the provinces, assisted by the federal government, and that the next step, medicare, is a problem only of timing and finance.

Hospital care and medical services are different in kind rather than degree. Hospital care is an impersonal, institutional service, but few relationships are more personal than that which exists between a doctor and a patient. Hospital care is controlled by the doctor, but medical services are initiated by the patient. Therefore to me the implementation of a medical services program that is compulsory for all, and controlled by government, is an entirely new concept which requires a quite different philosophical decision. Few of us can resist a bargain, and medicare, underwritten by government, is almost irresistible.

• (8:20 p.m.)

I am opposed to compulsion in any form in what is supposed to be a free democratic society. I believe we should recognize the principle of voluntary choice by the individual. After all, the cost of free medicare cannot be analysed except in terms of its success in attaining its legitimate objectives. Health insurance is one manifestation of a deep seated concern in each of us for protection against the hazards of medical costs. It is a part of our search for security, a phenomenon which is not confined to our generation. Health insurance began in Europe more than 200 years ago. With the advent of the industrial revolution, workers banded together to form craft guilds. These were the forerunners of the friendly societies which still exist in Europe today. An important feature of these guilds was their attempt to meet collectively the financial hazards of illness. At first participation was voluntary, but widespread compulsion was introduced in Germany in 1884.

Compulsion was first applied on a selective basis to wage earners below a stated income. However, subsequent developments saw political pressures being used to widen both the occupational groups and the income classes to be included in the scheme. Bismarck's reasons for introducing a compulsory form of health insurance were not humanitarian; they were political. One of his biographers stated:

> To his mind, the state, by aiding the workers, should not only fulfil the duty ordered by religion, but it should obtain in particular a claim on their thankfulness, a gratitude that was to be shown by loyalty to the government and by loyal pro government votes in elections.

His program was financed by premiums from participants with some employer and state contributions. His scheme only provided a minimum level of medical service because only a minimal service was available, but Bismarck's pattern was adopted by a number of countries during the early years of the 20th century. However, the social security schemes built on the Bismarck pattern were not geared financially to accept the change from preventive to curative medicine, with its consequent increases in expenditure.

Additional moneys could not be allocated for health insurance because of more pressing demands on limited funds. It was not politically possible to demand that employees and employers increase their contributions, so substantial reductions were made in the benefits provided and in the method and amount of payment to doctors. A few countries did learn something from the failure of the Bismarck plan. In 1945 France introduced a program which did not attempt to provide insurance against the full expense for medical services. Payment to the participant represented 80 per cent of the cost of the medical services, if obtained from a physician who by contract had agreed to charge not more than a scheduled amount. The participant, if he wished, could obtain services from a private non-participating physician and receive the same amount of reimbursement, but of course under these circumstances he was required to make a larger contribution from his own resources since the fees of private physicians were likely to be higher.

Norway and Sweden adopted arrangements similar to those of France, insuring all, or almost all, of their populations and providing an indemnity basis or a reimbursement basis. Both these countries amended the French system to suit their own specific purposes. Both schemes have worked out reasonably well. One other country has avoided a major degree of compulsion and has used a government subsidy of much smaller proportions. This is Switzerland. Switzerland has a large group of health insurance associations of varying size which, for the most part, provide health insurance on a voluntary basis. In addition to premiums of subscribers, these organizations receive a subsidy from the federal government of approximately 15 per cent of their total expenditures. Under Swiss law participants in these funds are obliged to meet directly a proportion of their own medical care expenses, usually about 15 per cent.