ambassadors for Canada and for our city.

On April 28 the Burlington Teen Tour Band is going to Holland to represent all Canadians at the celebrations marking the 50th anniversary of the liberation of Holland. Burlington is proud of these youths and of their parents and many supporters and volunteers.

While the band is in Holland it will be playing in the national parade in Apeldorn and at the remembrance service at the Groesbek war cemetery. I take pride in all the members of the Burlington Teen Tour Band as they represent Burlington and our country.

It is important we recognize the outstanding accomplishments of Canadian youth. The Burlington Teen Tour Band represents positive leadership for all Canadians. I salute it in its accomplishments and send it my best wishes for a fabulous trip.

[*Translation*]

HOLOCAUST MEMORIAL DAY

Mrs. Madeleine Dalphond–Guiral (Laval–Centre, BQ): Mr. Speaker, today is Yom Hashoah, which this year marks the 50th anniversary of the end of the Holocaust and the horror of the concentration camps in Europe.

Millions of men, women and children perished under the yoke of Nazi tyranny. Remembering the victims of the Holocaust and the tens of millions of people of all nationalities who died during the Second World War brings to mind how fragile life and liberty are.

(1405)

Fifty years after the war, the world is still the scene of planned exterminations. Mass killings and hatred are daily realities. To forget is to allow ourselves to condone violence. To remember is to be mindful of our collective responsibility to oppressed nations.

* * *

[*English*]

THE ECONOMY

Mr. Ray Speaker (Lethbridge, Ref.): Mr. Speaker, on the surface the Canadian economy appears to be sailing smoothly. Yet, as the Moody's downgrade revealed, the buoyancy is deceptive. Three indicators are pointing to rough seas ahead.

The first is our sinking dollar. Since the release of the government's first budget our currency has lost more than 20 per cent of its value versus the yen and the mark. The Bank of Canada has only kept it afloat through high interest rates.

However, it is these high interest rates which have knocked the wind out of our sails, housing sales, that is, which hit a 13–year low in March.

While the combination of high interest rates and a depreciating currency roil the waters, the third storm cloud has appeared on the horizon. Inflation is re–emerging which will prevent the Bank of Canada from offering the interest rate relief we all need as Canadians.

The message is clear. Unless the government charts a new fiscal course for deficit elimination, not deficit reduction, our economy will end up on the rocks.

* * *

AGRICULTURE

Mr. Vic Althouse (Mackenzie, NDP): Mr. Speaker, when the minister of agriculture appeared in front of the agriculture subcommittee on grain transport it was strictly do as I say, not do as I do. He said to prepare for the future. As our glorious leader on this important challenge, he then retired to the rear and complained about his administrative duties: how to make a payout, to whom, why, when and for what land. Such problems.

He avoided any discussion of the long term transport decisions already inflicted on agriculture by his government: no Crow payments August 1; branch line deregulation by January 1; full rate deregulation by 1999; decisions that will increase freight rates dramatically as rates rise to those of other products and U.S. freight rates.

With that much bad news facing us in the trenches no wonder our little general could not bring himself to look at or even alert the troops. What vision, what courage, what a total disappointment.

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SUSTAINABLE DEVELOPMENT

Mrs. Karen Kraft Sloan (York—Simcoe, Lib.): Mr. Speaker, two years ago the first session of the United Nations commission on sustainable development was held in New York. It was agreed at that time that members would report on activities undertaken to implement agenda 21, the global plan of action for sustainable development.

I am pleased to announce that Canada delivered its second report to the United Nations last week. This is a report to the United Nations from all Canadians. It reflects Canadians' efforts to embrace and promote sustainable development.

Canada has made progress this year in parks, agriculture, forests and in conserving Canada's plants and animals. We are developing Canada's resources and maintaining their health for the future.

Canada continues this week to share its own experiences with other United Nations members at the session, thereby helping to further promote sustainable development among all UN members and encouraging all member states to learn from each other.

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CROATIA

Mr. Derek Lee (Scarborough—Rouge River, Lib.): Mr. Speaker, I welcome two distinguished guests from the Republic of Croatia, Mr. Mladen Vedrish and Mr. Rodesh.

Mr. Vedrish is a member of the Croatian House of Representatives and president of the Croatian Chamber of Economy. Mr. Rodesh is a member of the Upper House. They are in Canada today to help promote stronger cultural and economic ties between our two countries. Specifically they are here to discuss the potential for business relations between Canada and Croatia and investment opportunities in Croatia.

They will be meeting with members of the Canadian business community and the newly established Canada–Croatia Chamber of Commerce.

The government has taken a leadership role in developing trade relations with new markets. Croatia is a new and promising market that I know Canadians will want to participate in.

I am sure all members join me in wishing Mr. Vedrish and Mr. Rodesh much success in their endeavour to promote business relations between our two countries.

* * *

(1410)

SOUTH AFRICA

Ms. Jean Augustine (Etobicoke—Lakeshore, Lib.: Mr. Speaker, today marks the commencement of the first multi–racial democratic election held in South Africa.

Last year, serving as a part of the Canadian observer team, I was fortunate to contribute to Canada's effort to ensure the election process was free and fair, an essential step in setting up a post–apartheid, non–racial democracy.

President Nelson Mandela remains one of the great moral and political leaders of our time. His lifelong dedication to the fight against racial oppression in South Africa continues to inspire individuals and nations alike.

On this anniversary I invite my colleagues in the House to join me in welcoming to our country South Africa's first black high commissioner, His Excellency Billy Isaac Letshabo Modise.

Canada remains committed to working to promote human rights and security for all communities in South Africa.

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[*Translation*]

MONTREAL ECONOMY

Mr. Michel Daviault (Ahuntsic, BQ): Mr. Speaker, this morning we learned that the number of welfare recipients in Quebec had increased drastically, from 550,000 in 1990 to 808,000 this year. To make things even worse, 188,000 of these recipients, or close to 25 per cent of them, live in Montreal. That city is in fact the main victim of the federal government's negligence and incompetence.

This deterioration of the situation also confirms that federal reforms designed to improve the plight of the poor have failed miserably. This government only managed to make things worse.

When will the federal government realize that it cannot deliver and that it must provide Quebec with the necessary tools to develop a real job strategy? This government's stubbornness confirms that sovereignty is the only solution for Quebec.

[*English*]

THE LIBERAL PARTY

Mr. Jim Silye (Calgary Centre, Ref.): Mr. Speaker, through hard work and determination Reformers have finally made perfect sense of the Liberal's promise to govern with integrity.

First, a cabinet minister can sue the government that employs them provided it does not infringe on the rights of their children to greet the Queen.

Second, $100,000 trips using Challenger jets are justifiable only on the condition that the minister speaks at a northern U.S. ivy league school.

Third, renovation costs exceeding $200,000 are justifiable only if the word turbot falls under the minister's portfolio.

Fourth, if your father is a senator you are fair game, but if your son–in–law works for Power Corp., back off.

Fifth, taxpayer funded, gold plated pensions for life are justifiable because MPs make less money than the worst player on the Ottawa Senators.

Now that Reformers have made perfect sense of Liberal ethics and integrity we will focus our attention on understanding Liberal math.

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SCHIZOPHRENIA

Mr. Mac Harb (Ottawa Centre, Lib.: Mr. Speaker, this week the Schizophrenia Society of Canada launched its first annual public awareness campaign.

This disease affects about 270,000 Canadians. That is one in every 100 people. Sadly, 40 per cent of the people with this disease will attempt to take their own lives; sadder still, one quarter will succeed.

Schizophrenia is caused by a chemical imbalance in the brain and often strikes young adults. It is one of the most common forms of mental illness in Canada.

While there is much work to be done, progressive discoveries are being made every day and more effective treatment programs are being developed.

The Schizophrenia Society of Canada provides information, advice and emotional support to those living with this disease and their families. Along with my colleagues in the House of Commons I congratulate the society for its continued commitment and hard work.

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HOLOCAUST MEMORIAL DAY

Mr. Sarkis Assadourian (Don Valley North, Lib.): Mr. Speaker, today, April 27, marks Holocaust Memorial Day. As the Prime Minister of Israel said, it has been 50 years since the doors of hell were opened.

In Israel and around the world humanity remembers and pays tribute to six million Jewish people, including one million children, who were murdered at the hands of the Nazis during the Holocaust of 1939–45.

This is the precise reason I introduced a motion on April 3, 1995, M–282, to designate April 20–27 a week to remember crimes against humanity. At that time I called on members of the House to view the Holocaust and genocide as more than crimes against one group, but to see them as crimes against humanity.

I call on Canada and the international community to oppose any oppression in all its forms, regardless of race or religion, and to defend the rights of victims of hatred and crime.

* * *

(1415)

LACROSSE

Mr. Walt Lastewka (St. Catharines, Lib.): Mr. Speaker, this time last year there was a debate in the House on Canada's national sport, lacrosse.

At that time we not only reaffirmed the importance of lacrosse to our culture and heritage, we named it as the national summer sport while hockey would become our national winter sport. This House actually came to an all–party agreement that lacrosse and hockey would be our national sports.

Lacrosse has been part of our cultural heritage for many years. The sport is indigenous to Canada through the First Nations and existed here before Canada did as a country. Now it is having its funding abruptly cut and the government is refusing to support this important national treasure.

I call on Sport Canada and the Minister of Canadian Heritage to review this decision. While all of us must tighten our belts to get our fiscal house in order, surely our national sport deserves better treatment.

ORAL QUESTION PERIOD

[*Translation*]

TELECOMMUNICATIONS

Hon. Lucien Bouchard (Leader of the Opposition, BQ): Mr. Speaker, yesterday, the government took the unprecedented step of tabling two orders concerning DTH satellite distribution which are a direct reversal of the CRTC's decision. One of the orders comes in response to the dearest wishes of the Power DirecTv Group, by allowing the group to use an American satellite. We know that one of the main shareholders and leaders of the group is the Prime Minister's son–in–law.

My question is directed to the Prime Minister. Would he confirm that the chairman of the panel appointed to advise the government in this matter, Mr. Gordon Ritchie, is a former associate of his principal adviser, Mr. Eddie Goldenberg, who intervened directly in this case?

[*English*]

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, we have been through this a number of times.

We have demonstrated repeatedly that the action the government took both in initiating a review of the exemption order issued by the CRTC and in adopting the report of the panel of experts chaired by Mr. Ritchie has been in conformity with the views of many disinterested groups, at least in terms of the commercial interests involved. These include Friends of Canadian Broadcasting, the Consumers' Association of Canada, ACTRA, groups which really are not involved other than as important users of the system. Newspaper editorials have also asked for this response.

If the Leader of the Opposition wishes to debate this matter on the basis of process, then we will have something of substance to talk about. So far, his only attack on this has been unbased innuendo, which I think reveals more about him than it does about our process.

[*Translation*]

Hon. Lucien Bouchard (Leader of the Opposition, BQ): Mr. Speaker, a long answer that could have been shorter if it had been the answer to the question.

The question is a question of fact: Is Mr. Goldenberg a former associate of the chairman of the panel that drafted the orders? The question is very straightforward. It is a question of fact that will clarify the matter for the public, since the Prime Minister took the unprecedented step—I do not think this has happened very often in Ottawa, and I think it is probably the first time ever in the history of the federal Parliament and the federal government—of trying, and I think he did so in good faith, to isolate himself as though behind a wall from a fundamental decision by his government.

I therefore want to ask the Prime Minister whether he would agree that his wall shows some serious gaps and whether he realizes that the actions of his principal adviser, Mr. Goldenberg, allowed him to do indirectly what his conflict of interest guidelines prohibited him from doing directly?

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, a lot of smoke but no fire.

[*English*]

The problem here for the Leader of the Opposition is very simple. He has a report of a panel of experts, yes, chaired by Gordon Ritchie, participated in by Roger Tassé and Robert Rabinovitch, three former deputy ministers in the Public Service of Canada. They produced a report which has been generally praised in editorial comments and by other groups.

The Leader of the Opposition has nothing to criticize in the report. In fact, as I recall from the publication of the report on April 6, the most telling criticisms came from the very party he claims it was intended to benefit. Why? Because the result of the report and the direction which was tabled yesterday really give nothing to anybody except the right to apply to the CRTC for a licence. That right is open to Power DirecTv. It is open to Expressvu. It is open to everybody else.

(1420)

Our intention has been to be very, very careful on process. We invoked a process which was transparent and open. We have initiated it with tabling a direction, a process which is statutory, open to debate in a public forum, namely the House of Commons and the Senate of Canada.

The Leader of the Opposition cannot find anything to criticize in that process so he is left to asking about irrelevant details.

The Speaker: Colleagues, it is early in the question period. May I please appeal to you to keep the questions and answers as brief as possible.

Hon. Lucien Bouchard (Leader of the Opposition, BQ): Mr. Speaker, it is very strange to hear the minister hiding himself behind the process while they have put aside the process, squashing a decision made by the CRTC. It is the first time that has been done in the history of Canada. That is something.

[*Translation*]

I have the following question for the Prime Minister. Considering the fact that the order is tailor–made to meet the demands of Power DirecTv, that this order is a carbon copy of the draft prepared by a panel chaired by the former associate of the Prime Minister's principal adviser and that this associate personally intervened by speaking to the responsible minister, is the Prime Minister not bothered by this impression that Power DirecTv and his son–in–law were given preferential treatment?

[*English*]

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, the Leader of the Opposition keeps trying to find something that would discredit the process but he does not succeed.

The fact is the process was initiated yesterday in the House of Commons. It is true it is the first time it has been used. I am sure the Leader of the Opposition would admit it is a power that has only recently been included in the statute, although it was proposed that it was included in the statute by the previous government. It is a relatively new power and was used in a circumstance which itself was unprecedented, namely the granting of the exemption order by the CRTC.

In the face of the exemption order being granted on August 30, many groups asked the government to act, saying there were problems with this. If we had not acted in response to those criticisms, I suspect that at least the Leader of the Opposition, or perhaps his critic who often claims to speak on behalf of groups like the Friends of Canadian Broadcasting, would be standing in this House criticizing us for having not acted in the way we have acted.

* * *

[*Translation*]

SEAGRAM

Mr. Michel Gauthier (Roberval, BQ): Mr. Speaker, the *Toronto Star* reported this morning that, through some strange coincidence, the Minister of Canadian Heritage happened to be in Edgar Bronfman's suite in Los Angeles when Seagram took control of MCA studios. Following this transaction, Seagram will have to secure Investment Canada's approval before it can also get the Canadian subsidiary, the movie theatre chain Cineplex Odeon, out of the deal.

My question, which is quite simple, is the following: Can the Prime Minister explain to us what business a minister of his government had in Edgar Bronfman's suite, when Investment Canada will have a very important decision to make regarding this transaction?

Right Hon. Jean Chrétien (Prime Minister, Lib.): Mr. Speaker, Investment Canada will review this investment proposal like it would any other. The Minister of Canadian Heritage is not responsible for this issue, the Minister of Industry is, I believe.

Mr. Michel Gauthier (Roberval, BQ): Mr. Speaker, the Minister of Canadian Heritage is a minister of the government.

Mr. Bouchard: Supposedly.

Mr. Gauthier: Yes, supposedly. So, the Minister of Canadian Heritage, a government minister, just happens to be in a businessman's suite at the moment that a transaction is taking place which will require the approval of Investment Canada, an agency over which the government has some influence.

(1425)

Does the Prime Minister not feel that the Minister of Canadian Heritage exercised poor judgment by putting himself in a situation of conflict?

Right Hon. Jean Chrétien (Prime Minister, Lib.): Mr. Speaker, the Bronfman Group's investment proposal will come before the government and will be evaluated in accordance with the laws of the country and we will see what will happen. The appropriate minister and commission will examine the case and make a decision. The government will then decide whether or not to approve the deal.

Many businessmen, citizens and opposition members speak to the minister every day, under all sorts of circumstances. That is normal. Because, before making a decision—

Some hon. members: Oh, oh.

The Speaker: Order, please.

[*English*]

Mr. Chrétien (Saint–Maurice): Mr. Speaker, a decision will be made when there is an application. I do not know if we are faced with an application but with any investment made in Canada from foreign interests trying to buy Canadian concerns there is a review process. The review will be there. There will be a decision and that is it. That is the law of the land and the law will be respected.

Mr. Preston Manning (Calgary Southwest, Ref.): Mr. Speaker, as has already been referred to, the Seagram company acquired an 80 per cent interest in the movie giant MCA. Investment Canada may be required to make a ruling as to whether Seagram should be regarded as a Canadian company. While all of this is going on, the Minister of Canadian Heritage was apparently in Los Angeles being wined and dined by the principals to the deal.

Did the Prime Minister personally know about these meetings? Has he had the ethics commissioner determine that the minister has not once again put himself in a conflict of interest situation?

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, the hon. member may know there is an issue here as to whether or not Seagram is a Canadian company. If so, then the transaction is not reviewable by Investment Canada.

I want to assure the hon. member that that determination, which will be made according to legal principles by Investment Canada, is done entirely without reference to the Minister of Canadian Heritage as if that were relevant.

Mr. Preston Manning (Calgary Southwest, Ref.): Mr. Speaker, the question was about ethics and not the regulatory decision.

Power Corporation's DirecTv involving the Prime Minister's son–in–law just got the government to reverse a ruling of the CRTC for which the Minister of Canadian Heritage is responsible. Now the Bronfmans and Seagram board member Paul Desmarais who are closely related to the Liberal Party appear to be seeking the minister's help to get Investment Canada to leave them alone. We fear that the Minister of Canadian Heritage may be ending up as some sort of errand boy for an emerging Liberal family compact in the communications field.

What assurances can the Prime Minister give that the government's decisions in this rapidly developing communications field will not only be free from political influence but will also be free even from the appearance of political influence?

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, the marriage of convenience between the Bloc and Reform is one formed in the gutter I must say.

Some hon. members: Oh, oh.

(1430)

The Speaker: I know today is Thursday, not Wednesday. I would ask hon. members to please be very judicious in their choice of words. I would go back to the floor to the hon. Minister of Industry.

Mr. Manley: Mr. Speaker, the process is really the assurance that the leader is looking for. I offer him a reminder of last Christmas when Canadians across the country told us loud and clear that they wanted competition. We have taken moves in the context of the DTH file to ensure that there is competition.

The member raises the issue of ethics. Surely he understands that the best assurance that ethical principles have been lived up to is a clear and transparent process. That is the process we invoked. We invoked one that was open to public debate and discussion. We have listened in a public manner to the submissions of Canadians from coast to coast.

If he disagrees with the submissions that we heard from hundreds of Canadians, from editorialists, from artists and from broadcasters then let him say so, but let him not criticize it on the basis of innuendo. It is below him.

Mr. Preston Manning (Calgary Southwest, Ref.): Mr. Speaker, the Prime Minister will know from history books that the Liberal Party evolved from a group of reformers in pre–Confederation days who fought against the family compact, a closely knit group of elites, many of them related to each other, who subverted responsible government to protect and advance their personal and collective interests.

If the Prime Minister is really committed to integrity, surely he does not want to allow such a clique to develop around his government.

My question is very simple. How does the Prime Minister propose to prevent the formation and activities of this Liberal family compact, la clique du château libéral, from undermining the integrity of his administration?

Right Hon. Jean Chrétien (Prime Minister, Lib.): Mr. Speaker, when I spoke in the House yesterday on this matter I said I did not participate in any discussion in committee or in cabinet. When the decision was made I was not there. I have absolutely no conflict of interest.

It is true that somebody who is earning his living working for the corporation in question is my son–in–law. This is why I

abstained in the discussion even though it had no conflict of interest at all. I know some people want to attack me but I have been standing proudly in the House for 32 years. Everyone can look at my record.

It just so happens there is a lot of controversy in Canada because there is not enough competition. We had complaints in December because there was an exemption to make sure there would be no competition. My colleagues in the cabinet, without my presence, using the laws of Canada, have made a ruling which is clear. Everybody who wants to can apply for a licence and it will be reviewed under Canadian law. I will not intervene.

However, I will not go down to the level of people who do not have the decency to realize that a Prime Minister of Canada has the right to have his daughter well married.

* * *

(1435)

[*Translation*]

TELECOMMUNICATIONS

Mrs. Suzanne Tremblay (Rimouski—Témiscouata, BQ): Mr. Speaker, my question is for the Minister of Industry.

By issuing unprecedented decrees, the government has reversed the CRTC's decision to license Expressvu and has allowed Power DirecTv to use an American satellite, rather than use a Canadian one exclusively, to broadcast its programs. The Minister of Industry has confirmed publicly that the Prime Minister's principal adviser, Eddie Goldenberg, intervened directly in the matter.

How can the Minister of Industry claim to have disregarded the financial interests at stake for the Prime Minister's son–in–law in discussing the Power DirecTv file with Eddie Goldenberg?

[*English*]

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, again the opposition is grasping at straws.

