much wider type of coverage than is included in the private plans available in this country. For example, most plans in operation at the present time do not provide for psychiatric service. If they do, it is on a very limited basis. The Hall Commission report envisaged psychiatric coverage. This is a very important point because this can be a very expensive type of care for persons who have to receive it. The Hall Commission, therefore, did go to great lengths to explain why we had to have universal coverage.

The first objection in the letter from the Canadian Medical Association refers to the right of a citizen to choose the insurance best suited to his needs. There is a suggestion here that the private plans which are now in existence should remain in existence so that a citizen could pick and choose what he wants. This means you would have a great many insurance companies remaining in the field, and you simply could not get good health care at the lowest possible cost if you have all these companies in the field.

I should like to refer to an article which Mr. Justice Hall wrote, and which was published in the Winnipeg magazine *Canadian Dimension* for the months of March-April, 1965. I quote this from page 13:

> Why not many carriers?
>
> Now why not a multiplicity of carriers: because it would cost too much administratively. If one carrier is designated in each province, such as we felt could be done by some adjustments to the structure of Manitoba Medical, the annual saving would be in the order of approximately $180 million a year. In our opinion that was too much to pay for the luxury of having upwards of a hundred carriers in each province. It is either one carrier in each province, or all commercial carriers being recognized in each province. Otherwise, how could the selection be made? A free enterprise government in Australia rejected the use of commercial carriers because it would cost too much. The administrative costs of the hospitalization plan are approximately 5 per cent. The administrative cost of operating the Saskatchewan medicare program in 1963 was slightly less than 5 per cent. An average retention figure for acquisition costs, taxes, profits, etc. . . . by commercial carriers is approximately 27 per cent of the premium.

So, if you allow a plan to operate with a multiplicity of carriers you are going to have excessively high administrative costs. The people of Canada will not get the kind of health care they could get at the lowest possible cost. I note the point he made there that you could save $180 million, by having a single carrier in each province.

[Mr. Prittie.]

Now, point No. 2 in the Canadian Medical Association letter to the Prime Minister is as follows:

> That pressure has been exerted on provincial governments to curtail them in establishing their own health priorities, since they are required to introduce unnecessarily expensive programs when less expensive programs would suffice.

This leaves the suggestion that the type of program which would be introduced as a result of the implementation of this bill as originally drafted would be more expensive than other health plans which are now in operation. In any case, every provincial government should make health its first priority.

At a meeting which was held with the provinces to discuss this plan, it seems to me that the poorer provinces raised no particular objection. The Atlantic provinces, if I remember correctly, all agreed that they were ready to go ahead with this plan. Saskatchewan, which is in the middle ranks of the provinces so far as per capita income is concerned, has had a program in effect for several years. This leaves provinces such as Ontario, Quebec, British Columbia and Alberta which could well afford this program. I suggest the government should go ahead, as the government did ten years ago with the hospital insurance plan. They should pass the bill to make the program available. If a province is ready it can come in; and if it is not, it can wait until it is ready to do so. I suggest that if the poorest provinces in Canada are ready to go ahead, the others can well afford to pay.

Now, another point raised in the Canadian Medical Association letter listing their major objections is as follows:

> That the underlying assumption that a government authority can administer an insurance program more efficiently and more economically than private programs operating on a non-profit basis has not been established, and we doubt its validity.

I suggest to you that it has been established, and I quoted earlier the case of Manitoba Medical. I noticed just this week a press report from my own province. It is a Canadian Press dispatch from Vancouver dated October 15 and reads:

> • (8:50 p.m.)
>
> Medical Services Inc., a doctor-operated medical insurance scheme in British Columbia, announced Friday it will abandon the field of individual medical insurance because it can't compete with the B.C. government medical plan.
>
> About 7,500 individuals will be dropped from the M.S.I. plan when the change takes effect Nov. 30.

The British Columbia government did during the past two years eventually introduce a