The hon. member is correct. I did confirm that I informed Mr. Goldenberg on the status of the file. That is normal. I received no submissions. Certainly I have never discussed the matter at all with the Prime Minister. I can assure the House of that. Nor did I receive, as the member describes, any pressure from Mr. Goldenberg in any respect with regard to this file.

What I did receive were hundreds of submissions through the review panel from Canadians from coast to coast who said: ''Please review the order that was issued in August by the CRTC''. When the report of the panel was issued it was again supported not only by editorialists but by many of the groups on behalf of which the hon. member claims to speak in the House of Commons and committee, groups like ACTRA, the Friends of Canadian Broadcasting, the Canadian Council of the Arts.

I do not understand what her problem is. If we did not listen to those groups she would be on her feet criticizing us for not having done so.

[*Translation*]

Mrs. Suzanne Tremblay (Rimouski—Témiscouata, BQ): Mr. Speaker, how does the Minister of Industry explain Power DirecTv's failure to apply to the CRTC for a license, which it could have done since last July, other than by the fact that Power DirecTv had been assured that the government would issue a customized order enabling it to take over Canadian airwaves with an American satellite?

[*English*]

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, this is a case of the more noise, the less substance. As the hon. member knows, the condition of the exemption order which required that all content be carried through Canadian satellites excluded essentially everybody but Expressvu from—

Some hon. members: Oh, oh.

Mr. Manley: They are getting louder and louder, Mr. Speaker. It excluded potentially everybody but Expressvu from—

Some hon. members: Oh, oh.

The Speaker: Order. The hon. Minister of Industry may finish.

Mr. Manley: The effect of the exemption order was that essentially nobody but Expressvu could possibly have carried on the service.

If Power DirecTv had got what I assume it wanted, the government would have tabled a direction that would have changed the conditions of the exemption order to authorize Power DirecTv to operate under an exemption order. Then it would have been able to do it right away. It did not get that from the panel. In fact it got an obligation to apply to the CRTC for a licence which had already set conditions that put it essentially out of business in Canada.

The whole hypothesis of the member's question is entirely unfounded, but is obviously inherently contradictory. She does not understand the case.

* * *

(1440)

INVESTMENT CANADA

Mrs. Jan Brown (Calgary Southeast, Ref.): Mr. Speaker, my question is for the Prime Minister.

The government abused Investment Canada over the Ginn Publishing affair and it is poised to do it again over the Seagram acquisition. The government blamed the Tories for the Ginn Publishing deal but it cannot blame them this time.

The Minister of Canadian Heritage attended meetings in Los Angeles with MCA and Seagram prior to this transaction being filed officially with the securities commission or cleared by Investment Canada.

Does the Prime Minister not understand that as a result of these meetings the Minister of Canadian Heritage appears to be influencing Investment Canada's decision?

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, I guess this is just my day.

Again we have a false hypothesis. With respect to the issue that is before Investment Canada at the present time, it is one simply of fact, whether or not Seagram is a Canadian controlled corporation. If so, then the transaction is not reviewable by Investment Canada.

The hon. member implies by her question that somehow or another the Minister of Canadian Heritage ought to be able to know in advance of a visit to a facility such as MCA that a takeover is about to be launched. If he has the ability to see in advance, then my suggestion would be that perhaps he would have succeeded very well as an investment counsellor.

How could he possibly have known in advance that this transaction was to occur? It is a ridiculous question.

Mrs. Jan Brown (Calgary Southeast, Ref.): Mr. Speaker, the insidious backroom family connections continue.

Investment Canada has confirmed that the ADM for cultural affairs in the department of heritage is directly responsible for the Seagram file. He also has family ties with the Bronfmans. He is—

The Speaker: I appeal to the hon. member to put her question now.

Mrs. Brown (Calgary Southeast): Mr. Speaker, why is the Prime Minister allowing this sensitive issue to be handled by an individual who is in a direct conflict of interest and whose family stands to benefit from the decisions made?

Right Hon. Jean Chrétien (Prime Minister, Lib.): Mr. Speaker, the Minister of Industry, who is responsible for Investment Canada, has explained very clearly that there is a process.

There will be an application from the buyers of this complex. They will have to establish very clearly something that is very easy to understand: Is this company Canadian controlled or not? It is a matter of fact. Investment Canada will review this. If it is a Canadian company it means the huge corporation will be controlled by Canadian interests. I do not see anything wrong if that is the case.

If it is not the case and it is an American concern, it will have to follow the same route as any other foreign investment. Therefore, it will be decided by Investment Canada. Investment Canada will look at the books of the Seagram corporation and decide if it is Canadian or not. It is not my decision. It is for Investment Canada to decide.

* * *

[*Translation*]

TELECOMMUNICATIONS

Mr. Pierre de Savoye (Portneuf, BQ): Mr. Speaker, Power DirecTv needed an exemption order from cabinet, since the use of its partner's American satellite violates current CRTC rules. Moreover, because of such exemption orders, the federal government could be liable to court action, this according to the CRTC's secretary general.

Will the Minister of Industry recognize that, with this made–to–measure order for Power DirecTv, the government is allowing that company to use DirecTv's American satellite, thus avoiding having to pay tens of millions of dollars in fees for using the Canadian satellite?

(1445)

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, I want to say two things. First, the legal opinion which the government received does not support CRTC's contention. Second, the process which we undertook yesterday is of a parliamentary nature. If the hon. member has suggestions to make regarding the handling of this issue, we are prepared to listen.

Mr. Pierre de Savoye (Portneuf, BQ): Mr. Speaker, we know that legal opinions are usually debated before the courts, which raises the following question: How can the Prime Minister, as head of the government, accept a decision which not only favours his son–in–law's interests but, more importantly, which makes his government liable to court action?

[*English*]

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, I am sure the hon. member knows there are often differences of opinion among lawyers. I can assure the hon. member our view is that the government acted entirely legally and is not subject to any civil suit for the actions it has taken in issuing a direction in pursuance of its powers under the Broadcasting Act.

However, I want to make clear that our objective in this, as I have stated several times in the House on previous days, is to create a competitive environment for direct to home satellite services, a level playing field. We think the direction we have tabled is the best means of achieving it.

Again, since there is a parliamentary process invoked here, if members in either of the opposition parties think there is a better way to do it, they may want to suggest changes to the direction.

SEAGRAM

Mr. Randy White (Fraser Valley West, Ref.): Mr. Speaker, the backroom family connections continue. Investment Canada has confirmed the assistant deputy minister for cultural affairs in the department of heritage is directly responsible for the Seagram file. Surprise, surprise.

He has family ties to the Bronfmans. He is Victor Rabinovitch, the brother of Robert Rabinovitch, who wrote the DTH satellite directive that benefits Power Corp and who works for the Bronfmans.

Why is the minister allowing this sensitive issue to be handled by an individual who is in direct conflict of interest and whose family stands to benefit from the decisions?

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, let me help the hon. member to understand the process that is being invoked here.

The public servant in question does not work either for Investment Canada or for Industry Canada. Until it is determined that Seagram is not a Canadian company, there is in fact no role to be played by the Department of Canadian Heritage in the matter.

If Seagram is a Canadian company, the transaction is not reviewable by Investment Canada. As far as I can tell, the consequence of that would simply be that the sequel to ''Jurassic Park'', which I know is one of the hon. member's favourite movies, could perhaps qualify for the Oscar for best foreign film.

Mr. Randy White (Fraser Valley West, Ref.): Mr. Speaker, I do not have to go very far in the House to find ''Jurassic Park''.

This morning when asked about the heritage minister's trip to Los Angeles to meet with MCA and the Bronfmans, the ethics counsellor admitted that he had no knowledge of the trip. Considering the strong ties of the Bronfman family to the Liberal Party and the decisions that lie before Investment Canada, we have yet another problem of conflict of interest.

Why did the minister fail to consult again the ethics counsellor on an issue that affects the integrity of the decisions made by the government from ''Jurassic Park''?

Right Hon. Jean Chrétien (Prime Minister, Lib.): Mr. Speaker, now I will have to inform my cabinet ministers that when they go on trips they should ask the permission of the ethics counsellor.

Come on, look at the facts. This Canadian company of the Bronfman family, a great business success in Canada, has expanded into the United States. We should not be ashamed of that.

If it is still a Canadian company, it does not have to apply to Investment Canada. If it has too many interests outside Canada and has no more Canadian interests, it will have to apply.

(1450)

There is no mystery. Why do they use innuendoes to try to destroy the reputations of people when the process is completely open and when we want to introduce some competition in the communications system of Canada?

I know le désespoir of these guys on the other side of the House. They do not have anything to say. They are trying to find fault when there is no problem. That is why the Canadian public is not responding to them and why they are so low in the polls.

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[*Translation*]

WELFARE

Mrs. Francine Lalonde (Mercier, BQ): Mr. Speaker, my question is directed to the Prime Minister.

In January 1995, nearly 5,500 Quebec households applied for welfare for the first time. More than 40 per cent of these new applicants were young people under the age of 25. Altogether, sadly enough, we have a record 808,000 people in Quebec, 25 per cent of whom live in Montreal, who must turn to welfare as a last resort.

Considering that 40 per cent of new welfare recipients—

Some hon. members: Oh, oh.

Mrs. Lalonde: Mr. Speaker, the people I am talking about do not have the same lobbying power as those who were referred to repeatedly just now, but I would like to be heard just the same.

Some hon. members: Hear, hear.

Mrs. Lalonde: Considering that 40 per cent of new welfare recipients were either on unemployment insurance or were denied access to UI, would the Prime Minister agree that these cuts in unemployment insurance totalling $5.5 billion over three years are simply—

The Speaker: Hon. members, we should be listening to questions and answers today.

The Prime Minister.

Right Hon. Jean Chrétien (Prime Minister, Lib.): Mr. Speaker, like the hon. member I too deplore this state of affairs in Quebec. And that is why, since we came to power, we have discussed the need for job creation, and we have had some results. Nearly 100,000 new jobs were created in Quebec since we formed the government, and unemployment in Quebec dropped by 1.3 per cent over the past 18 months.

Unfortunately, at a time when Quebec has the most serious social problems in Canada and unemployment is increasing, the Government of Quebec only thinks about independence, separation and the Constitution. And while it does its political fancy footwork, the poor in Quebec are paying the price. That is what is so unfortunate. We want to talk about job creation, while it dreams of separatism at the expense of the poor in that province.

Some hon. members: Hear, hear.

Mrs. Francine Lalonde (Mercier, BQ): Mr. Speaker, it is because these people are not as well connected, and because we are convinced that only sovereignty will give Quebec a chance to deal with the terrible scourge of unemployment.

Some hon. members: Hear, hear.

Mrs. Lalonde: Does the Prime Minister not realize that the federal system has failed us in this respect and that the situation will go on deteriorating under the Canada Social Transfer, which will further reduce federal funding for welfare assistance?

Right Hon. Jean Chrétien (Prime Minister, Lib.): Mr. Speaker, as a result of changes in unemployment insurance benefits, 250,000 families in Quebec now receive an additional $1,000 since the changes in the program came into force.

I am glad that we are starting to talk about these problems, because Quebecers like me, and other Canadians as well, are sick and tired of hearing about the Constitution and separation. At last we are going to talk about the real problems of Quebecers: unemployment and employment. If they would only stop bothering us with all this talk about separation.

* * *

(1455)

[*English*]

HARBOURFRONT CENTRE

Mr. Barry Campbell (St. Paul's, Lib.): Mr. Speaker, my question is for the Minister of Public Works and Government Services.

There is concern in the greater Toronto area about the future of Harbourfront Centre, one of Canada's premier cultural, entertainment and recreational facilities.

Given the financial challenges facing the centre, would the minister provide an update on his recent discussions with representatives of the centre and on the status of the upcoming Today's Japan Festival?

Hon. David Dingwall (Minister of Public Works and Government Services and Minister for the Atlantic Canada Opportunities Agency, Lib.): Mr. Speaker, the hon. member will know that in the past the Government of Canada has made contributions to this important cultural and tourism facility in the city of Toronto.

As a result of our fiscal situation and as a result of the financial pressures the group at Harbourfront is facing, I invited both parties to get together to see whether or not discussions could take place to see if we could find solutions to the problems.

Metro Toronto members of Parliament have been very helpful in providing suggestions and directions as to the ways in which we may proceed to find solutions to a very difficult situation.

I report to the hon. member that I am reasonably confident, as I stand here today and negotiations proceed, we will be able to find some common ground between ourselves and Harbourfront to ensure the facility and, most important, the Today's Japan Festival will be able to continue in the weeks ahead.

* * *

SEAGRAM

Mr. Ken Epp (Elk Island, Ref.): Mr. Speaker, yesterday during question period the Prime Minister admitted that he consulted no government officials in regard to the Power Corp. deal.

In an interview the heritage minister indicated that there was no reason to consult. The Prime Minister has just now repeated again that there was no need to consult.

In view of the fact that in these affairs Liberal insiders stand to gain millions and maybe billions of dollars, why not ask the ethics counsellor to put the thing to rest, to have a free and open investigation?

Right Hon. Jean Chrétien (Prime Minister, Lib.): Mr. Speaker, the ethics counsellor told me that I am acting absolutely properly.

Mr. Ken Epp (Elk Island, Ref.): Mr. Speaker, during the campaign the Liberals said that they wanted to rebuild trust. We would like them to do it.

The way to do it is to have an independent investigator make an investigation and rule on the matter. Why does the Prime Minister resist having the ethics counsellor apply his skills to resolving the problem?

Hon. John Manley (Minister of Industry, Lib.): Mr. Speaker, the member needs to understand that he is asking for an investigation when we have in fact launched a process.

The process began yesterday with the tabling of a direction in the House of Commons. It is a process that includes Parliament. Parliament has the right to discuss the direction and to propose changes.

I have yet to hear from members of the Reform Party. Is it that they oppose competition? Is it that they oppose licensing? Is it that they oppose that part of the revenue of DTH undertakings

that should go to Canadian production? Which of those three things is it that they oppose?

* * *

[*Translation*]

OLD AGE SECURITY

Mr. Maurice Dumas (Argenteuil—Papineau, BQ): Mr. Speaker, my question is for the Minister of Human Resources Development.

Since last Friday, Communication–Québec, MP's offices and even the PMO have been flooded with calls from obviously very concerned pensioners. According to the Consumer Help Office, approximately 258,000 pensioners will see their old age pension cheques reduced by 50 per cent.

(1500)

How can the minister explain that so many seniors received or will receive this year a pension cheque not including the guaranteed income supplement to which they are entitled?

[*English*]

Hon. Lloyd Axworthy (Minister of Human Resources Development and Minister of Western Economic Diversification): Mr. Speaker, I have no idea who is behind these unfounded rumours or where they come from, although I have my suspicions as to who is behind them, and I may be looking at them right now.

I would hope the hon. member would use his good offices to assure that there will be no 50 per cent reduction in seniors' pensions. In fact, just last month we increased them. On the basis of the improvement in the consumer price index, we improved seniors' pensions.

[*Translation*]

Mr. Maurice Dumas (Argenteuil—Papineau, BQ): Mr. Speaker, does the minister deny that the Department of Human Resources Development's difficulty in processing requests is creating hardship this year, mostly among seniors?

[*English*]

Hon. Lloyd Axworthy (Minister of Human Resources Development and Minister of Western Economic Diversification): Mr. Speaker, if in some cases there have been overpayments or problems that do not fit the regulations, of course we will be sending out these letters. But to make the kinds of exaggerated claims the hon. member has, purely to frighten and scare people, is frankly not the responsibility of a good member of Parliament.

Some hon. members: Oh, oh.

Some hon. members: Order.

PRESENCE IN GALLERY

The Speaker: My colleagues, today, as on other days, but especially today, I want to draw your attention to the presence in the gallery of a man who has brought great distinction to our country. As a matter of fact, I would say that he gives us part of our identity. I want to introduce to you the world renowned Canadian photographer, Mr. Yousuf Karsh.

Some hon. members: Hear, hear.

The Speaker: This concludes question period, but I am going to hold a short reception in my chambers, 216–N, and I would invite you, my colleagues, to come with me and meet Mr. Yousuf Karsh.

* * *

[*Translation*]

BUSINESS OF THE HOUSE

Mr. Michel Gauthier (Roberval, BQ): Mr. Speaker, I ask the Leader of the Government the typical question for a Thursday. What is on the agenda of the House for the next few days?

[*English*]

Hon. Herb Gray (Leader of the Government in the House of Commons and Solicitor General of Canada): Mr. Speaker, before some members of the House go to the Speaker's reception for Mr. Karsh I would like to present the weekly business statement.

On Friday we will call third reading of Bill C–43, concerning lobbyists. This will be followed by Bill C–67, the veterans bill, and by Bill C–70, the income tax bill.

On Monday we will call the motion in my name concerning a special joint committee on a code of conduct for parliamentarians. If this is completed before the end of the day, we would return to Friday's business at the point where it left off.

(1505)

Tuesday shall be an opposition day. On Wednesday we will take up the business at the point of progress where we left off on Monday, followed by Bill C–41, concerning sentencing, and Bill C–54, concerning the old age security pension.

Mr. Speaker, this is the weekly business statement.

GOVERNMENT ORDERS

[*Translation*]

SUPPLY

ALLOTTED DAY—NATIONAL HEALTH CARE SYSTEM

The House resumed consideration of the motion.

Mr. Bernard Patry (Pierrefonds—Dollard, Lib.): Mr. Speaker, in 1984 the members of this House unanimously adopted the Canada Health Act. It was a particularly noteworthy event for two specific reasons. This legislation guaranteed quality health services to all Canadians, regardless of their income or their place of residence.

Furthermore, this piece of legislation was adopted unanimously by the members of all the parties. Everyone felt a national health insurance scheme was invaluable.

[*English*]

This government's commitment to universal health care remains unshaken. The Canada Health Act and the system we have built under its framework is a defining feature for our society. The essence of medicare is not to be found in the mysteries of a funding formula. It is certainly not to be found simply in the amount of money we spend. Rather, it is to be found in providing quality health care equally to all Canadians.

[*Translation*]

The five main principles underlying the Canada Health Act are: universality, accessibility, comprehensiveness, portability and public administration. They are rooted in values of fairness, social justice, compassion and respect for human dignity. These values are shared by all Canadians. They are part of our social fabric.

Some claim that our health insurance system is too costly and that we can no longer afford the luxury of a government funded system. On the contrary, I believe that our health insurance system is no luxury but a necessity and that public financing of this system helps keep health care costs under control.

In investing in health in general and in health care services, our government is helping to keep Canadians healthy and fit. They will be able to meet the economic challenges of the 21st century. Studies indicate that many days of work are lost to illness or accident. They all reach the same conclusion: these days lost have a negative effect on workers, society and the economy.

[*English*]

A health care system that Canadians can access without fear of financial hardship encourages people to seek medically necessary treatment before an illness or injury becomes life threatening or debilitating. Early diagnosis and treatment are far less expensive than chronic care, both to the individual and to the system. Such a system does not encourage patients to seek inappropriate care.

For those who think in terms of the bottom line, the principles of the Canada Health Act support an economically efficient health care system. These are economies of scale obtained from governments being the only buyers of medically necessary hospital and physician health care services and of the entire population being the customer base. A system that is publicly administered saves this country billions of dollars annually in administrative overhead. In hospitals and in clinics this frees up the resources in time to practise medicine, not administration.

(1510)

Finally, medicare produces a healthy population, which in turn means a healthy and productive labour force. This is a reciprocal relationship between business and the health sector. A healthy business sector means economic growth. Economic growth means jobs. Jobs reduce unemployment, and less unemployment means a healthier population and reduced health costs. In other words, a healthy Canada is a wealthy Canada.

[*Translation*]

The fact that the Canada Health Act is both to flexible and too rigid was also deplored. Yet, according to the Canadian constitution, it is up to the provinces and territories to provide and administer health care services. Consequently, the provinces and territories must identify their own priorities and manage their resources.

Under the act, the provinces and territories must provide the required medical and hospital services. However, nothing prevents them from providing other types of services. This means that a province may pay for the costs of prescription drugs or dental care for children, while another may finance air ambulance services.

As long as it abides by the five basic principles underlying the Canada Health Act, each provincial or territorial government is free to provide additional services at its own cost, or experiment with different structures. The basic criteria governing federal financing under the Canada Health Act are the five principles previously mentioned. The government is not prepared to compromise on these principles.

[*English*]

The basic criteria for federal funding under the Canada Health Act are the five principles mentioned earlier. It is these that the government is not willing to negotiate.

The first principle is universality, meaning that all residents of a province must be insured under the provincial health plan if it is to receive federal support. We as Canadians believe we must all have access to medically necessary services. People cannot be deinsured because they might be costly for the system to cover. They cannot be turned away at the hospital door because, for example, they have not paid their quarterly tax bill or even their provincial premium. Any one of us needing health care will be treated the same as everyone else. This is what is meant by equity.

Accessibility on uniform terms and conditions is the second principle. We should not face any financial barriers in receiving health care, no extra billing, no user charges, no facility fees, no upfront cash payments. If the service is medically necessary, we

will get it at the time defined by medical consideration and not by money.

[*Translation*]

The principle of comprehensiveness is a recognition that Canadians have a number of needs which must be met. It would be unfair to insure only certain medical services. We will continue to contend that the provinces and territories must insure all medically necessary services.

However, comprehensiveness does not mean uniformity. It does not mean that the provinces and territories must all meet health care needs in exactly the same fashion. These needs must be met, but there is some flexibility as to how this can be achieved.

Portability means that Canadians are always covered by medicare when they travel or move within Canada. This is what gives our health care system its national dimension.

[*English*]

Canadians enjoy the freedom to work and travel anywhere in the country, without fear of losing their health insurance coverage. Each separate health insurance plan may be provincial in origin but is recognized nationally in every province across the country.

The fifth and final principle is public administration. Our health insurance plans must be operated by provincial governments on a non–profit basis. It is at the core of our ability to contain costs in a system and thus to deliver quality care at an affordable price.

Public administration is the key to ensuring all the other principles. When health insurance is operated and funded by the government, we can guarantee that health care is universal, accessible, comprehensive and portable because we have direct control over it. Public administration not only ensures that more of our health care dollars go toward patient care but it also makes governments more successful than the private sector in keeping health care costs under control.

(1515)

In 1993 we spent about $72 billion on health care. This represents 10 per cent of our gross domestic product. The public component of that 10 per cent has been growing at less than 2 per cent. Compare that to private health spending which has been growing at 6.4 per cent.

[*Translation*]

However, complying with the provisions of the Canada Health Act does not prevent the provinces and territories from adopting innovative strategies to meet the challenges in providing health care services.

For example, British Columbia has set up emergency response teams, New Brunswick has established an extramural hospital and Quebec has achieved excellent results with its local community health centres. All these initiatives have solved different problems and demonstrate how flexible the legislation is.

The Minister of Health even recognized that private clinics offering medically necessary services can be an effective way to give such services, provided that the medically necessary services are fully covered by provincial or territorial health plans. What is totally unacceptable is, first, physicians extra–billing for services already covered by provincial or territorial health plans and, second, charging user fees for medically necessary services covered by provincial or territorial health plans.

[*English*]

In this era of fiscal restraint, Canadians want value for money. We pay for our health system collectively through our taxes. We all pay so that everyone can benefit according to need. There are altruistic human reasons and hard economic arguments for doing so. Whichever we support, the system works to our benefit. This government is committed to preserving the Canada Health Act because in spite of what its critics may say, it works.

[*Translation*]

For many of us, health care insurance is an essential part of the Canadian identity. We belong to a nation where all citizens are equal. Anyone in Canada can rely on reasonable access to health care services, not on the basis of wealth but according to need. Every Canadian can rest assured, now and in the future, that he or she will not be ruined financially by a serious illness. The Canadian health care system has no equal in the world. Treatment priorities are set in light of medically necessary services and not according to the patient's wealth.

The Canadian government takes very seriously its role as a defender of universal health care. The Minister of Health has expressed her strong opposition to facility fees, extra–billing and any other sign of a two–tier health care system. Canadians have entrusted their government with protecting their health care system. As the Prime Minister has repeatedly said, this government intends to show that it is worthy of this trust.

Mr. Philippe Paré (Louis–Hébert, BQ): Mr. Speaker, I think there is not one Canadian or Quebecer who questions the importance and value of the five principles set out in the Canada Health Act. However, the greatest threat to these principles, in my view, is the underfunding the Government of Canada has caused these past few years by phasing out financing in these areas.

Does the hon. member for Pierrefonds—Dollard recognize that this seriously threatens the principles he referred to and with which I totally agree? Reduced funding from the federal government may well place the provinces in a situation where,

while recognizing these principles as normal and necessary, they can no longer uphold them.

(1520)

Mr. Patry: Mr. Speaker, I thank the hon. member of the Bloc Quebecois for his question. I am very pleased to hear him say that he came to the same conclusion as I did, in that he agrees with the five principles I listed earlier.

There is a real problem with underfunding but it lies in the fact that social and health programs are provincially administered in Canada. Every province made its own choices. It is now up to these provinces to make new choices to cut their costs within the health system as we know it.

In certain parts of the country, provinces have allowed non–essential services to be provided to their citizens. I think that the ball is in the court of the provinces now.

[*English*]

Mr. John Williams (St. Albert, Ref.): Mr. Speaker, the hon. member may congratulate the Bloc for endorsing the five universal principles. However, I hope he will not congratulate the Reform Party because we do not endorse these five principles.

I would like to know what the hon. member is trying to do when he acknowledges there is a serious reduction in the amount of money being put into health care by this government. The provinces are cutting back as they try to balance their budgets. There is a significant reduction in the amount of cash going into the health care system, yet the Liberals with their heads in the sand seem to think it is business as usual. They seem to think that health care is going to continue on as it has been, uninterrupted without any problems while they cut back on the cash without having any opportunities or initiatives allowing the health care system to resolve its own problems through the market forces or whatever.

When will the Liberals get their heads out of the sand and recognize there is a real problem in health care that is caused by the lack of funding? When are they going to allow this additional funding either through taxpayers' dollars or by letting the marketplace put some money into it?

[*Translation*]

Mr. Patry: I thank the hon. member of the Reform Party for his question.

I will answer the second part of his question first. There is no way that government will ever grant the Reform Party its wish for a two–tier health system, with one system for the rich and another for the poor. That is out of the question.

Extra billing and private clinics lead to a two tier system: one for the rich and another for the poor. The government in office in Ottawa will do no such thing because it is against its principles.

As for the first part of his question, I think that it is up to the provinces; they can and must cut their costs, which have become astronomical. There are certain things that must be looked at, costs, hospitals, provinces and even physicians, and I am one myself. Therefore, it is within the medical and social service community that the solution should be sought, and not in terms of the accessibility per se of the services.

[*English*]

Mr. Hugh Hanrahan (Edmonton—Strathcona, Ref.): Mr. Speaker, it is my pleasure to address the issue of established programs funding in regard to health care.

The issue of established programs funding is of great concern to the constituents of my riding of Edmonton—Strathcona. While Alberta is battling its debt and deficit problem without increasing taxes, it is also doing it with less and less resources from the federal government. Since health care is Alberta's largest single area of government expenditure, I feel it is of the utmost importance to debate this issue.

In 1993–94 the federal government provided transfers of $40.5 billion to the provinces. The majority, approximately 71 per cent of these transfers, was for the established programs financing and equalization program. Out of this $40.5 billion, tax transfers were approximately $13 billion. It is the established programs funding, the tax transfers which I wish to spend most of my time discussing today. However, before we can discuss these transfers, it is important to look briefly at the equalization program.

(1525)

Alberta has been deemed a have province. According to a recent study by a University of Calgary professor, it has paid in $139 billion more than it has received since Confederation.

An hon. member: We want it back.

Mr. Hanrahan: Albertans are gracious individuals and they have felt that being part of Canada has had its costs, but they also feel the benefits have outweighed these costs. I agree with that attitude, yet I also find that many Albertans are rethinking this attitude of generosity.

Another area that has become extremely contentious, particularly in Alberta and B.C. is the established programs funding. This funding is an arrangement between the federal government and the provinces relating to the funding of post–secondary education and health care. I will try to limit my comments solely to health care due to time limitations.

First, the Reform Party has no intention of dismantling medicare, nor do we want to create some form of a U.S. style

two–tier health care system. Instead, the Reform Party argues that our health care system is already gravely ill as its costs are going out of control in relation to the funding available.

Our intention is to ensure the long term viability of health care in this country. Health care is an issue which lies at the heart of most Canadians. It is Reform policy to ensure that no Canadian is denied adequate health care services for financial reasons, regardless of where they live in Canada.

Currently, provincial governments possess the legal and constitutional responsibility to provide health insurance and services. They do not however, possess the authority to take the administrative steps to control medical costs and/or raise additional revenue for health care services. Reformers believe that this arrangement puts both the federal and provincial governments at odds with each other, rather than allowing them to get on with the job of providing improved quality health care to all Canadians.

In fact, the Canadian Medical Association has argued that the country's health insurance system will be colliding with the economic reality in which it, the health care system, cannot be maintained in its present form. I believe this collision has already begun. This is apparent if we look at the federal budgets throughout the 1990s.

We have seen virtually a non–stop series of cuts and freezes in the federal government's transfers to the provinces. This has pushed the federal government into a corner. It realizes that it is risking losing control over national standards in health care should the cash transfers to any province cease entirely.

This problem is further troubled by the fact that federal provincial relations regarding transfers has been marked by decisions which have nothing to do with the search for balance or fairness in the use of our resources. I refer here to the national energy program and the recent gas tax that hit Alberta harder than any other province.

Miss Grey: And public utilities.

Mr. Hanrahan: Yes. It is for this reason that the Reform members of Parliament believe the only viable solution to safeguard our health care system from a fiscal crisis is to redefine the Canada Health Act. It should allow the provinces to find solutions that make the most sense for their region, through exercise of their constitutional jurisdiction over health care. The role of the federal government should be to provide financial support and equalization through the taxation and transfer system and to ensure that no Canadian is denied health care for financial reasons.

The Reform Party advocates amending the health care act to restore to the province the administrative jurisdiction the federal government has expropriated through the use of its spending powers. In other words, we will leave it in the hands of the provinces where it belongs.

What worked yesterday does not necessarily work today. What was taboo in the past is possibly accepted today. This applies to the federal transfer payment system which, after having its successes, is now coming up against its failures. Few people would dispute that to rectify the inefficient allocation of resources it is urgent that we put our public finances on a more solid footing to create an economic environment that will contribute more to efficiency and growth. However, the way to achieve this may not be compatible with certain political, social or provincial expectations.

(1530)

As just stated, the federal government would seem to be feeling more and more trapped by its policy of imposing national standards and its desire to reconsider the refinancing of transfer payments.

We must continually remind ourselves it is the provinces and not the federal government that have the constitutional jurisdiction to operate the health care system. It is the provinces and not the federal government that provide the bulk of health care funding. It is the provinces and not the federal government that have the greatest expertise in health care delivery.

We on the Reform side of the House have to move ourselves away from the corner and into the forefront of health care policy issues. The way to do this is to focus the federal government's role on making no strings attached transfer payments to bring adequate health care within the financial reach of all provinces and citizens.

The provinces in consultation with patients, health care workers and taxpayers should be left to explore new options for greater health care efficiency without fear of being penalized by Ottawa.

We ultimately should be transferring additional tax points based on the notion that each province will clearly define what its core level of basic services will be. This list can ultimately and should differ from province to province. This would be our version of national standards to which the federal government could rate the provinces on their record against their core level of services.

Not only would we like to have a clearly defined level of basic core services but would also expect the provinces to shift more toward a community based development philosophy of delivering health care. This process and approach is to work with a community to address unmet needs and issues of concern to that specific community. It is based on the principle that the community affected by an issue is in the best position to articulate its needs and desires and to devise appropriate strategies to address these needs.

The core services and community based development approach, linked with the no strings attached tax point transfer, would ensure accessibility for everyone in a cost effective and efficient manner. This accessibility will ultimately be redefined to recognize that long waiting lists for essential services are a denial of access.

Ms. Maria Minna (Beaches—Woodbine, Lib.): Mr. Speaker, I am having some difficulty understanding the logic of the hon. member for Edmonton—Strathcona. He is talking about transferring tax points with no strings attached. This is transferring more money to the provinces, giving them carte blanche and letting them decide what their core programs would be. Each province would decide what its core program would be and we would have different core programs from province to province.

He says he does not want to create a two tier program. I do not understand how the member can say that he would have an accessible health care system across the country where one province's accessibility would be defined in one way and another province differently. It is quite conceivable that in some provinces health care would not be accessible to people who are poor because they would have to pay certain types of remuneration or what have you.

I do not understand what the member is actually asking. Basically the current health care system structure has allowed the provinces to administer their health care systems as they wish as long as they are able to respect the five conditions. That is not so difficult. Those are not very difficult conditions to respect. His colleague earlier said they do not endorse the five principles. They are pretty broad.

(1535)

I would like to know from the member exactly what kind of medicare system the Reform Party envisions. If it sees one different for every province with accessibility varying without any national principles, however broad, I have some difficulty with that. I would really like to understand where the provinces are now hampered in the administration of the health care system.

The Acting Speaker (Mr. Kilger): While the hon. member for Edmonton—Strathcona is on his feet replying to the question from the hon. member for Beaches—Woodbine I wonder if he could refresh the memory of the Chair on whether he is splitting his time with a colleague.

Mr. Hanrahan: Mr. Speaker, we will be splitting our time.

I thank my colleague for her question. With respect to the distinction between provinces, she is aware that already happens. From the investigations I have made with various medical people they suggest there are health problems relatively unique to certain areas, to certain provinces, to certain communities. In those areas they should be able to direct as much of their resources as possible. We are trying to localize it to the people most affected.

With respect to the core area, that is something which we have to debate as a national government, a national society, and we have to come to some agreement as to what is universal from one end of the country to the other. However, there are certain aspects which do not require that.

In terms of accessibility, the essential core agreements must be available to all regardless of income. I believe I made that relatively clear in my speech.

Mr. John Williams (St. Albert, Ref.): Mr. Speaker, one of the five principles Liberals keeping talking about is the publicly funded one to the exclusion of all other input of cash into the health care system. I want to ask the hon. member for Edmonton—Strathcona if he feels their proposition of refusing any other means of funding health care will preserve our health care or should we allow other moneys into the program?

Mr. Hanrahan: Mr. Speaker, if we do not allow other moneys into the program, if we continue the decline in financing for medicare which has been occurring over the last number of years, combined with increase in the interest on the debt, we will find there will be a no tier system, not a two–tier system. There will be no medicare for anyone.

This is an attempt to save medicare.

Mr. Speller: Do you want a three tier system?

Mr. Hanrahan: I said very clearly in my speech that is exactly what we do not want. We want to save the basic elements of medicare for all Canadians regardless of income.

Miss Deborah Grey (Beaver River, Ref.): Mr. Speaker, on this business of a two–tier system, do we want it or do we not want it, we have had it for years. Let me draw to the member's attention that we have a two–tier health care system right now.

If my friends would like to get out their wallets or their purses or whatever, I would refer them to their benefits card from the public service health care plan. Mine says: ''D.C. Grey, hospital level three''. As soon as we see other levels we ask whether this is a two–tier health care system or a one tier system. Members opposite shun that and talk about the fact that we could never have a two–tier health care system. My card says level three, so how many tiers are we looking at here?

Let me also draw to their attention that MPs pay exactly zero; zero comes off their paycheques every month.

(1540)

Anyone in the gallery who works for the public service or anyone who works in our offices, anyone who is a public servant, has the option to have a level three health care card. My

staff members have those. They pay if they are single $5.32 a month; if they are a family they pay $10.35 a month. I got that today from our pay and benefits clerk in the comptroller's office.

If we are to talk about two tier health and be so sanctimonious about it, that we in the Reform Party will only have an American system in two tier health, this is nonsense. We cannot beat around the bush because that is fact. We pay zero for this level of hospitalization. Public servants, people who work for us in our offices, pay $5.32 or $10.35 a month. That is two tier or spending differently. MPs are off the hook again; zero comes off our paycheques for that. We have some serious problems in the country and that is one tiny example.

We are in favour and believe every Canadian should have access to health care regardless of their ability to pay. That is a fact. That is important across the country. It comes down to how we will pay for that. The country is $550 billion in the hole and yet the health minister this morning said it is just going along fine and we have lots of money.

Deficit spending in the late sixties and early seventies has dug us into a hole so deep that if we do not get this thing under control even the size of the Chamber would not hold the cash we owe. It is rising at a rate of $1,500 per second.

For people on the government benches to say we are dreaming on this side of the House and everything is as safe as could be forever, that is not true.

My friends across the way know it. We cannot be eating up interest rate payments at the rate we are paying and expect everything and the status quo to go along as it has.

There are discrepancies in the system right now. The system needs to be fixed. There are many tiers, many levels of health care. Let us admit it rather than having a shade pulled over our eyes and trying to go out to Alberta and scare the daylights out of us and my health care minister. Do not try to frighten anybody. Do not accuse Reformers or the Bloc of fearmongering.

We are dealing with the facts. We have serious economic problems. We do have a two tier health system. My friend from Winnipeg this morning, a doctor, said he was all in favour of the Liberal plan of health care. He was specifically asked whether he had ever in his medical practice referred one of his patients to the Mayo Clinic. I suspect he did. I suspect there were many times in his medical profession because I think he was an excellent doctor who would tell someone they needed to get to the Mayo Clinic fast. Winnipeg is plenty close to the Mayo. I bet he referred lots of patients there.

I bet the doctor from Vancouver Centre who lives close to the American border, in someone's best interest if they could afford to pay, would send them down to the Mayo Clinic, California, Seattle or wherever for health care if they could afford it. This is happening all the time.

To say we are just fearmongering in the Reform Party, forget that. Let us get on with solving the problem.

They also talked about our position in the campaign. That was $150 billion ago. The national debt is now at $550 billion, $150 billion more than when a lot of greenhorns walked into this place not even a year and a half ago. The debt and the interest on it are chewing so quickly that if we do not get this problem under control it will destroy the national medicare program more than anything else.

Is there a mix of health care plans? I was really surprised as a westerner when I first came down here to discover that even though I in my teaching career had been paying for my Alberta health care forever people in Ontario do not even pay for their premiums. That sounded pretty strange to me. They do not in Manitoba either.

Mr. Harvard: Why should we?

Miss Grey: Why should we, he says. I guess if everything is self–financing and self–funding and the country is in great shape, sure, let us offer freebies.

We continue to pay for health care premiums and I do not think people mind that because they know the service they get is absolutely terrific. Some provinces charge health care premiums, others do not. That is the way it is.

(1545)

Some people have private insurance to supplement their basic coverage. That is the way it is. People who can afford to pay are perfectly entitled to do so. In my province, some can afford to get eye laser surgery at the Gimble clinic either in Calgary or the new one in Edmonton. Those people say: ''I want to pay for it. I will step out of the queue of those waiting for laser surgery, perhaps at the University of Alberta Hospital, and I will get it done at the Gimble clinic. I will pay my $1,200 and I will free up a spot in a public institution for somebody who is waiting in the line''. That is not reprehensible. That is the way it has been for a long time.

Somebody says: ''Yes, it is reprehensible''. What about people who live on welfare? Do we who have jobs say: ''Isn't it dreadful about all of those on welfare''. No, we are grateful to have a job and we will pay our taxes. We will make sure those who are needy in our society are able to collect welfare. Surely that is not reprehensible.

Would my friend over here quit her job right now as an MP and not pay taxes any more because she does not think her tax money should support welfare for the people who really need it?

Of course not. Well, she is thinking on that. Those of us who pay are blessed. We are able to pay our taxes and we want them to go to the more needy in our society. Why should we not do it with health care? It makes perfect sense to me.

The hon. member should not hog the line–up. She has her place in the queue. If she is in there and says that she gets health care because, or maybe she is demanding child care, who knows? She is making $60,000 a year. I would say let her pay her own babysitters. This is nothing different. If you are able to pay, pay and step aside for someone who may be a little more needy. Perhaps not so sanctimonious but maybe a little more needy.

We are under no illusion here. We have some serious problems with health care. Federal cash transfers in support of health care are projected to go down to zero in the next 10 to 15 years. This is from a government, a Liberal government. Medicare is having its 30th birthday. It is wheezing and gasping its last breath on its 30th birthday.

There are real problems. Funding? Sorry, the well has dried up. Under successive Liberal governments year after year we are deficit spent and we are really sorry but the well has run dry. The Liberals cannot go to the Canadian public and say: ''Sorry that is just the way it is'' yet pretend, give speeches, go on CBC and CTV News saying: ''We have all the money we need for it''. The minister said that today. I hope they show a clip of that on the national news tonight. There are a lot of people, a lot of taxpayers who know that is absolute fantasy.

It would make sense to prepare for that day. We know we have problems. Let us prepare for that day. Let us be ready for it rather than just saying: ''Do not touch it, do not do anything to it''. We are in bad shape financially and we need to make sure we move ahead and solve the problems instead of just complaining about them.

In my province of Alberta there have been huge cuts. I want to let the hon. members know that in 1970, 25 years ago, the whole budget for Alberta was $1 billion for everything, not just health care. In 1982, 12 years later, the entire budget was $12 billion. We had some boom years in our province. With the oil boom we went from a $1 billion budget to $12 billion in 12 years. That is a lot of money. Imagine what happened. Hospitals sprang up all over. We were spending two to three times per capita on each Albertan as many other provinces were doing. Many of these cutbacks may just be bringing us back to some of those levels.

Recently I underwent major surgery at the University of Alberta Hospital in Edmonton. My experience there—I can only talk for myself—is that for major surgery, for a hysterectomy, I waited my time in line. I did not want to go to the National Defence Centre and jump the queue. I said: ''I will go. I pay my health care. I pay premiums in Alberta. So I will take my turn and just go in with the regular run of the mill people''. I was asked: ''Do you want a room of your own?. It is $40 a night''. I thought: ''That is cheaper than the Relax Inn so sure I will book in for it''. Little did I know because I have never been sick and am grateful for that, my health care card, level three for which I pay the goose egg, absolutely nothing every month, covered my room. I was grateful for that.

The people in that hospital were professional. They were kind, looked after me and treated me really well. I am standing here, two months later, fully recovered and recuperated. Perhaps I am an example that the health system works. However, let us make sure that we do not let it get any sicker or in any worse shape than it is already.

(1550)

Health care is worth it in this country. Regardless of the fact that members say there are no tiers in it, let us shed some tears for the system and make sure we make it right.

Ms. Maria Minna (Beaches—Woodbine, Lib.): Mr. Speaker, I would first like to correct the first statement the hon. member made with respect to the two–tier system for MPs versus our staff.

The two tiers do not exist. Medically necessary physician or hospital services are the same. There is no difference. One gets the same hospital and the same doctor. The only difference is there is a TV in the room which one can decline. The hon. member chose the TV but she could have said no. The medical care is not different. There is no difference between the hospital one goes to, the doctor one gets, the services one receives or the nurses who serve us.

I heard today from the hon. member and other colleagues about core medical services and that core services should be identified. I am trying to understand what the difference is between core services and medically necessary services as defined in the Canada Health Act. What is the real difference between core and medically necessary? I think they are one and the same and that we are playing with words here.

I would like the Reform members to define for me what core services are and how it differs from what we now have in the act.

I am very proud to pay my taxes. I do not consider welfare to be charity. I consider welfare to be the right of needy people who have fallen on hard times.

Miss Grey: Needy people.

Ms. Minna: Absolutely. I am quite proud to pay my taxes to help those people. I do not consider it charity which is why I am not for workfare or any such thing. These people have a right to be assisted by the system and the government. They have paid taxes before and they have earned the assistance.

With respect to the Gimble clinic, laser surgery and stepping out of line, I do not want that system. Before we know it we will have a system where the people who can afford it will always be stepping out of line. The best specialists can charge more money because profit as a motive will always be working in the best clinics. Before we know it we will end up with a two–tier system

no matter how we look at it. I have seen it happen in other jurisdictions and it will happen here. It is not necessary.

The publicly administered health care system is the most cost effective system in the world. It saves money because the motive is not profit, it is to deliver the best possible system to the citizens of the province.

Those are my comments and some of my questions. I would really like to understand what core services are to the Reform Party as I have not quite understood that yet.

Miss Grey: Mr. Speaker, I appreciate the member's remarks. What part of this two–tier system does the member not understand? It just baffles me. I am usually not at a loss for words and my friend knows that. Anybody who has ever known me, and my family certainly knows, I am usually not stumped for something to say, but I can hardly believe it. I can hardly believe that someone would say we get the same hospital care and there is no difference in it.

Somebody who says that the Gimble Eye Clinic is only for people who can afford it should know they have been doing this for years. People go to abortion clinics. The minister talks regularly and incessantly about facility fees and that she will not allow them in Alberta. What about the people going to free-standing abortion clinics right across the country? Is that a facility fee? Sure it is. Somebody talked earlier today about Quebec psychoanalysts being de–insured now. This goes on and on.

Core services and medically necessary services are things that are absolutely essential. These could be life saving devices or a hysterectomy, if there is cancer, all those types of things. If someone wants to get a nose job, if it is necessary, is affecting one's breathing, let us let the medical profession determine this. However, if one just wants to go in and get plastic surgery, a nose job, a face lift or whatever other lift one might want, those are the kinds of things that the medical community is quite capable of deciding which is core and which is not core.

(1555)

Those procedures which are life saving are core. But it is not a government's responsibility to sit in the House of Commons and make those decisions. Let the medical profession do it.

There are very capable doctors on the government side as well as over here. Let them decide and then we will support that.

Mr. Reg Alcock (Winnipeg South, Lib.): Mr. Speaker, I was interested in the last few remarks made by the member opposite when she said: ''Let the doctors decide. Let the physicians decide. Let the people who are responsible for delivering the care decide''.

That is exactly what we do. That is exactly what the Canada Health Act does. Her proposal would put a bureaucrat in their place. There would be a schedule or a list decided by someone other than the physician, someone other than the person who is providing the care. That is one reason why we do not support the proposal that party brought forward today.

I want to step back a little bit and look at exactly what the Reform Party is saying today. The members sat down, thought this out and put it into their political planning that they would have this debate today. They stood up and put forward a motion which states:

> That this House recognize that since the inception of our national health care system the federal share of funding for health care in Canada has fallen from 50 per cent to 23 per cent and therefore the House urges the government to consult with the provinces and other stakeholders to determine core services to be completely funded by the federal and provincial governments and non–core services where private insurance and the benefactors of the services might play a supplementary role.

Some hon. members: Hear, hear.

Mr. Alcock: I am pleased that the members recognize that I can read.

I would like to balance what members opposite talked so strongly about, of putting greater control in the hands of the province, against a statement made not too long ago by another Reform member in the human resources committee. The statement made was: ''Well, I come from a have province. We contribute money to Confederation. Should we not be able to dictate the kinds of services those people in the poor provinces get?'' At the root of my feelings about this debate is what it says about us as a country.

We made a decision a long time ago that we were going to provide health care. We were going to see that every person no matter where they lived in the country, no matter what their income level, would be entitled to basic health care. We made that decision as a country. We have followed through on that promise.

Reform members talk so loudly about supporting the wishes of their constituents. There is no other service government delivers that the people value as much as their health care system.

The Reform Party reminds me of the old story about the doctor whose only answer to a query was: ''Take two aspirins and call me in the morning''. On every policy issue that is debated its members say one thing: ''We have a deficit. We do not have the money for it so we have to cut somewhere. We have to get out of it''. It strikes me that a party that has been around here for a while which has some intelligent, thoughtful people in it, could think a little harder about what they are really saying.

We spend between 4 and 4.5 per cent of the federal budget on health care. In doing so, we buy ourselves one of the finest health care systems in the world. This is the point of attack

Reformers have chosen to solve the deficit problem. It is not funny. It is tragic that they would attack a service that is so valuable to so many people who have so few options.

It is fine to talk about the wealthy individual who can walk into any place in the world and buy what he or she needs. However we also have to think about the person who cannot do that. It is something that has been a part of our values for all my working life, and hopefully will be for all my life.

(1600)

There is another aspect to this. I think we have to ask the Reform Party to be a little more intellectually honest. In the proposal put forward it talks about the fall from 50 per cent to 23 per cent. I suppose it is done to heighten the fears it might engender in people or to heighten the arguments that can be made about the role of the federal government and what the federal government has or has not done. However, that is simply not true. It is false information, which the party has put on the record in order to strengthen its debate.

The fact is that the first number refers to the federal government's share of spending on hospital and physician services, our contribution to medicare. The second number refers to the federal share of total health spending, things like non–prescription drugs, cough drops, et cetera. The Reform Party knows this, and its researchers should know this, and to bring it forward simply discredits the debate it wishes to have.

Reform members talk about creating a list of services, which presumably some bureaucrats in Ottawa would manage, having consulted with doctors, and they would tell us what medical services we could have and what medical services we could not have.

The Reform Party has been accused on occasion of looking south for its policy initiatives. I do not want to spend all of my time walking through that particular model, but I would like to note a couple of things.

I had a recent experience in the United States. I lived there for a few years. I met a man in Los Angeles, quite a wealthy man, who had a very serious cancer of the jaw. He received very good medical service. Following a technique that is available here in Canada, they replaced his jawbone with a piece of bone taken from his thigh. It was marvellous. It was truly a wonderful piece of work.

He walked out of that hospital and was told that was it, his insurance was now cancelled. Despite the fact that he is wealthy and despite the fact that he has the resources, he cannot at any price buy service. In the system the Reform Party promotes, he cannot buy service for the rest of his life.

I would like to give another example. This happened to my nephew, who lives in Los Angeles. He drove to another state on a vacation and he fell and cut the palm of his hand on a piece of glass. He cut a tendon, so it was a little more serious than just a cut in his hand. He was rushed to the local hospital and they looked at it and put a compress on it and said: ''Your insurance only covers this immediate service. To get the tendon repaired you have to go back to a health jurisdiction that your insurance respects''. He had to drive some 500 miles to get a fairly serious repair. He could have lost the function of his finger.

When we talk about letting the provinces decide and when we talk about letting individual hospitals decide, are we not talking about a system that says that a person may not be able to get service because the level of coverage in their province does not cover them for all of those things? Is that not exactly the kind of divisive force that the Reform Party promotes when it talks about the have provinces being able to dictate the level of services in the have not provinces? I reject that.

Frankly, in this country we have a very serious problem. We are seeing an increasing polarization between those who are well to do, who can take care of themselves and live a comfortable life, and those who are not so fortunate. We are fast building a community not unlike those we see around large cities in the U.S., walled cities, walled communities, which have a wall built around them to keep the bad folks out. We are building a society that is less inclusive, less caring, less Canadian than the one I believe in. The Reform Party needs to consider very carefully what it is promoting when it talks about the destruction of our health care system.

One of the discussions the Reform Party brought forward in its motion is the idea that we would have a matrix of services or a list of services. It is interesting that the provinces and the federal government do not want to impose a list of services. They do not want it because they want to do what the member for Beaver River said in her closing remarks: they want the decisions about care to be decided between the doctor and the person who needs the care. The federal government believes that. It is enshrined in the principles. The provinces also want that.

(1605)

The member who spoke just before the member for Beaver River made a comment about universality. It is odd to me that the Reform Party finds universality such a difficult concept to understand. All universality means is that everyone has access. If they do not want to have universality, as they have been stating, despite the agreement, who are they going to exclude? If they are not going to have universality, who then is outside of that universal range?

Mr. Williams: Nobody.

Mr. Alcock: They cannot have it both ways. They cannot say they are opposed to universality and they are not going to put

anybody outside. That is all universality means: that we are going to cover everybody, we are going to give everybody access to the services.

The leader of the Reform Party made a speech on medicare not too long ago. I would like to talk a bit about it. Perhaps the members can get ready to jump up and down, as they do.

There was a suggestion that we might want to ask the member for Beaver River to try to define where facelifts are free.

The leader of the Reform Party, in his speech not so long ago, said that the real long run threat to medicare is the financial threat caused by deficits, debts, and skyrocketing interest payments. Skyrocketing interest payments on the national debt eat up the federal government's ability to finance any and all social programs, including medicare.

Miss Grey: Hear, hear.

Mr. Alcock: Mr. Speaker, I thank the hon. member for Beaver River, once again, for giving me a standing ovation.

Take two aspirins and call me in the morning.

We have a problem so cut the deficit. That is their only solution. Do not look at what is happening within the services that are being provided, do not call upon the medical community to find more efficient and more effective ways to deliver services. Cut the deficit. Cut the funding.

The member for Beaver River called upon me to talk a bit about the Liberal approach to this. The leader of the Reform Party talks about cutting the deficit. In fact, total savings from our Liberal budget will be $29 billion over the next three years. This budget represents, by everyone's criteria, the strongest fiscal action taken by a government, certainly since the war years.

I was on a local radio show with a fellow by the name Peter Warren back home, who has been on the air for 25 years. I asked him if he had ever seen a tougher budget, and he said no.

This government is living up to its promises to be fiscally responsible, but it is being fiscally responsible in a morally responsible way. It is not throwing the weakest people out of the boat. It is not saying let those folks who can afford it go off on their own and do what they want and forget about the others. It is saying we are all in this together, we are all part of the same family, we are all part of the same country, and we will solve these problems.

One of the issues the Minister of Finance talked about over and over again was fairness, that we would do this, we would swallow the tough medicine, we would make the tough decisions, but we would do it fairly.

In the speech of the leader of the Reform Party he talked about how the Prime Minister's speech contained no workable framework or plan whatsoever for the reform of medicare.

(1610)

I do not know where the leader has been. He has not been in the House that much, but certainly has people who can read, who can talk about the council, who can look at the work the minister has been undertaking to work with the provinces, to work with people to find solutions for what are some very difficult, very complex issues that confront all of us.

The federal government is already engaged in discussions with all the key players. A number of provinces, the conference of the Ministers of Health, the federal–provincial advisory committees, bilateral meetings with health organizations, and consultations with Canadians through the National Forum on Health, ensure that all parties are informed and working together to ensure that Canadians have access to a responsive, effective, and affordable health system.

There is another aspect to this. If the member for Beaver River wants to talk about the cost, there is a very significant cost to poor health. There is a very significant cost to poor children. There is a very significant cost to unhealthy children.

The fact is that universal access means, yes, that my children get coverage, which I can afford to pay for, but it also means that those who cannot afford it get coverage. It means that we also care about their public health needs. It means that kids go to school stronger, more fit, more physically active and more ready to learn. It also means that people are able to pursue careers. It means that people are more able to be productive, working and contributing to society. Good health care is a foundation of a healthy community. To risk destroying that in the cavalier way the Reform Party does is irresponsible.

The Reform Party has been accused at times of speaking in code. I want to add a bit more code to the discussion. The leader of the Reform Party said: ''Reform therefore favours the decentralization, localization, and personalization of health care delivery'', and to amend the Canada Health Act to provide this kind of flexibility.

Is it not interesting that mere minutes ago, when I talked about the problem that my nephew had in a different state trying to access health care, the members opposite said: ''Oh no, we do not mean that''. Then what does decentralization mean? What does localization mean, except specific services in a specific area? What does that do if I do not come from that area, if they are not insured in my area?

Do we really build a system where certain Canadians have certain kinds of services and other Canadians have different kinds of services when it comes to our health? Is that really what we are promoting?

What does personalization mean? Does it mean user pay? Does it mean the ability of those who can pay will pay? Does that not just promote a greater fracturing of the community?

The Acting Speaker (Mr. Kilger): I have been somewhat generous with the time. I have taken into consideration the applauses and so on and so forth. I would ask the member for Winnipeg South to summarize in the next minute and a half.

Mr. Alcock: Mr. Speaker, I appreciate your alerting me to the time.

I would simply like to say that I want to thank the members opposite for bringing forward this resolution. I reject its intention absolutely and completely. I am saddened by the position that they have taken on so vital a service to this country. I do appreciate the opportunity they have provided me to stand up and say how strongly I and my party support health care and medicare in this country and reject the position taken by the party opposite.

[*Translation*]

Mr. Ghislain Lebel (Chambly, BQ): Mr. Speaker, I listened with great interest to the member's speech. His views are diametrically opposed to those of the Reform Party.

(1615)

However, some of the issues raised by the Reform Party are not totally erroneous. I do not agree with the hon. member when he says that the Reform Party's views are irresponsible. I do think that, unfortunately, our debt ratio will force us to make some hard choices, as is already the case with the UI program, for example.

We learned today that the number of welfare recipients in Quebec climbed to 808,000, with a more or less corresponding decrease in the number of UI beneficiaries. It is pretty easy to figure out that those are UI exhaustees who have now joined the welfare rolls. If the Liberals continue to close their eyes, as they have a tendency to do, instead of tackling the issue of the national debt, we will have to make even harder choices in the future. We will have to cut our social programs, including medicare.

This Liberal government set aside a tidy sum for things such as the purchase, by the Department of National Defence, of four secondhand submarines, which will of course have to be upgraded with state–of–the–art detection systems, the very best enemy detection systems. Given what is happening with the frigates that have to be refitted, we can expect this government to once again spend billions of dollars. If the government stopped spending uselessly, it might be able to delay cutting into social programs.

But this is not what the government does. Consequently, I do not agree with the hon. member's comments on the Reform Party vision. I am not a Reform member either, but I do think that our debt ratio is dangerously high. This is the real threat for our society and, without going as far as the Reform Party, I do believe that the provinces, which are closer to the taxpayers, are in the best position to assess their needs, and should therefore be the only ones to decide which medical services to provide.

The other day, in Quebec, we had—

The Acting Speaker (Mr. Kilger): Order, please. I hesitate to interrupt at any time, but particularly during the period of questions and comments. When I called the question and comment period, I noted that a number of members wanted to ask questions of or make comments to the member for Winnipeg South.

This is the period that permits an exchange of viewpoints between members from both sides of the House. In noting the number of members wishing to debate the hon. member for Winnipeg South, I would ask the hon. member to ask his question and conclude his remarks so that I may give the same opportunity to others who have indicated their desire to speak. I hope you will trust in my being as reasonable and fair all the time.

Mr. Lebel: Mr. Speaker, I understand very clearly and I will be quick. I would ask the member for Winnipeg South if the solution, which would not be entirely that of the Reform Party or, at the other extreme, the Liberal Party, if it could not be a joint one with respect to expenditure cuts, particularly in the area of defence, that might satisfy everyone?

The Acting Speaker (Mr. Kilger): I thank the hon. member for Chambly for his co–operation.

[*English*]

Mr. Alcock: Mr. Speaker, I thank the member for his question.

I absolutely agree with the member. All sorts of areas have to be looked at, evaluated and tough decisions have to be made. That is what we are doing. That is what the budget which was tabled here not so long ago was all about. That is why people in every constituency across the country are feeling the pinch. It is because we have made some of the toughest fiscal decisions made by a government, at least in the last quarter century.

The difference comes in this way. I was in a provincial legislature that supported health reform. We said that we have to get costs down in health care. We advocated very strongly and the health care professionals worked very hard to do exactly that.

(1620)

Procedures which used to cause a week or 10–day stay in the local hospital near me are now done in one night. Many are done on an out patient basis. All sorts of reorganizations have been undertaken in order to reduce costs, be more efficient, deliver better service, faster and cheaper. However, we have not made the reform of saying one person can have health care but another cannot. That is the difference in the Reform approach and what we are doing.

Change is a fact of life. There can always be change. There can always be improvement. We can always do things differently. But as Canadians we made a commitment that we would be in this together. That is the difference.

Mr. Lee Morrison (Swift Current—Maple Creek—Assiniboia, Ref.): Mr. Speaker, I wish the hon. member for Winnipeg South were the minister of fisheries because I have never seen so many red herrings dragged through this Chamber in the brief year and one–half I have been here.

Mr. Williams: Call them turbot.

Mr. Morrison: Yes, perhaps turbot. We were supposed to be debating the Reform Party's motion on the reform of the Canadian health care system. We heard a dissection of the American health care system which is totally irrelevant to the discussion being held here today.

We heard the hon. member saying that we must have good health, that good health is so valuable. Who is arguing? Let us get down to basics and talk about the motion instead of dragging in these straw men, setting them up and kicking them down.

I wish I had the hon. member's gift of eloquence but I thank heaven I do not have his gift of logic. He will not stick to the issue. He wants to know what local administration of health means. I can give him a good example.

I was born and raised near Swift Current, Saskatchewan in what was known when it was first formed 50 years ago as health region number one. It was the first medicare system in Canada. It was an experiment. My family helped to create it. They worked hard for it. It was a great success and do you know why? Because it was run by a bunch of country doctors and municipal reeves. It did not have a giant bureaucracy leaning over its shoulder telling people what should or should not be done. It was a wonderful system.

When the Canadian medicare system was finally set up some 20 years later the results of that experiment were ignored. It was thrown out the window. A massive federal bureaucracy was set up to oversee the medicare system we had worked so hard for. Our system was efficient, it was effective and by God it was cheap. Nobody went without medical care. If we did not have the specialists available in our rural area to do certain procedures, we sent them somewhere and we paid the bills. That is what local control means.

In this day of marvellous communications we do not have to go that small. However surely to heaven we can put it at the provincial level where politicians have to respond directly to the people who elected them, where the system is run by the people who are most directly concerned. That is what local control means. That is anathema to the Liberals because they are the great centralizers, the great controllers.

Mr. Alcock: Mr. Speaker, I will only take a minute to respond.

I would urge the member to get a copy of the Canada Health Act. There is nothing in the Canada Health Act that prevents local involvement, local control. We have medical regions in my province. The hospitals have boards. There are some restrictions. The Canada Health Act states that the provinces will pay for any service that is medically necessary. We cannot decide in a local region to de–insure somebody for a medically necessary service. We cannot make that decision because we as Canadians made a decision that everybody in all parts of the country would have access to medically necessary services.

(1625)

The member raises the spectre of a huge bureaucracy centralized in Ottawa that makes all these decisions. Does the member know how many people it takes to administer the Canada Health Act? Has the member ever bothered to check the size of this huge bureaucracy? There are 25 people who make the decisions about the Canada Health Act.

I have nothing against local control and local involvement. That is something we promote. We went around designing a series of health regions with elected boards and everything else. It was done in British Columbia and Manitoba. However, that is very different from saying that we will have a two–tier system where the rich get one kind of help and others do not, or that rich provinces will have a particular kind of health care system and poor provinces will not. We are all Canadians who want to see a country that includes and brings everybody into the Canadian family, not one that kicks a few out.

Mr. John Williams (St. Albert, Ref.): Mr. Speaker, I am glad to participate in the debate on the Reform's motion on health care today. I would like to try to put to rest some of the misconceptions and untruths by our friends on the other side of the House.

We have heard so much about the two–tier system. The two–tier system has already been created.

Someone who has money can get something fixed today. He can go south to the United States and get any medical treatment

he wants. It alleviates the necessity of the Canadian taxpayer to pay for it. It costs, but the person can have it right away.

The other is our Canadian health care system which will deliver non–emergency services sometime down the road in maybe a year or more. That is the health care system we have today. It is the one which is eroding and deteriorating significantly. It is being starved for cash by this government.

The government clings to its five universal principles that it cannot ensure and guarantee any more. That is the two–tier system which exists under this Liberal government and the two–tier system we are opposed to.

Now we are in a financial crunch. The system is broke and is falling apart. People are in desperate need of surgery and are having to wait a long time. One per cent of Canadians are waiting for elective surgery. This is not 1 per cent of those who are sick. According to the Fraser Institute, today 1 per cent of Canadians are waiting for the health care system to deliver and it cannot.

Those who have money can go across the line and spend money in another country. This is equivalent to importing which is detrimental to our economy. They can buy any service they want. Therefore, we have a two–tier system. It is not the one we would propose or that we even like. In fact it is the one we are totally opposed to.

However we are saying that there is a guaranteed need. The Reform Party is absolutely committed to ensuring that all Canadians have access to medical services and they should be able to have it now.

Someone may want more than the basic minimum and may want to pay for a longer hospital stay or a private nurse at their bedside. I say be my guest, at your cost.

(1630)

There are many ways that we can resolve the problem. However, before we talk about resolutions let us continue to look at the problem.

I have a letter from the Sturgeon Health Unit in my riding. It is dated September 9, 1994. It is a generic letter to its patients:

> Dear Home Care Client:
>
> As you may be aware, the increased demand for home care services has far exceeded the available resources. There is decreasing access to acute hospital care. Increasing numbers of people in the community need high levels of support to compensate for disabilities.
>
> In order to continue to provide essential, basic service to those in greatest need, we have asked home care co–ordinators to review their caseloads and reduce services where possible.
>
> We recognize that assistance with homemaking enables many clients to remain at home longer. Currently, however, homemaking will be limited to those people who would face an immediate move without the service. This means that families may have to provide more assistance or purchase the service. The Home Care Program recognizes the significant contribution family caregivers make to home care clients and regrets the increasing expectations placed on families. It is hoped that increased funding will soon follow the demand for community based care.
>
> Sincerely,
>
> Carol Sims, R.N.,BScN.
>
> Director, Home Care

The letter says there is decreasing access to acute hospital care. That is not Reform policy. That is not because of Reform Party actions. That was happening in 1994 and it is happening in 1995. It is happening in the country now under the government and it accuses us of proposing a two tier system. The letter says: ''In order to continue to provide essential, basic service to those in greatest need, we have asked home care co–ordinators to review their caseloads and reduce services where possible''. Only those in serious need will be looked after. The rest will be passed over to the families to look after because the government does not have any money.

This is not a letter from someone who is peripheral to health care. It is not a letter from someone being denied health care. It is a letter from the very heart of our health care operation where decisions are being made to deny health care services except to those most in need.

We have a two tier health care system today. We have it in the worst possible way. That is exactly why the Reform Party put forward this motion which says things must change. It is not because we simply want to change things; we recognize the health care industry is sick and needs to be revitalized. We are asking questions about how that should be done.

I said earlier the Liberal Party seems to be stuck with its head in the sand on the five principles: universal, affordable, comprehensive, publicly funded and publicly administered. The Liberal Party says that is it, the debate is finished and there will be no more discussion. In the meantime the government is cutting back the money it is prepared to put into the health care system by the billions. In the last budget the Minister of Finance cut it back again and said: ''Provinces, it is all yours. Remember that you must abide by our five principles that we refuse to let you off the hook on''.

In Alberta the Minister of Finance gave a severe warning. He said unless it stops these practices that do not meet the definition of the five basic principles, Alberta will be cut back on its funding.

(1635)

We all know that every province is providing these same types of services where doctors, hospitals and clinics are charging additional fees. For some reason Alberta was singled out as the big bad ogre and was told to toe the line or it would be cut back. The Minister of Health said nothing, not a word, about the other provinces.

Alberta is wrestling with reduced budgets and less money to resolve the problems. It is being innovative. It has reorganized its system. I will not say I think it has resolved every problem the best way it should but it is trying and it is doing its best to grapple with a system with less money to ensure the services are there for those who need it.

With respect to the two tier system in order to reduce the cost of health care, we must introduce that dreaded word competition. That is deemed the code word for the American style of health care but I say there is no competition in the United States. That is a closed shop. It may be privatized but it is a closed shop and there is no competition.

If we are to control the cost of health care we must introduce competition. Competition can show up in many different ways. Competition means that we have a choice. If we have a choice between A or B and we decide to always choose B, then A disappears through lack of funding.

We find our health care costs are 50 per cent higher than those in Europe. In the last few days they have made some references in the Liberal camp to the fact that we are trying to bring health care costs down because Europe has a wonderful system and it only consumes 5 per cent or 6 per cent of GDP, but we are up closer to 10 per cent of GDP. Why is that?

I was in the UK last summer. To give an anecdote, my sister who lives over there had surgery a year ago and had to attend the outpatient department in a large hospital. When I say a large hospital, I mean a large hospital. It serves .5 million people.

We had to be at the outpatient department at 11.10 a.m. and after we had been there my wife and my sister and I were to go shopping and so on. I thought: The day will be gone before we get out of the hospital; an appointment at 11.10, they will see us at 1 p.m and by the time we get out of the doctor's office it is 2 p.m and it is time to go home.

I could not believe it. My sister had seen the doctor and we were back out on the street at 11.30 a.m., 20 minutes after her appointment time. I was amazed. How did this happen? I investigated to find out.

Medicare is free there. What has changed since I had last seen medicare there is the UK has introduced a couple of things. One is internal markets and the other is called social charter.

The social charter basically says any government organization that deals with the public in a monopolistic environment has to publish minimum standards. These minimum standards are not enforced on them but they have to decide their own minimum standards and publish them.

In the outpatient department of this hospital the minimum standard that the hospital had published was to see its patients within 30 minutes of their appointment time. It sounds good to me. It went a little further. It said that if the hospital cannot see the patient within 30 minutes, fill out this card, pop it in the mail and the hospital will not get paid for providing the service.

(1640)

All of a sudden we have accountability. Right there we have accountability. If it cannot meet its minimum service standards it does not get paid. Now it has a challenge to provide service. Two out of five principles, publicly funded and publicly administered, which the Liberal government has, totally and absolutely fall down.

Until one provides competition there will never be service. That is why we have to wait a year or more for surgery. Competition ensures it looks after its patients. That is the type of thing we are trying to start a debate about in this country, that provided accessibility.

I talked about the concept of internal markets. Every hospital is required to get on to a true and proper cost accounting basis, just like business. That is all; we are not asking them to do something impossible. We are asking them to do their accounting by the same rules as business. Then when the regional health units have a budget to look after their clients, they have to spend money. Let us take something quite expensive such as bypass surgery.

They will choose the hospital that meets and exceeds standards, that can provide the service and also does it for a lower fee. Now we have hospitals competing on price. That ensures that each hospital keeps its costs down. That is how we introduce cost savings and bring health back into the medicare system.

Health care in the UK to the consumer is still free but the UK has introduced internal markets, social charters and it has competition. The health care system in the UK is costing a half to two–thirds of what it does in this country.

The Liberals cling to the idea that only publicly administered and publicly funded hospitalization and medicare is the way to go as we watch it crumble before our eyes. The UK was the pioneer of socialized medicine. Fifteen or twenty years ago it was in the turmoil we are in today as far as trying to afford health care services. It introduced these new ideas and has been able to improve the service, improve the quality and ensure competition. By allowing competition it has also allowed private funding to come into health care.

When I say private money, is that such a dirty word? We all say we cannot have profit in medicare. I defy anyone to find anybody in the health care industry to say they will continue to do what they are doing for nothing.

Everybody is in for the paycheque, the profit they make on the sale of the equipment, on the hospital they build, and so on. That is why the other thing we have to introduce is a real and true market. Market makes the right decisions.

We have seen it time and again. My riding is a perfect example. Health care built a brand new hospital four or five years ago at a capital cost of $50 million. It sat empty for a couple of years before the operating money could be found to open the doors. Now it has been downgraded from a hospital to a health care unit. This is in the city of St. Albert. All these were political decisions. They were not market decisions. We have wasted millions and millions of dollars on these kinds of decisions.

(1645)

Access to health care is not available today, even though universality is talked about. The definition of universality does not mean access because people are waiting up to a year and sometimes longer for elective surgery.

Affordable? Yes, we want to ensure that all Canadians in any part of the country have access to health care. That can be basic health care. There can be a deductible charge of 5 per cent or $5 or $10 to make people think because as soon as it is free, there is abuse.

Yes, we want to ensure that health care is available for all. However, we totally disagree that publicly funded, publicly administered, non–competitive, political decisions by bureaucrats, politicians and committees are the only way to run a health care system.

There are all kinds of situations in the private sector. From the food we grow to the vehicles we drive and the buildings we live in are all provided at standard or above standard by the private sector. It is done on a competitive basis. It ensures the highest quality and a variety of choices for the consumer.

In conclusion, I strongly endorse the Reform Party proposal. I would like to see a national debate on health care. I would strongly ask my Liberal colleagues to re–examine, and I have to say it again, their heads in the sand approach to publicly funded, publicly administered health care that has proven it does not work.

The Acting Speaker (Mr. Kilger): We will go to questions and comments. I would ask you to keep your questions and comments brief so that I might recognize as many members as possible.

Mr. Dan McTeague (Ontario, Lib.): Mr. Speaker, I am pleased to have the opportunity to question my learned colleague from St. Albert.

Where are these great waiting lists the member talked about? Who are the thousands of people who have gone to the United States in search of services? I have one of the largest ridings in the country. I do not have these large numbers telling me about this. On the contrary, I hear a lot of people complaining about the provincial government and the way it administers services.

It is interesting that the hon. member used the Fraser Institute to support some of his information. Really, that is the *Pravda* of the political right in this country.

While I agree with some of the comments the hon. member made with respect to the home care issue, I would hope he would take the time to read the Canada Health Act. Under the Canada Health Act our requirement is only to deal with hospital services and MD services. If we want to talk about the home care issue, we have to go beyond the act. Therefore, he is really speaking out of context.

All the provinces, including Alberta where the member comes from, support the five principles. It is interesting that the comment has been made that the province is not in agreement and in particular that the member is not in agreement with the five principles. Could he tell us which part of the five principles he or the Reform Party is prepared to abandon? I presume he is speaking on behalf of the Reform Party since he is a member of that party.

I also want to point out to the hon. member that when we compare ourselves to the United States where competition and market forces exist, 39 million people in the U.S. have absolutely no protection and are in no position to get sick. Another 39 million in that same jurisdiction where this great aura of competition exists are also underinsured.

Does the position the member has taken here today really deal with whether or not members of his party are prepared to understand the full implication of what they are lamenting here today? Before the hon. member answers that question, there are some other examples which I think have to be taken into account.

(1650)

Dental services are not covered in Canada. Most people will not go to a dentist to get necessary treatment because they are concerned about the possible costs being assigned to them.

Mr. Grubel: How do you know that?

Mr. McTeague: I know that for a fact because my wife is a dentist. That is the evidence I am prepared to support because I am speaking from truth, unlike my hon. colleague's friends over there.

My concern is with the hon. member. I would like—

The Acting Speaker (Mr. Kilger): Order. I hope I am not overreacting. I know members feel very strongly about each and every issue we debate. I think there would be unanimous agreement in the House that the issue being debated today is of critical interest to all Canadians and all parliamentarians here in the House, particularly those taking part in this debate.

As to the matter of truth and who has the best ownership of truth, there is certainly no sole ownership and I will leave it to all of us to debate. I would ask members to be very judicious in their selection of words. Would the hon. member for Ontario please conclude and ask his question to the hon. member.

Mr. McTeague: Mr. Speaker, I take that under advisement. Can the hon. member tell me what he really means when he talks about competition and its full implications on Canadians given that we have a universal, acceptable system that is working for the benefit of all Canadians?

Mr. Williams: Mr. Speaker, I will answer the question of what I mean by competition.

I gave the United Kingdom example, not the United States example, where the cost to the consumer is absolutely free. Yet even the United Kingdom has developed internal markets where hospitals can compete against each other in delivering price, service and quality. These are the three fundamental elements of service one finds when there is competition. If we eliminate competition, we find waste, mismanagement, poor service and declining quality. These are the things we have in our health care system today because of lack of competition.

I said nothing about the American situation except that I did not even consider it to be a competitive market. I used the United Kingdom as an example. It is the cradle of social health care systems in our western world.

The hon. member's first question was on which of the five principles we would abandon. We would abandon the 100 per cent publicly funded principle. We would still ensure that health care was largely funded by the taxpayer, but we are not saying there should be an ironclad guarantee that it has to be 100 per cent. I believe publicly administered elimination of competition is totally detrimental to our system.

Mr. John Harvard (Winnipeg St. James, Lib.): Mr. Speaker, I think the member for St. Albert really does not get it especially when he advocates competition among insurers. The evidence is absolutely overwhelming that when there is a single public insurer as we have in this country, that is by far the most efficient and cost effective system. The one way we can control costs is when we have one public single insurer.

I was watching an American doctor on CBC television last night. Perhaps the member also saw him. His name was Dr. Katz. He spoke about the American system with competition among insurers which the hon. member champions. He said that the doctors and insurers cherry pick. They are not interested in you if you do not have money and are not wealthy. Can you imagine a system in this country where there was competition among insurers? Does the gentleman from St. Albert really think if he had a long history of heart trouble, the competitive system would be interested in him? Of course not.

The system with competition among insurers is only interested in the healthy and the young. You talk about privatizing the system. That is what you are talking about.

The Acting Speaker (Mr. Kilger): Order. I would like to remind members to direct their interventions through the Chair.

Mr. Harvard: Mr. Speaker, I want to make one more point. When we privatize the system there is no trouble in taking costs off the public books. We could transfer $1 billion or $2 billion, perhaps even more from the public books, that is medicare, over to the private sector. When those costs show up in the private sector, because of wasteful competition the cost will not then be $1 billion or $2 billion, it will be $3 billion or $4 billion.

(1655)

The hon. member is dealing in illusion, is that not true? That is my question.

Mr. Williams: Mr. Speaker, if the hon. member for Winnipeg St. James does not understand how competition works, then I would propose that he is the one who is under complete and absolute illusion.

I will refer to the point made earlier by the member for Beaver River in talking about health care and will use the point of the member for Winnipeg St. James who is a government member. Why are members of Parliament entitled to a benefit under the public service health care plan that costs us absolutely nothing yet all other members of the plan, be they civil servants, have to pay $10.35 a month as family members? That is the first of this two–tier system which is creeping in.

Not only that, the member for Ontario has told us that dental services are not covered under health care. Why not? Why would people not want to have dental plans if they want to have their health plans? Because the country cannot afford it. We must realize that there will be abuse of the system unless there is a fee for use, however small.

I will finish on the last point the hon. member made. The member for Winnipeg St. James may think that one single insurer, be it the government, is the most efficient way to run a program. I am sorry but I think he does not understand the first simple fact about economics which realizes that competition gives the best quality and the best service at the lowest price. That is the point.

Mr. Ronald J. Duhamel (Parliamentary Secretary to President of the Treasury Board, Lib.): Mr. Speaker, it seems to me there is a certain amount of confusion in the member's mind and I do not say that unkindly.

Would the member take the time to rapidly identify the expectations from the federal and provincial governments in the

ideal health care system he described? Many of his expectations in his comments do not belong to the federal government, constitutionally speaking.

Just to give a very quick example about the confusion, in the Canada Health Act there is no prohibition on profit. There is a section where it is not possible to have a health care system that makes a profit. It must be operated on a non–profit basis.

My colleague seems to confuse the two in the Canada Health Act on that particular feature. I get the impression that my colleague is looking for a Pizza Pizza health care system. That is what it sounds like to me. Would he care to comment?

Mr. Williams: Mr. Speaker, my comments were made in all seriousness and had nothing to do with pizza whatsoever. I was merely trying to make a point that competition provides the best service and the best product at the least price.

As I said, in the United Kingdom, not the United States, the cradle of social health care has introduced internal markets where one health care institution competes against another. In that way they are seeing the price come down, the service go up and the quality remain high. At the same time the taxpayer is getting a better deal and a better return on his investment. That is in the United Kingdom. It has nothing to do with the United States. It is still absolutely free to the consumer.

My point is there are many options. The hon. member asked me how I would see the ideal system. The federal government is retreating from funding of health care from 50 per cent down to 23 per cent and falling rapidly. Surely it should recognize that its insignificant contribution it is now making will force the hands of the provinces to go their own way. Therefore because it is a provincial responsibility under the Constitution I feel they should be making up their minds on how it should be done.

(1700)

[*Translation*]

The Acting Speaker (Mr. Kilger): It is my duty, pursuant to Standing Order 38, to inform the House that the question to be raised tonight at the time of adjournment is as follows: the hon. member for Notre–Dame–de–Grâce—Access to Information Act.

[*English*]

Mrs. Dianne Brushett (Cumberland—Colchester, Lib.): Mr. Speaker, I will share my time with the hon. member for Winnipeg North.

It is a great pleasure for me to participate in the debate on health care today. There are few issues which we speak of here which touch as many Canadians as health care. It is a central issue to the people of my riding, as it is to all Canadians. They appreciate the security which our health care system gives them and they firmly believe that commitment must be continued.

As we are in a time when there are questions about the commitment, some in the House favour steps which I believe would move us down the road to a two tier system, one for those with money, another for those without. Some in the House favour the balkanization of health care with a withdrawal of federal government from any real role in the health care field. How much support is there really for either of these perspectives? From what I hear from my constituents, not very much. They support the leadership which the federal government has taken on health care issues.

Leadership does not mean rigid centralization. In my remarks today I want to emphasize the flexible nature of federal co–operation in health care. More specifically, I want to talk about the Canada Health Act. This law is not a straight–jacket on the provinces; not now, nor has it been, nor will it be in the future.

The Canada Health Act is a very short piece of legislation. At its heart are five principles grounded in common values which we hold as Canadians, values very close to the hearts of every Canadian. They represent the essential ground rules that most Canadians expect the provincial and territorial governments to respect when it comes to guiding principles of the Canada Health Act. Let me talk about each one of them and the reasons for which every one still matters to the federal government and to every single Canadian.

The first principle is universality. Quite simply, the federal government provides financial support to provincial health insurance plans, plans that cover all citizens. People cannot lose their health insurance because they might be too costly for the system to cover or because they may be unemployed or because their health may be a high risk.

The second principle is accessibility. This means we should not face any financial barriers in receiving necessary health care: no extra billing, no user fees, no facility fees. If the service is medically necessary it will be delivered on the basis of medical considerations, not financial considerations.

The third principle is comprehensiveness. It recognizes Canadians have a range of health care needs and that those needs should be met. The Canada Health Act requires that all medically necessary services be covered.

The fourth principle is portability. This means Canadians should maintain their health coverage when they travel.

The fifth principle is public administration. Our health insurance plans must be operated by a public authority accountable to provincial governments and operated on a non–profit basis.

At various times since the act was passed in 1984 there have been issues that have brought these principles into focus. Between 1984 and 1987 extra billing and user charge penalties were levied against several provinces.

(1705)

More recently, extra billing has occurred in British Columbia and we have acted by making deductions to the transfer payments. We now see other questions emerging, for example, as the Government of Alberta pushes its agenda of private, for profit health care.

These principles do not extend to dictating how provinces should run their system or what they should cover. Since the beginning of federal support for health care in 1957, decisions regarding what is a medically necessary service have been up to each of the provinces to determine. After all, they manage the system. They have the constitutional authority. They work with the appropriate medical experts and also pay a substantial portion of the cost. It is not for Ottawa to say this procedure or that procedure must or should be covered.

It is better to leave the responsibility of determining medical necessity to the provinces and to physicians who deliver services and are aware of the circumstances under which they are delivered.

The Canada Health Act also leaves much to the discretion of provinces; ensuring the services of health care professionals other than physicians, charging for semi–private or private room accommodations requiring prior consent for elective health services provided out of province, and financing for a variety of methods not including those that require point of service charges.

Remember, the Canada Health Act does not force a province to comply to its requirements. The provinces can accept the cash penalties and allow the non–compliant situation to persist.

These facts alone show that any claims of rigid centralization are simply not founded. That will continue to be the case as we renew the health system.

The federal government and the provinces recognize the health system has to change. Provincial authorities are trying many different ideas in their efforts at renewal. They will continue to experiment but as long as they adhere to the five principles of the Canada Health Act it is unlikely there will be any disputes.

Not one of the principles in the Canada Health Act prevents us from looking at innovative solutions to health care issues. They simply define the limits of the system in a way that Canadians who rely on the system want it to continue. It is not a free for all. Canadians believe some limits are necessary and useful to preserve our accessible and comprehensive health care system which is available to all Canadians.

The federal government is equally committed to finding better ways to achieve our health goals. The most high profile element in that approach is the National Forum on Health. This was a red book commitment and it is a commitment that we have met.

The forum was created to help us adapt our health care system to the new social and economic realities of today. It will create a vision for health in the 21st century. It is made up of 24 Canadians, health care professionals, volunteers and health care consumers from across the country. It is chaired by our Prime Minister, with the Minister of Health acting as vice–chair.

Canadians understand these issues, as does the forum. They want to spark a frank and open dialogue with each citizen about the challenges that will influence the kind of health care we will receive in the future.

There is the impact of technology, the impact of new drugs, of aging and emerging possibilities thanks to research and great technological innovations. Our challenge is to deal with them in a thorough, comprehensive and sensitive way.

We anticipate an open process of consultation that reflects the attachment Canadians feel toward health issues and the commitment to finding real solutions. The government believes the National Forum on Health represents an excellent opportunity to address the future of health of all Canadians in a comprehensive and open way.

The forum is not going back to square one. It is working within the principles of the Canada Health Act quite simply because those are fundamental values that every Canadian has asked the government to respect, to maintain and to deliver on.

(1710)

I want to end my remarks by saying that despite the ill informed critics, the Canada Health Act is still a valuable piece of legislation, one that enjoys the greatest support of the public. It is probably the greatest factor that binds Canadians together today. It is the underpinning of a system based on universal access to high quality, efficiently run health care. It is not a monument and our task is to find new and efficient ways to achieve better health goals for all Canadians.

As we undertake this process the federal government will continue to be an important source of the funding that keeps the system going. It will continue to be a staunch defender of the Canada Health Act. It will still work with medical practitioners and professionals, but we will protect the system.

The federal government intends to play the national role in health care that Canadians have asked us to do and that Canadians expect we will do. The Canada Health Act will be an important and flexible part in the role of health care in the future.

Mr. Rey D. Pagtakhan (Winnipeg North, Lib.): Mr. Speaker, I am pleased to address this motion put before us by the hon. leader of the Reform Party:

> That this House recognize that since the inception of our national health care system the federal share of funding for health care in Canada has fallen from 50 per cent to 23 per cent and therefore the House urges the government to consult with the provinces and other stakeholders to determine core services to be completely funded by the federal and provincial governments and non–core services where private insurance and the benefactors of the services might play a supplementary role.

I hasten to say that by laying out his party's true agenda for health care in Canada, the leader of the Reform Party has dispelled any doubt that his party stands against medicare as we know it today with its five principles of universality, accessibility, comprehensiveness, portability and public non–profit administration.

So many times in the House we have heard members opposite insist they support medicare. What we have in this motion is the Reform Party's advocacy for a multi–tier health system, one standard for the rich and one standard for the poor.

His motion proposes governments get together with stakeholders to determine core services and non–core services. The member further proposes that only core services be completely funded by governments, while non–core services be left to patients who, in the Reform Party vision, should pay out of pocket for supplementary health insurance.

The Acting Speaker (Mr. Kilger): I wonder if I could draw the attention of the colleagues nearest the member for Winnipeg North. A microphone very close by is also open and we sometimes have some difficulty hearing interventions. I ask for your co–operation.

Mr. Pagtakhan: This kind of approach by the Reform Party of cost cutting simply will not work.

I call the attention of the member opposite to a recently published book entitled *Public Finance in Canada*. It states that increased cost sharing in government medicare plans, where the policyholders can afford them, have great potential for reducing health care spending. However, it adds for such plans to be effective governments will have to ban the development of supplementary health insurance that will turn the patient's share of cost into a third party payment.

Simply put, increased cost sharing will have to be made mandatory and applied to all insurance plans, public and private, which would require increased government regulation of the health insurance industry.

I am perplexed that the Reform Party with its penchant for less government involvement is now calling for the very opposite. Is this a deliberate change of policy or a lack of understanding of the dynamics of health care financing in Canada?

(1715)

The Reform Party is proposing a return to user fees. One very noted Canadian health care economist said that this is like a zombie, not to be resurrected again. User fees deter necessary care just as much as frivolous care. Reformers are showing signs that they have not even read the literature.

I am proud to be a member of the Liberal Party of Canada, which in 1919 conceived the idea for a national medicare plan. It is a party that in government gave birth to its reality. It is a party that when in government again nurtured and restrengthened the national health policy with the passage of the Canada Health Act of 1984. It is the legal centrepiece of our medical system as we know it today and a system that bans user fees and insists on equal access for all citizens regardless of their financial means.

The proposal by the Reform Party might not pose a problem for those with six or seven figure incomes but for me, for my Winnipeg North constituents and for the vast majority of Canadians it is utterly unacceptable. Inevitably we would be left with a system in which only the financially fit would survive. That sort of social Darwinism is anathema to the government.

The government is not looking to make Reform Party style compromises where the health of Canadians is at stake. Yes, this government has acknowledged the need to contain health care costs, which in 1991 were roughly equal to 10 per cent of the gross domestic product.

The difference between the government approach and the policies embraced by the party opposite is that the government is not prepared to surrender the principles of medicare to fiscal constraints but instead is working to balance fiscal responsibility and the preservation of medicare.

The solution is not easy. The government believes in a more imaginative approach than simply wielding a broad scalpel and cutting away indiscriminately at medicare as the Reform Party proposal would do.

Utilizing alternative modalities to achieve desired health outcomes and substituting equally effective lower cost treatment approaches for the traditional are parts of a strategic approach to meaningful reform of the health care system.

For example, more patients could be managed at home on an outpatient basis rather than in hospital. Patients could be encouraged to see their family physicians before consulting specialists. Medications could be used instead of surgery where possible. Other health care professionals could substitute for medical doctors in defined areas of treatment. Some of these approaches may require legislation to ensure that health care professional substitution does not compromise standards.

Another means of controlling expenditures without compromising quality of care involves eliminating costly waste in our system. Just as certain established medical routines, such as annual physicals and routine chest radiographs of tuberculosis patients on follow up have been discredited as effective and efficient health policies, other diagnostic and therapeutic routines should be scrutinized. There could be a greater reliance on physiotherapy and less on orthopaedic surgery.

Physicians should not hesitate to debate the issue of human resources supply in relation to the per capita needs of the community nor the issue of arranging funding so that moneys will be allocated according to patient needs and not the provider's level of activity.

All of these elements and many more constitute an effective health care reform strategy which would ultimately yield greater dividends for all Canadians in contrast to the quick fix, multi–tiered system the Reform Party proposes.

The government has positioned itself as a staunch defender of medicare as we know it but that does not mean it is committed to the status quo. It means that the government will continue to explore creative and cost effective options for maintaining health care for all Canadians in accordance with the five principles of medicare.

That is why the government has launched the National Forum on Health chaired by the Prime Minister. That is why the Canada health and social transfer program is now being negotiated between the provinces and the federal government, giving provinces the flexibility to deliver the health care system but, at the same time, maintaining the five principles of medicare. Then and only then can we ensure the crown jewel of our social programs survives and is strengthened. We can also ensure the quality of health care for all Canadians, rich or poor.

In conclusion, I appeal to the Reform Party to withdraw its motion rather than face the certain defeat it merits from the majority of the House, who have been sent here by the vast majority of Canadians to be their voice and their guardians and to defend, preserve and strengthen medicare.

(1720)

Mr. John Williams (St. Albert, Ref.): Mr. Speaker, I was quite eager to note the emphasis the member for Winnipeg South put on one of the principles of their pillars of health care, accessibility. If I may read again from the letter from the director of home care at the Sturgeon Health Unit, Carol Simms: ''There is decreasing access to acute hospital care''.

I would like to ask the member for Winnipeg South if this is the type of access he wishes to guarantee where people who have need of access to an acute care hospital cannot get it under this system? Is that the type of access he wishes to guarantee for Canadians?

Mr. Pagtakhan: Mr. Speaker, of course that is not the access I would like to see happen. We recognize the problem and it must be solved. But their treatment for the problem is wrong. That is the difference between the Reform Party and the Liberal Party.

We must explore the means to solve the problem, not propose a solution that will create another problem where the ultimate result is even an greater lack of accessibility to the health care system.

Mr. Alex Shepherd (Durham, Lib.): Mr. Speaker, I was interested in the comments from the last exchange. The hon. member for St. Albert mentioned his concern about home care in his riding.

I read an interesting article the other day. It said that the evolution of the medical practice involves more home care. Patients are better taken care of in their home environments and to some extent actually display better recovery rates. I wonder if what he is looking at is not a problem but a possible positive solution to some of the problems in health care.

Mr. Pagtakhan: Mr. Speaker, I thank the hon. member for his comment and question. Before I entered Parliament in 1988, I presented a paper in Australia at the International Congress on Cystic Fibrosis. My paper was about home care treatment of patients with cystic fibrosis, giving them intravenous antibiotics at home. It can be done. We were able to decrease the health care cost sixfold. At the same time, even more important, we were able to enhance the quality of care for these patients.

I congratulate the hon. member on his insight as to the importance of home care. We must provide the resources for home care and not misplace our focus on a wrong approach as the Reform Party is trying to propose.

Mr. Herb Grubel (Capilano—Howe Sound, Ref.): Mr. Speaker, as a professional economist before coming to Ottawa I had taken some interest in the economics of health care. In 1992, I published two editorials on the subject in the *Medical Post*.

Today I would like to share the most important insights about the problem of health care I have gained from these studies and suggest some policy initiatives based on them. These ideas are my own and not necessarily those of the Reform Party.

I believe the public provision of health care through the present Canadian system is bedevilled by a fundamental problem which is due to the absence of a deductible and of co–insurance. This problem is amenable to relatively easy solutions once political and ideological rhetoric is put aside.

Of course, the system has other problems. There are no patent solutions. Some of these problems involve fundamental issues of technology, incentives, values, ethics and morality. I will not discuss these today.

(1725)

I would like to remind everyone that the Canada Health Act has created a gigantic system of insurance. Every Canadian contributes premiums through general taxes. Benefits are provided to anyone without the need to pay financial deductibles and co–insurance. As everyone knows, our system has produced a wonderful world in which every taxpaying Canadian is eligible to receive free of any charge general medical care, specialized services and hospitalization. Congratulations Canada.

In my view, one of the most important reasons for the financial problems which undoubtedly now are haunting our system stem from the absence of deductibles and co–insurance. I have reached this conclusion because the absence of restraint on demand stemming from this completely costless service has resulted in very large increases in demand. This is not a universally accepted proposition. Therefore, I would like to illustrate its validity by making reference to two historic experiments of public insurance systems that failed because of the absence of deductibles and co–insurance.

The first involves the government automobile insurance monopoly introduced by the NDP government in British Columbia in 1972. It started with great fanfare, having no deductibles at all on any repairs on cars, on the grounds that even small scratches and dents on cars ultimately lead to more serious problems. Therefore, it was argued it was wise to encourage repairs of such damage at no cost since some shortsighted owners might be discouraged from having the work done by a deductible of $50 or $100 or whatever it might be. The rest is history. The policy was cancelled by that same caring, foresighted NDP government because it was simply too costly.

The second experiment involved the British government, which in the early days of the public health scheme argued that no one in Britain should suffer because he or she did not have the money to pay for medication. I have heard the same arguments here about access to health care. I wonder why the rhetoric from members of the Liberal Party has not also extended to medication. After all, some people are suffering because they do not get all the medication they want just like that. They may have to spend some money.

The universally free dispensing of medication was ended after only a short time. Costs had become much higher than had been anticipated by a study of demand, a study which had been conducted under conditions when people paid for their medication. Studies have shown that if the cost is free it is easier to go back to the pharmacy to get medication rather than look for it in the medicine cabinet. People ended up with huge stocks of medication which were finally flushed down the toilet at an extremely high cost to society.

These two examples are instructive for Canadian medicare. The policy of having no deductibles or co–insurance in Canadian health care was motivated by the noblest of intentions, just like they were in the case of automobile insurance and free medication in England.

We need to take care of the needs of the most poor in society and we must prevent serious problems which might develop if small ones are neglected. The two experiments were terminated because of the universal law of demand. The price was too low and demand became too high. I believe that what we are seeing after 20 years of operation in Canada is exactly the same situation. That is one of the main reasons why the Canadian health care system is in such financial trouble.

There is a fairly straightforward solution: introduce user fees. However, there is a strong resistance in Canada to the use of this instrument.

(1730)

We heard them just a few minutes ago. The arguments are the traditional ones: care about access for those who cannot afford it, and those who, even if they can afford it, are stupid enough to let illnesses go and the consequences will be more costly than if they had taken care quickly of the illness symptoms at the beginning.

Some even argue, somewhat more sophisticatedly, that the inconvenience of visits to physicians and the risk associated with all medical procedures represent a strong deductible and co–insurance. Others argue that the deterrent effect of such measures is small and not very cost effective. This is the position taken by my colleague at the university of British Columbia, Bob Evans, a professor of health economics, one of the most highly respected and best known economists in Canada. I disagree with him.

The arguments against deductibles and co–insurance involve empirical judgment on the way in which these incentives are introduced. I would now like to propose and outline briefly a scheme for the introduction of co–insurance and deductibles, which I have published in the *Medical Post*. It can be summarized quickly as follows.

Every doctor visit or treatment by a Canadian elicits a government notification of the cost involved. One gets a little postcard saying that your visit on such and such a day cost society and you $30. At the end of every tax year, the value of the medical services consumed is added as income when we file our income tax.

Think about what this would do. The poor would have access. Universality of access would be preserved. In the end, the poor would not pay anything. One of the most cherished, basic,

fundamental characteristics of our system would be preserved, one I think is worth preserving. Of course, the better off who have income tax to pay would as a result pay a share of the cost they have incurred on society.

Now I must state something that immediately comes up whenever I discuss this in a public forum. Of course there would have to be a ceiling to the amount of money that individuals would have to add to their income tax as income and on which they pay taxes. I do not even want to venture what it is, but maybe nobody would have to pay more than 5 per cent or 10 per cent of their income.

One of the most important things that every health care system must present is protection against the catastrophic consequences of serious illnesses. That could be preserved and will be preserved by the proposal I have just outlined.

One of the biggest problems I have is with the idea that these incentives of people paying their own money, in a way, having a deductible and co–insurance, would not work. Just recently I received some information about experimentations that are going on in the rest of the world. I would like to share these ideas with members.

I found the following. Most health economists agree that the primary reason why health care costs are rising is that the money we are spending in the medical marketplace is usually someone else's. More than a decade ago, the Rand corporation discovered that when people are spending their own money on health care, they spend 30 per cent less, with no adverse effect on their health.

Now it turns out that in the United States some employers are experimenting in putting this principle to work. Please do not be turned off by the idea that I have just mentioned that this is taking place in the United States.

Let me set the stage. Here are companies whose names I will read off that have for their employees systems of health care that are superior to that available to every Canadian. They have health insurance from the first dollar. They have catastrophe insurance. They are employed. They are very well taken care of.

(1735)

Here is the experiment: *Forbes* magazine pays each employee $2 for every $1 medical claim they do not incur up to a maximum of $1,000 a year. For every time they look at what it costs to go to the doctor and they decide not to go during the year, they can earn as much as $1,000 extra income. *Forbes'* health costs fell 17 per cent in 1992 and 12 per cent in 1993.

Another example: Dominion Resources, a utility holding company, deposits $1,620 a year into a bank account for the 80 per cent of employees who choose a $3,000 deductible rather than a lower one. The result is the company has experienced no premium increase since 1989, while employers face annual increases of 13 per cent.

Another example: Golden Rule Insurance Company deposits $2,000 a year into a medical savings account for employees who choose a $3,000 family deductible fee. The result is in 1993, the first year of the plan, health costs were 40 per cent lower than they would otherwise have been.

Take the United Mine Workers, a union that is very concerned about the welfare of its members. Last year they had a health plan with first dollar coverage for most medical services. This year they accepted a plan with a $1,000 deductible. In return, each employee receives a $1,000 bonus at the beginning of the year and employees get to keep whatever they do not spend. As a result, the mine workers still have first dollar coverage plus all the catastrophe insurance coverage and all that, but now the first $1,000 they spend will be their own money rather than their employer's money.

These plans are popular with employees. They can save money in an amount directly related to their own effort. They are not deterred from seeking medical care by the traditional out of pocket deductible. They can usually use their medical savings to buy services not covered by traditional services, and they are usually not restricted to certain doctors, as they would be under a managed care plan.

We have here very strong evidence that deductible co–insurance works. It works in ways that satisfy the people who are involved.

Let me try in my own words to explain what are the fundamental benefits. These experiments have permitted individual employees to feel clearly and voluntarily that under a wide range of conditions they would have gone to the doctor if it cost them nothing, but when faced with the true cost of the doctor visit they preferred having the money instead.

It is important to note that under these medisave schemes that I have just described individuals retain the benefit of full protection against the consequences of serious illness. They are making these choices with their own money. We have just deleted the distortion the zero deductible and co–insurance system has introduced into the incentives of the individual. They are being misled by the system into believing that for them and society the cost of going to the doctor is zero. It is not.

As we can see, individuals like it if they are given the choice, the freedom to do so. They prefer it. And the system itself saves money. It is an opportunity that I believe we in Canada can also take advantage of. Of course there have to be modifications, because we want to preserve the current system of universality of access and all the other aspects we have just discussed.

(1740)

Let me conclude by suggesting that these well documented experiences provide strong support for the effectiveness of introducing deductibles and co–insurance into the Canadian health care system through the tax system I just sketched. It could be modified and create more positive incentives by giving every Canadian a $1,000 tax offset against which the cost of medical services would be deducted. I think that very quickly after such a system is introduced people would know about it and they would pay attention to these things.

However, I believe these are details. I want to add to the current debate over the possible reform of the health care system the idea of using deductibles and co–insurance for routine medical services, administered through the tax system, while the system continues to provide universality of access and protection against catastrophic health costs.

Let me repeat: It is possible that this scheme—which not only I have proposed in the *Medical Post* editorial, but which has been proposed by the Fraser Institute competition for the reduction of the cost of government and has been proposed by other doctors who wrote to me after my publication—may very well be a way in which Canada can have all the wonderful qualities of our system we now have and create incentives for greater efficiency and prevent the demise of the system, which otherwise might collapse under the threat of excessive financial costs.

The Acting Speaker (Mr. Kilger): Questions or comments. I just want to remind the House that at 5.46 p.m. I will suspend the debate to move on to private members' hour.

Mr. Dan McTeague (Ontario, Lib.): Mr. Speaker, I will ask two very direct questions to the hon. member, given that time is limited.

The system he is proposing is a claims bonus system. In my view, it contradicts the public health preventative care policy we are concerned with in this country. Someone who might, for instance, suffer a headache and does not go to a doctor or a health care facility might otherwise wind up with an aneurism, which of course will be more expensive to the health care system. That is only an observation, but it connects with my previous question.

A more important point is the one the hon. member made concerning deductibles. I am wondering if the hon. member has discussed this with his colleagues, including his leader, who during the 1993 campaign cited: ''I want to make it absolutely clear that the Reform Party is not promoting private health care, deductibles or user fees''. I think the hon. member has to check his facts and perhaps check with his leader. Could he please respond to that?

Mr. Grubel: Mr. Speaker, I thank the hon. member for this silly remark.

We are talking about something that has potential, regardless of what my leader said a year ago. I do not care. I present this as my personal opinion. Every time I go on a radio program or any time I present it to a general audience, they ask why we are not doing this. It is because of silly remarks of the sort I just heard.

Mr. McTeague: Your leader said it.

Mr. Grubel: My leader had not had the opportunity to hear what I had to say when he made this remark. It takes time for these ideas to spread.

I think it would be very much in the interest of Canada if members from the other side opened their minds just a little bit. There might be ideas out there that they have not thought of that would do exactly the same thing they want to do, except it would save the system at the same time.

Let me read something. Some critics claim that these medical service accounts that have been experimented with in the United States will encourage people to avoid preventive care. Yet experience shows that the reverse is true.

I wonder if the member would please listen.

Medical service accounts make money available immediately when the medical need exists. This allows people to make purchases they might not make if they had a traditional deductible requiring an immediate out of pocket payment. Therefore his objection to this scheme is simply incorrect. We would preserve exactly what we have now. It is not a traditional deductible system.

On the other hand, it is quite clear that I am prepared to continue to support a system which has no co–insurance and no deductibles if ways can be found to finance it.

The Acting Speaker (Mr. Kilger): It being 5.46 p.m., it is my duty to inform the House that pursuant to Standing Order 81, proceedings on the motion have expired.

I have a statement concerning private members' hour for tomorrow, Friday, April 28, 1995. I have received written notice from the hon. member for Winnipeg Transcona that he will be unable to move his motion during private members' hour tomorrow.

[*Translation*]

As it has not been possible to arrange an exchange of positions on the order of precedence, pursuant to Standing Order 94(2)(*a*), I ask the clerk to drop this item to the bottom of the order of precedence.

Pursuant to Standing Order 94, private members' hour will be suspended for tomorrow, and the House will continue with consideration of business before it at that time.

[*English*]

The House will now proceed to the consideration of Private Members' Business as listed on today's Order Paper.

PRIVATE MEMBERS' BUSINESS

[*English*]

PEACEKEEPING ACT

Mr. Chuck Strahl (Fraser Valley East, Ref.) moved that Bill C–295, an act to provide for the control of Canadian peacekeeping activities by Parliament and to amend the National Defence Act in consequence thereof, be read the second time and referred to a committee.

He said: Mr. Speaker, I am very pleased today to have the opportunity to speak to Bill C–295, which I will refer to as the peacekeeping bill. It offers a golden opportunity for all members to rationalize and focus Canada's peacekeeping efforts. I am especially pleased that the House leader for the government affirmed his intention on April 6 to treat all private members' bills as free votes. This means that all members will be able to make up their minds purely on the merits of this legislative suggestion.

This is a breath of fresh air in the House. I sincerely hope members speaking to the bill today and those voting on it later will have taken the time to study it thoroughly. Free votes may mean a little extra work for individual members of Parliament but as an exercise in democracy free votes help to establish the credibility of the House.

Bill C–295 is a good idea, worthy of all party support because it would not cut off or even reduce Canada's peacekeeping role in the world. Rather, it would affirm and institutionalize the role of peacekeeping in Canada's foreign policy and strengthen Canada's place as a leader among the United Nations.

Neither would it reduce the power of the government to make decisions about the deployment of Canadian troops. The bill deals strictly with peacekeeping and allows cabinet full authority to act on a temporary basis. However, it also places the responsibility for our long term commitments squarely where it belongs, in the capable hands of the Canadian people through their members in the House of Commons.

At the moment there is no legislation governing Canada's peacekeeping effort. Legally peacekeeping is still regarded as sort of a side show, an informal duty that Canada undertakes almost as an afterthought. However, in reality peacekeeping has become one of the most visible aspects of the Canadian forces. Certainly Canada's international reputation hinges to a large and increasing degree on its peacekeepers.

However, the only legislation that acknowledges this reality is the National Defence Act which allows cabinet to place Canadian soldiers on active service and pay our soldiers as if they were at war. This is purely an administrative necessity and it does not even address the modern questions about peacekeeping that demand attention.

(1750)

I quote from the defence policy review tabled last fall:

> Defence policy cannot be made in private and the results simply announced—Canadians will not accept that, nor should they. Nor should the government commit our forces to service abroad without a full parliamentary debate and accounting for that decision. It is our expectation that, except in extraordinary circumstances, such a debate would always take place prior to any such deployment.

I agree wholeheartedly with this recommendation which was made by an all party committee of the House. I assume it should become parliamentary policy and I note the government allotted three hours on March 29 to debate the renewal of Canada's commitment in the former Yugoslavia. The government has thereby acknowledged that Parliament does have a role to play in making these important decisions.

Unfortunately the effectiveness of that role is questionable because the matter was not put to a vote on March 29. Although 20 members of the is House spoke to the issue that day, the input from those MPs was not as effective as it could have been because it was just a take note debate. The motion put before the House was non–votable. We have no idea of the consensus of the Canadian people. The debate was not brought to its logical conclusion. Some people have speculated the decision was finalized before the debate had begun.

Would it not have been better if at the end of that debate, where the pros and cons of the peacekeeping proposal had been discussed in this most public of forums, we had considered this issue important enough to stand up and be counted? Canadians deserve to know our position on this important subject. We are ready to move past the old ways of doing things where this House rubber stamps decisions which have been made in the bureaucracy. Canadians want and need assurance that it is their members of Parliament who actually make the decisions in Ottawa.

Failure to bring a debate to its proper conclusion on such an important topic as this results in a patchwork policy which does not seem to make sense. Bosnia is an example. The UN has 44,300 people on the ground from 38 nations. It is the largest UN mission ever. The operation began over three years ago and has continued at great expense and high risk to Canadians in a situation where neither side seems to appreciate the value of Canadian peacekeepers.

Last July I attended the funeral of Corporal Mark Isfeld, one of the Canadian soldiers killed by a land mine while performing his peacekeeping duties in the former Yugoslavia. His family and friends and all Canadians knew peacekeeping frequently means lives are put at risk. Mark was one of nine people who

have made the ultimate sacrifice in service to their country in that war torn zone.

Our peacekeepers are honoured to represent Canada on missions overseas and I am honoured to be represented by them. However, it needs to be said that the mission in Bosnia has no foreseeable end and it seems to have a diminishing hope of success.

I refer now to a different situation. A few weeks ago a Canadian, former Major General Lewis MacKenzie, investigated Canada's oldest peacekeeping effort. Canada has been in Cyprus for 30 years, since 1965. The original UN mandate was just three months. Three full decades later the UN is finally thinking of withdrawing, only because other nations are starting to mutiny. Canada, of course, soldiers on.

Both of these situations tax the very idea of reasonability. They also tax our resources and denigrate the reputation of the United Nations. At the same time we look at a nation like Rwanda where genocide was attempted last year, or Burundi where unrest is threatening to boil over again into mass slaughter, perhaps another attempt at genocide. However, the UN sits on its hands and Canada's hands are also bound in part because so many of its resources are committed in so many other places in the world.

The obvious disparities between these operations show that Canada's approach to our peacekeeping function is not rational. We lack an orderly process by which we can sit down together and weigh the increasing numbers of peacekeeping requests we are receiving. We need a way of ordering our priorities to make sound decisions about where to become involved, what to do when we get there, how much to spend and, most important, when to call it quits.

Major General MacKenzie made a good suggestion:

> Perhaps what is required is a deadline. What if the UN were to say we will give you a set period of time, say three years. You sort your problem out during that period or we are out of here.

(1755)

This is a celebrated peacekeeper saying we need a new mechanism for dealing with Canada's peacekeeping decisions. It certainly would have helped in the case of Cyprus. We need guidelines and mechanisms so that all Canadians whether they are taxpayers, men and women of the armed forces or members of Parliament will know what we are committing ourselves to when we go overseas.

The peacekeeping bill provides the mechanism we need. Let me describe the basic elements. It is a very simple bill, worthy of the support of all members of the House.

In summary it says that when Canada is approached by the United Nations to participate in a multinational effort the government should develop a peacekeeping plan and present it to the House by way of a motion.

The elements of that plan are very simple: estimate the cost of the mission, its location, its duration and its role. That is it. The House would debate it for less than five hours. It would pass the resolution and the mission would be in full force.

If the government had to act immediately it could do so by joining the mission without any debate and sending as large a contingent of troops and materiel as it needed to. A peacekeeping mission is carefully defined in this bill as more than 100 soldiers sent under a UN mandate for more than one month.

This means soldiers deployed with a UN mandate would not require legislation approval. The cabinet needs that authority and ability. It means that fewer than 100 Canadian forces personnel acting for more than a year would not constitute a mission. They as well could be sent by the cabinet.

A thousand soldiers on a mission lasting less than a month, something that we had to do quickly, would not require parliamentary approval.

When we get into major commitments for long periods of time Bill C–295 would come into play. Once Parliament has approved a peacekeeping plan that plan would become the mission's mandate. If the mandate expired the mission would automatically be over and the troops withdrawn. If a situation called for the mission to be extended that process is also contained in the bill. The government would simply come back to the House with amendments to the plan and pass a new resolution.

This simple process in many ways mirrors a letter I received last May from the Minister of National Defence which detailed the criteria for Canada's peacekeeping commitments. He said there must be an achievable mandate. The principal antagonists must agree to UN involvement. Are the lines of authority clear? Is the mission adequately funded? What is the risk for peacekeepers and the rules of engagement?

Laws are simply a codification of what is necessary and reasonable. The things the minister mentioned are both reasonable and necessary considerations. Now it is time we codified these requirements into a law that allows Parliament to have significant and effective input.

I can think of important benefits to this idea. The first is participation. Through the political process Canadians would decide Canada's priorities, where Canada should be involved around the world. There would be a special benefit for the government of the day in that it could lay before Parliament a peacekeeping plan from which it could gauge support for a mission before we actually made the commitment in the international arena.

Also, the debate would allow all political parties to endorse a proposal in an official way through a vote. Having endorsed a mission a party would be reluctant later to criticize a plan it had helped finalize.

The second benefit is preparedness and co–ordination. The government as well as our international partners would know beforehand exactly what Canada is prepared to do in each situation and other nations could prepare accordingly. Our national defence people could better prepare for a mission if they knew its parameters in advance.

The third benefit is budgetary. By putting a cost ceiling on all our missions we would know how much the country will allot for peacekeeping and in these days of tightening budgets the ability to fix our costs as much as possible ahead of time is vital.

If governments had to return to the House for more money the political hurdle this would pose in some cases would cause the government to be more careful about the money it spent and committed to in the first place.

Governments need to be held accountable for the money they spend and certainly the current government needs to recognize that the budget for peacekeeping is like other departmental spending plans for which they present estimates to the House. We simply must be able to keep to the budget allocated by Parliament.

(1800)

Some people will argue political situations change so rapidly that Canada cannot make firm commitments ahead of time. I would answer that firm commitments ahead of time could in themselves positively affect the political and military decisions others will make.

Firm decisions will allow us to direct our circumstances and set our own course rather than have external events lead us around by the nose. As General MacKenzie implied, by giving generous but firm guidelines ahead of time, we may even influence warring factions to resolve their differences in a timely fashion.

In any case, the bill is flexible. It allows for the government to make corrections in midstream, to extend, for example, a peacekeeping mandate. Having said that, all of us elected to this House know our first duty is not to satisfy the wishes of other nations. The government's first duty is to satisfy the Canadian people that our foreign involvements are necessary and fiscally prudent before running around the world putting out other people's fires. For Canada's peacekeeping function to continue to be legitimate in the eyes of Canadians, it must pass the test of continuing public approval.

We also need a bill that touches on other areas of Canada's peacekeeping function. This bill does that. It refers to the command structure of Canadian forces and requires that our troops be placed under the command of other Canadians. As we know, a major complaint about the UN is the notoriously low quality of its commanders. We feel that Canadians, especially Canadian soldiers, will feel more secure with Canadian commanders.

Even here we have constructed this bill to allow some flexibility. Clause 6 states that cabinet may delegate that command structure if it wishes to another body for periods of six months at a time. At least cabinet would have to make a conscious decision to place our troops under someone else's care.

We also talk about the neutrality of our armed forces. Neutrality is a precious commodity in this world. Once we give our reputation away for neutrality it is very difficult to restore. Canada is known and welcomed around the world for its fairness, impartiality and even–handedness. We should not be seen to be installing and deposing governments, even non–democratic governments, at the behest of the UN. It is not our role to take political sides in political disputes.

Our peacekeeping task, our role, our function is to enforce ceasefire agreements and to deliver humanitarian aid, thereby earning the respect over the long term of all sides in the dispute rather than breaking the bounds of neutrality in a short–sighted way and turn half of a population against us. This is a delicate task. It can only be accomplished if our armed forces continue our traditional neutrality in peacekeeping roles.

There has been some question about the use of deadly force in peacekeeping situations, situations in which our peacekeepers have felt ashamed of themselves and deeply frustrated by their inability to protect themselves and others. My bill helps to resolve this problem by allowing our peacekeepers to use deadly force in self–defence, in defence of innocent civilians or to stop serious abuses of human rights where deadly force seems to be the only way to do it.

What is an army for? An army exists to pit force against force. That is its only purpose. Even peacekeepers are an army that moves physically into a dangerous area to provide a physical check on another armed force. But we fight a different battle than either of the antagonists. We are warriors stepping between other warriors in a battle for peace, risking everything in our striving to end war and deliver hope where little exists.

We cannot ask our soldiers to go into these types of situations completely unprotected. Although we must minimize our own use of deadly force, I feel it is justified in the situations I have just outlined where it will clearly forestall an immediate situation that is obviously worse. However, I acknowledge this is a difficult area.

Let me sum up by talking about Canada's identity. Canada is a young country. As such, its personality, if we want to call it that, is still developing. Different nations seem to be known for different things. When we think of Switzerland we naturally

think of neutrality. Germany is an industrial giant and Sweden is perhaps a classic welfare state.

What do people think of when they think of Canada? I would say that other nations long ago recognized Canada's peaceable nature, her natural co–operativeness and her concern for stability in the world. We offered a novel idea, that there is a third option between defeat and victory.

(1805)

The UN requested our assistance as peacekeepers. Canada did well and the public supported it. We have continued to respond proudly and generously for 40 years. In doing so, we have defined our own nature, shaped our identity and become comfortable with our role in the international community.

We are peacekeepers. It is a role that receives applause around the world. A peacekeeping bill would formalize this positive definition of Canada. It would cement it in the minds and hearts of Canadians. I can think of no more noble role than being a peacekeeper, no higher legislative aim than to entrench this function as a formal element of Canada's identity.

It is said that we reap what we sow. If that is true, and I think it is, what kind of harvest do we reap, what kind of fruit grows when peace is sown? Peaceable people co–operate more. The food of peace is better health, prosperity, long life, happy relations, improved working conditions. To strive for peace is to strive for all that is necessary for humanity to thrive on this planet.

Finally, in addition to those tangible benefits of peace, the fruit of peace is also hope. That precious seed of hope is sown in peace by those who make peace. I trust that all members of the House would see fit to formalize Canada's peacekeeping identity by voting to submit the peacekeeping bill to committee for consideration.

Mr. Fred Mifflin (Parliamentary Secretary to Minister of National Defence and Minister of Veterans Affairs, Lib.): Mr. Speaker, I am pleased to speak on Bill C–295, an act to provide for the control of Canadian peacekeeping activities by Parliament and to amend the National Defence Act in consequence thereof.

I have no doubt that the bill was motivated by the concern of all members for the well–being of the Canadian forces personnel and for a wise and sound decision making process on the part of the government.

Unfortunately I have to say that after close study of the bill, in my opinion it might on serious consideration make the process a little worse than the situation that we now have in place. For that reason I oppose it.

Before describing the details of my opposition, I have a general observation to make that applies to much of the thinking that emanates from our hon. colleagues on the Reform benches. It is a tendency that I see reflected in this bill to look for American models in matters of public policy in Canada.

This tendency skews the vision and certainly on our part. I do not believe we can make policy on the basis of the trends and obsessions of our American neighbours, as much as we respect and admire them. We are not them and their examples are foreign to our needs and purposes.

The government has gone to great lengths to ensure a made in Canada defence policy. In fact, members of all parties were members of the special joint committee that put together an outstanding report. I say this not in any sense of gloating but in modesty. Ninety–five per cent of it is reflected in the white paper. It is a Canadian defence policy and one that reflects Canada's needs and aspirations. I for one—I am sure I am joined by many others—would want to keep it that way.

Bill C–295 would restrict the prerogative, the speed and the discretion of the crown to determine Canada's contribution to the United Nations for reasonable peace operations. Like other military operations, peacekeeping is carried out under the authority of the Minister of National Defence under the National Defence Act. It provides that the minister has the management and direction of the Canadian forces and of all matters pertaining to national defence. The bill would remove the responsibility and the discretion not only of the minister but also of the government respecting military operations.

As a result, the bill would adversely affect the speed with which the government can respond to UN requests for assistance in peace operations as well as the timeliness with which it can respond to changes in the peacekeeping mandate.

One of the major problems cited by many former Canadian UN commanders is that it takes too long for the international community to become involved in times of crisis. Most recently Major–General Romeo Dallaires has been an eloquent and passionate advocate of the need for speed in emergencies, claiming that he could have saved tens of thousands of lives had he received the troops he needed when he requested them.

Bill C–295, which would add another layer in the decision making process, would ensure that it would take still longer for Canada to become involved and to provide help. In an emergency we should treat it like one and act urgently. The bill would also create an unworkable structure for the management of international Canadian forces operations. All potential operations are evaluated against a series of guidelines that include the broad political and foreign policy context, the overall mission requirements and, of course, our own military capability.

(1810)

[*Translation*]

The 1994 defence white paper outlines certain key principles intended to help the government assess the various factors to be considered before deciding whether Canada should participate in a mission. These guidelines are based on the peacekeeping experience we have acquired over the last 40 years. They also illustrate in a careful but pragmatic way the new international world order that has followed the end of the cold war.

The white paper highlights the key principles that must guide the design of all peacekeeping missions. These principles are as follows: first, there must be a clear and enforceable mandate; second, there must be an identifiable and commonly accepted reporting authority; third, the national composition of the force must be appropriate to the mission, and there must be an effective process of consultation among mission partners; fourth, in missions that involve both military and civilian resources, there must be a recognized focus of authority, a clear and efficient division of responsibilities, and agreed operating procedures; finally, with the exception of enforcement actions and operations to defend NATO member states, Canada's participation must be accepted by all parties to the conflict.

[*English*]

Canada's experience also suggests that successful missions are those that respect certain essential operation considerations. Some were touched on by the hon. member. The size, training and equipment of the force should be appropriate to the purpose at hand and remain so over the life of the mission. There should be a defined concept of operations, an effective command and control structure and clear rules of engagement.

To look at another aspect, I believe Bill C–295 would give up Canadian sovereign command of Canadian forces elements and would create in its place an unworkable command and control relationship. In this area, in particular, I have problems with the intent of the bill.

Canadian forces personnel now serving on peace operations are always commanded by a Canadian. Command of Canadian forces personnel is no longer given up to allied or UN command, as it was during the first and second world wars. Canadian units and personnel can only be placed under the operational control, not the operational command, of the UN or other multinational commanders for specific tasks.

The practical difference between the two is that when Canadian forces are deployed under operational control, changes to the task assigned or significant changes to the area of operation cannot be implemented. For example, the UN would have to seek Canadian approval to deploy Canadian forces UNPROFOR personnel to the former Yugoslav republic of Macedonia from Croatia, should the need arise. Such approval would not be required under operational command.

On the other hand, a non–Canadian commander who only has operational control cannot assign separate deployment of components of a unit. For example, the force commander of UNPROFOR who has operational control of Canadian forces personnel cannot unilaterally assign, for example, B company of 2–PPCLI to the British battalion. Such a deployment would require Canadian national approval. If the commander had operational command, there would be no requirement for such Canadian approval.

Currently, commanders of Canadian contingents are directly responsible to the chief of defence staff for the Canadian contribution to the overall mission and tasks of any given operation abroad. The subclause of Bill C–295 which calls for the Canadian commanding officer to be placed under UN or other international command would be contrary to current practice and would mean less, not more national control, something my instincts tell me is far from being the intent of the bill.

(1815)

[*Translation*]

Bill C–295 would restrict Canada's capability to contribute to the strength of a fast reaction force on standby. As the hon. members probably know, the Minister of Foreign Affairs and myself have launched an initiative to assess the short, medium and long term implications of a United Nations fast reaction force and a possible Canadian contribution to this effort in the future.

Let us come back to Major–General Dallaire's plea for rapid deployment to Rwanda and in response to other international crises. Whether or not Canada participates in a given mission, when the decision is made to participate, timeliness is often crucial. This bill, if passed, would slow the decision–making process down almost every time there is a crisis.

[*English*]

In summation, I regret I do not support Bill C–295. I know the hon. member has put a lot of work into it and I appreciate the comments he has made. However, under the guise of providing greater control by the Parliament of Canada of international peacekeeping operations, I believe it tends to confuse certain key concepts, some of which I have alluded to. It reduces national authority over our peacekeeping troops abroad. It significantly restricts one of the government's prime assets, the flexibility and ability to manoeuvre and shape our resources to suit rapidly changing requirements in dangerous times.

[*Translation*]

Mrs. Maud Debien (Laval East, BQ): Mr. Speaker, I rise today to speak to Bill C–295. This bill provides for the control of

Canadian peacekeeping activities by Parliament and amends the National Defence Act in consequence thereof.

Bill C–295 has three main objectives: first, to enhance parliamentary control over the involvement of Canadian forces in international peacekeeping missions; second, to limit it to a neutral or non–combatant role; third, to control the placing of Canadian forces under UN or other non–Canadian command.

I would like to stress at the outset that the members of the official opposition are glad to have the opportunity to discuss such changes to the way the Canadian forces participate in peacekeeping missions. And we would like to thank the hon. member for Fraser Valley East for giving us the opportunity to express our opinion on these matters.

Much of the content of Bill C–295 is in step with the concerns already expressed by the Bloc Quebecois, as much in the debates in this House as in the dissenting report we submitted regarding the Canadian foreign policy review.

I would briefly like to reiterate the Bloc Quebecois' position on the issue being discussed today. Firstly, I would like to stress that the official opposition believes that one of the most important roles of the Canadian forces on the international scene is to support peacekeeping operations and to take an active role in them. This is one of Canada's crowning achievements which has helped earn us our reputation.

Nevertheless, we believe that, in the future, Canada should select more carefully the operations in which it will participate. Recent peacekeeping missions have, as you recall, had their difficulties, of which Canada should take note. Examples are the missions to Rwanda and the former Yugoslavia, or even the situation in Haiti, which reminded us of the need to ensure that our operations serve to further legitimate democratic causes and are meticulously planned.

(1820)

The conflicts I just cited as examples clearly show how important it is to define, under the auspices of the United Nations, specific objectives and mandates for each mission beforehand. The Bloc Quebecois also recognizes that we need to give the Canadian forces special status, in order to maintain the credibility of our operations.

At the same time, Canada should review its current military alliances and adapt them to strategic missions in accordance with the needs of the United Nations. This approach would inject new life into these organizations and would make them more effective in protecting safety and in resolving conflicts. It would also make it possible for Canada to meet its public security objectives, which are crucial to its own domestic security.

Furthermore the official opposition feels that Canada should encourage the creation of a permanent contingent that would be at the disposal of the UN to carry out its peacekeeping missions abroad. The number of personnel assigned by Canada to these peacekeeping missions should be limited. Unfortunately, Bill C–295 is silent on this point.

Finally, as we have said many times before, for instance in our dissenting opinion, we believe that Canada should put its decisions to participate in peacekeeping missions to a vote in the House of Commons, and do so as soon as possible, if there is enough time. We are of course delighted to see some of our suggestions reflected in the bill before the House today. However, some sections raise a number of problems, and we would like to suggest some improvements.

For instance, in clause 4 of Bill C–295, there seems to be no provision for the eventuality that Canadian forces might be asked to take part in peacekeeping operations at a time when parliamentarians are not sitting in this House. On the other hand, with respect to the order that would place the officer in command of the Canadian forces under the command of the United Nations or an international organization represented by an officer of another state, in subclause 6(3), the bill provides that the order would be laid before the House of Commons on any of the first three days on which the House sits following the day the order is made. Perhaps the same provisions could be included in clause 4?

Furthermore, clause 4 makes no provision for renewing the mandate given to Canadian forces. Perhaps it would be advisable to add a provision to that effect. Still in clause 4, and more specifically in subparagraph 4(1)(v), the Minister of Defence is asked to specify a maximum planned expenditure for the mission.

We realize such provisions are necessary. Canada's financial situation demands that we act responsibly. However, instead of immediately patriating military personnel once the expenditure limit previously approved by the House has been exceeded, this clause should provide for increasing, always by a resolution of the House of Commons, the resources allocated for an operation in exceptional cases, such as emergency humanitarian aid.

We also have some questions about the scope of subclause 5(3). This subclause mentions three circumstances in which Canadian forces would be allowed to use deadly force. We must ensure that Canadian military personnel take part in peacekeeping rather than peacemaking missions. Would it not be more prudent to make the rules specifying the circumstances in which force may be used subject to criteria set by the UN? Otherwise, we might have a situation where the participation of Canadian military personnel in peacekeeping missions would be subject to criteria that are different from those for other national con-

tingents. These questions show how important it is to specify the scope of subclause 5(3).

As for clause 6, I have two comments. First, in clause 6(3), we want all references to the other place deleted. As you know, the Bloc Quebecois considers it a waste of public funds to maintain the other house, which should be abolished as quickly as possible.

(1825)

As our final amendment, to clause 6(4), we believe that the renewal should be submitted to the House of Commons and not to the Governor in Council. This amendment is in keeping with the spirit of the bill, which attempts to involve Parliamentarians more in decisions pertaining to peacekeeping activities.

In closing, I would once again like to thank my colleague for Fraser Valley East for allowing us to debate this important question. I assure him that the Bloc Quebecois supports the principles underlying Bill C–295. For this reason, we support the bill in second reading.

We would like the questions raised by the opposition to be given serious consideration so improvements may be made to the bill before its passage at third reading.

[*English*]

Mrs. Carolyn Parrish (Mississauga West, Lib.): Mr. Speaker, I am pleased to have the opportunity to participate in the debate on Bill C–295, an act to provide for the control of Canadian peacekeeping activities by Parliament and to amend the National Defence Act in consequence thereof.

I will take a few minutes this afternoon to talk about the context of the bill, namely the nature of Canada's current involvement in peacekeeping activities and the way in which we currently manage our participation in the operations. I should also like to look at a number of specific details in the bill and explain why I cannot support the changes the bill proposes.

Since World War II successive Canadian governments have argued that a safer, more secure international environment is key to Canada's own security and prosperity. As a responsible international participant and as a major trading nation, Canada is concerned with the dangers of a spillover of a localized strife and the threat it poses to the larger international community. At the same Canadians desire a reduction or end to the widespread human suffering in situations where there are strong indications that outside assistance can make a difference.

To this end Canada has worked with other countries to create a stable international environment. One of the instruments we have used in this effort has been peacekeeping, a technique of multilateral conflict management and resolution that has proven exceedingly useful over the years, and at which Canada has excelled.

Canada's contribution to peacekeeping is rooted in the belief that a stable international order sustained by substantial multinational consensus is the best foundation for Canada's long term peace and security. Hence, we willingly make available well trained and suitably equipped military personnel for peacekeeping and related operations.

However, our commitment to peacekeeping cannot be taken for granted. Canada carefully examines all requests for peacekeeping assistance and turns down those it regards as inappropriate. Our record of support is unparalleled, but that does mean our decision to take part in such missions is automatic. Canada has declined opportunities to participate in the third UN Angola verification mission, the UN Aouzou Strip observer group and the UN observer missions in Georgia and in Liberia. In recent years Canada has also significantly reduced or withdrawn contingents from Cyprus, Western Sahara, Somalia and El Salvador.

Traditionally the international community has turned to Canada for peacekeeping resources, not only because our foreign policy has been inclined to support involvement but also because our armed forces are flexible, multipurpose and combat capable. Our personnel are well trained, suitably equipped and have a very impressive track record. The world has come to depend on Canada for peacekeeping.

Canadian participation must always be placed in a larger international context. Our decision to join in a mission is a unilateral one and any changes to the way we operate would also be unilateral. However, the actual mission is always multilateral and complex. With many partners affecting our understanding we become team players when we join. This is an important consideration because UN Security Council resolutions are not always absolutely precise in specifying all the aims, duties or roles of a mission. Decisions evolve as circumstances change.

I should like to turn now to a discussion of some specific provisions of Bill C–295 which in my mind are not workable.

(1830)

Clause 8 of Bill C–295 requires that once the aims of a particular mission have been achieved the Canadian contribution is to be terminated. The bill is not clear as to how the UN objectives or those expressed in the resolution might be reconciled. Yet the withdrawal of a Canadian contingent based upon an arbitrary expiry date would have two undesirable effects. First, the entire Canadian contribution might prove pointless if withdrawn too early. The second and more serious impact is that withdrawal could be counterproductive to the mission as a whole and thereby in itself threaten peace and security.

I also question those provisions of the bill related to active service. This bill would deem members of the Canadian forces assigned to peacekeeping missions to be on active service for all purposes. The bill proposes that the National Defence Act be amended so that an officer or non–commissioned member assigned to a mission that is subject to the proposed peacekeeping act shall be deemed to be on active service for all purposes.

Quite simply, this proposal is unnecessary. Pursuant to an order in council dated April 6, 1989, all regular force members anywhere in or beyond Canada and all reserve force members beyond Canada are currently on active service. Moreover, all members of the regular force have in fact been on active service continually since 1950.

There is therefore no legal requirement for individual orders in council placing members on active service as a consequence of a particular peacekeeping operation. These orders in council are simply a parliamentary convention. But convention though they may be, the practice certainly reflects the government's desire to consult more frequently with Parliament concerning the general thrust of Canada's peacekeeping policy and practice.

As members well know, there have been two substantial debates on international peacekeeping commitments since this government came into power, the first on September 21, 1994 and the second just recently on March 29.

Bill C–295 does not adequately address the scope of UN peacekeeping operations or chapter 7 action taken by the UN Security Council. This is the third element of the bill with which I have serious concerns.

The definitions and structure imposed by the bill do not accord with international treaties and the UN charter obligations. In trying to encompass the broad range of operations that may be authorized or directed by a UN Security Council resolution, the definition of a peacekeeping service in clause 2 of the bill is very imprecise.

The Secretary General of the United Nations, Dr. Boutros Boutros–Ghali, in his June 1992 report to the Security Council defined four terms: preventive diplomacy, peacemaking, peacekeeping, and peacebuilding, all of which contribute to the maintenance of international peace and security. Each of these UN concepts can, and most often do, entail the use of military force. However, civilian personnel such as elections officials and civilian police are also becoming common in UN peacekeeping operations. The problem with Bill C–295 is that it does not provide a clear delineation of which operations are covered, nor does it offer any specific rationale for applying such regulations only to Canadian forces.

I would also like to question the section dealing with the rules of engagement. Bill C–295 creates overly simplistic legal obligations for rules of engagement and the use of force. Rules of engagement are always issued to armed Canadian forces personnel participating in international operations. They often operate under UN rules of engagement, although these are always drafted in conjunction with the Canadian forces staff at National Defence Headquarters as well as the Canadian contingent commander.

In this way, UN rules of engagement reflect a distinctly Canadian approach in structure, terminology, and interpretation of the mandate within which the rules operate. Occasionally, when the UN is slow to produce an acceptable set of rules of engagement, Canadian forces will operate under Canadian rules while permitting the UN to maintain overall control of an international operation.

Clause 5(3) of the bill restricts the use of force to self–defence. However, this restriction cannot, unless specifically authorized by a UN Security Council resolution, extend to the protection of civilians, even if they are subject to the actual or immediate threat of deadly force or if they are threatened with a serious abuse of human rights. All rules of engagement must be carefully analysed, taking into account the specifics of the mandate. That mandate could require troop–contributing states to use force for reasons other than those specified in the bill.

The issue of neutrality in Bill C–259 is also insupportable. The blanket requirement in subclause 5(1) that Canadian forces be neutral and not engage in combat is itself contradicted later in paragraphs 5(3)(a), (b), and (c) of the bill. The authorization this later subclause gives would violate the neutrality provisions because force could be used to protect one civilian group against the actions of another. There may be cases in which combat is the only means of restoring peace. Once again, this bill, if implemented, would restrict the flexibility of our Canadian forces in what are often very fluid and unpredictable circumstances.

(1835)

In conclusion, I think that the same argument could be applied to the bill as a whole. The provisions of Bill C–259 foreclose options and restrict the flexibility of the Government of Canada to direct and manage the peacekeeping operations it undertakes.

I urge all members of the House to give careful consideration to how this bill would affect the ability of our Canadian forces to perform the tasks they have been assigned. This bill, however well meaning in its intent, would, in my view, have a detrimental effect on Canada's ability to undertake peace operations.

Out of respect for the admirable work that our Canadian forces are doing on a day to day basis and with their interests in mind, I cannot support this bill.

Mr. Jim Hart (Okanagan—Similkameen—Merritt, Ref.): Mr. Speaker, it gives me great pleasure to stand in the House today and support Bill C–295, put forward by my colleague for Fraser Valley East.

The part of this bill I would like to address is clause 4, dealing with the authority of the House of Commons. As everyone in this House knows, much to the distress of the Liberal government, the Reform Party strongly endorses the notion that the House must be accountable to Canadians, and not just financially accountable. Everything we do in the House must reflect the desires and expectations of the people. Only under the most extreme circumstances should Parliament act without consulting the people who elected us. This is especially true when Canadian lives are at stake.

Last year I had the privilege of being a member of the special joint committee reviewing Canada's defence policy. During this year of intense research and consultation with Canadians, we made a number of recommendations in our report, entitled ''Security in a Changing World''. This is one of the recommendations, and I quote:

> Defence policy cannot be made in private and results simply announced. Canadians will not accept that, nor should they. Nor should the government commit our forces to service abroad without a full parliamentary debate and accounting for that decision. It is our expectation that, except in extraordinary circumstances, such a debate would always take place prior to any such deployment.

This recommendation was endorsed by all members of the committee, including those sitting opposite today. Though there have been eleventh hour debates on peacekeeping in the former Yugoslavia and the government's white paper on national defence did recognize many of the special joint committee's recommendations, this specific recommendation was overlooked by the minister and the government.

Currently, cabinet has the full authority to designate soldiers to be on active service for war or for peacekeeping activities. If Parliament is not sitting, section 32 of the National Defence Act requires that the House reconvene 10 days after placing soldiers on active service. Strangely, the government is not required to hold a debate on this. The notion of accountability is conspicuously absent. Canadians have no say in committing our troops to life threatening circumstances.

Clause 4 of Bill C–295 provides a method for full parliamentary review in the spirit of the special joint committee report and holds the government accountable for all peacekeeping commitments. Clause 4 states: ''No Canadian forces shall serve or be committed to service in peacekeeping service or continue in such service beyond the time or expenditure limit previously approved by the House of Commons, pursuant to this section, unless the Minister of National Defence has moved in the House of Commons a resolution'' outlining five criteria that must be debated and passed.

This opportunity for debate is essential. Since the end of the cold war the government has designated more troops to active service than any time since the Korean war. While we are very proud of our international recognition as peacekeepers and in some cases peacemakers to the world, the missions we have engaged in are becoming increasingly dangerous and uncertain in purpose. Canadians should be proud of our peacekeepers, because our troops are indeed the best in the world.

(1840)

The first criterion in the resolution authorizes the specific mission for peacekeeping service. This is extremely important. The House of Commons must be told exactly what the specific mission is.

When I talk to my constituents about defence issues many ask me what our specific mission is in hot spots such as the former Yugoslavia. They also ask why we are still there when the troops are fired on and held hostage by the combatants. They seem to realize there is no will for peace in that troubled nation and wonder exactly what we are doing to resolve the conflict.

This brings me to my second criterion. Bill C–295 would ensure the resolution specifies the objectives, duties and role of the mission. This is important in the new peacekeeping roles we find ourselves in.

In the former Yugoslavia it is often unclear what objectives we are striving for. The classic peacekeeping role of keeping two warring factions apart from each other while they negotiate a final peace or maintaining a ceasefire to which all parties agree is absent in Bosnia. In a conflict such as this where all warring sides clearly do not want peace and look at our troops as occupiers, it is difficult to ascertain exactly what our objectives are.

If we are to send peacekeepers into dangerous situations such as this it is imperative Parliament pass a resolution specifying the objectives of our troops, what objectives they will be attempting to meet.

Canadian troops cannot be pawns in any conflict. We must have a clear role spelled out. This is particularly important when communications between Canada's peacekeeping forces and the Canadian public are weak.

The third criterion of the resolution defines the state or area in which the mission is to operate. Only Parliament should have the authority to specify where our troops are to be committed.

The fourth criterion in the resolution specifies the date on which the authority expires. It is essential for Parliament to decide the exact date on which the mission ends.

Some of our former commitments have seemed unending in scope. Our service in the former Yugoslavia is on a six–month term but other peacekeeping missions, such as our mission to Cyprus, lasted 30 years.

Giving Parliament the authority to determine the date on which the authority is to expire for a mission also gives Parliament the opportunity to cancel or renew the mission. Parliament will be able to evaluate the mission and decide whether we have accomplished our objectives. It can also re–evaluate the conflict and assess whether it has changed in scope and whether we still have a role to play.

In common with the fourth criterion is the fifth. It specifies a maximum planned expenditure for the mission. Peacekeeping missions, like anything else the government does, must have financial bounds. The nation does not have a bottomless purse. We must determine what we can afford.

Clause 4 of the bill also provides for a five–hour debate on the resolution before the question is put to the House. As with any bill, the resolution can pass with or without amendments and it can also be defeated.

The time for Parliament to become accountable to the Canadian people for designating our troops on active duty is now. We must be the ones to decide and those who represent them in Parliament are their voice.

I strongly urge all members of the House to support Bill C–295.

The Acting Speaker (Mr. Kilger): The time provided for the consideration of Private Members' Business has now expired. Pursuant to Standing Order 93, the order is dropped to the bottom of the order of precedence on the Order Paper.

ADJOURNMENT PROCEEDINGS

[*English*]

A motion to adjourn the House under Standing Order 38 deemed to have been moved.

ACCESS TO INFORMATION

Hon. Warren Allmand (Notre–Dame–de–Grâce, Lib.): Mr. Speaker, on March 13, I asked the Minister of Justice if he would order a full review of the Access to Information Act as recommended by the information commissioner in his 10th anniversary report. In response, the Minister of Justice said that he was considering such a review and hoped to come forward with reforms in due course.

(1845)

In 1986–87 I was a member of the justice committee which made an extensive review of this act. It issued a report entitled:

''Open and Shut'' which made 87 recommendations for amendment. Unfortunately, none of those recommendations were implemented by the former Conservative government.

Recently the information commissioner made similar recommendations in three documents entitled: ''The Access to Information Act: 10 Years On''; ''The Access to Information Act: A Critical Review''; and ''Information Technology and Open Government''.

The basic principle of this act is that Canadians should have the right to information about their government and to information compiled and held by the government. Of course, this is information paid for with taxpayers' money.

For years prior to the Access to Information Act the government's general policy was to say no whenever information was requested and only to say yes by exception. The purpose of the Access to Information Act was of course to reverse this process. There would be exceptions, of course, for national security, for privacy and for cabinet confidence, but the general rule was to make information available.

The ''Open and Shut'' report concluded that the act had major shortcomings and weaknesses which should be corrected. As I said, the committee made 87 recommendations to do that.

Among those recommendations were first, that all government institutions, including much of our parliamentary process, be included under the act.

Second, it was recommended that all crown corporations except the CBC be included under the act. These institutions are not included under the act at the present time.

Third, it was recommended that all persons in Canada, not just citizens and residents, have access to the act.

Fourth, it was recommended to entrench the status of the information co–ordinators who are present in every department to facilitate the operation of the act and to give those co–ordinators senior rank in the departments.

Fifth, there were several recommendations with respect to the exemptions. We said that the exemptions should be subject to a significant injury test. We also recommended narrowing certain exemptions.

With respect to the cabinet confidence exemption we said that it should be covered under the act, but subject to a class tested discretionary exemption. In other words, cabinet confidences would not automatically be outside the scope of the act.

We also said that the information commissioner should have the power to issue certain binding orders in some cases, although generally he would still act by recommendation only. We made recommendations that the social insurance number be restricted in its use by outside agencies.

We recommended that the time for answering information requests be reduced from 30 to 20 days. We also recommended that there be legislation to protect whistle blowers within the Government of Canada.

Those are some of the recommendations which were made in 1986–87 in the ''Open and Shut'' report. I would like to ask the government again tonight if and when it intends to move on the recommendations made in ''Open and Shut'' in 1986–87 and also on the recommendations made recently by the information commissioner in his 10–year report.

Mr. Russell MacLellan (Parliamentary Secretary to Minister of Justice and Attorney General of Canada, Lib.): Mr. Speaker, the hon. member for Notre–Dame–de–Grâce has asked about the government's intentions with respect to reforms of the Access to Information Act.

The act is now 12 years old and much has changed since the act was first adopted. At that time access to information was seen as innovative and statutory rights to government information was thought to be a bold step.

Now we are fully in the information age. Canadians are increasingly purchasing computers and equipping them with modems. They are on the eve of the convergence of the television with computers. Those who have a television will also have the mechanism by which to retrieve information from the world at large. The Internet has completely changed our earlier notions of what access to information means.

The Access to Information Act was studied by a parliamentary committee in 1987. The information commissioner issued extensive recommendations to reform the act on the occasion of its 10th anniversary. The information commissioner also released background information studies he had commissioned, including one on information technology and open government.

The federal government recently adopted a blueprint for improving government services using new technology. It has created the Information Highway Advisory Council which is scheduled to report to the Minister of Industry in the spring.

Federal and provincial governments are engaged in a variety of pilot projects designed to provide more government information and services electronically. In the United States the department of justice has issued a draft consultation paper on electronic access to government information.

These initiatives are making more government information available than has previously been the case. This information is being provided outside the Access to Information Act and therefore with less red tape, more quickly and at virtually no cost to citizens.

All commentators on the Access to Information Act agree that what is needed most of all is a change in attitude that results in more government information becoming routinely available without requiring citizens to request it under the expensive and sometimes slow process of the Access to Information Act.

Progress is being made. There is no question that the Access to Information Act needs reforms. The minister has promised that the government will come forward with reforms.

The Liberal Party has made open government a promise in the red book. The minister has indicated that the Department of Justice is at work identifying areas where reforms could be made. We need to take the minister at his word. Reforms are coming. While precise details and dates are not now available, these will unfold in due course.

[*Translation*]

The Acting Speaker (Mr. Kilger): Pursuant to Standing Order 38, the motion to adjourn the House is now deemed adopted. Accordingly, this House stands adjourned until tomorrow at 10 a.m., pursuant to Standing Order 24.

(The House adjourned at 6:52 p.m.)

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